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definition of service requirements. There is no exploration of how these fit with eligibility criteria or agencies' definitions of acceptable risk and need, in particular in work with involuntary clients in mental health and the criminal justice system.

'Care planning should not be seen as matching needs with services 'off the shelf' but as an opportunity to rethink service provision for a particular individual' (Practitioners' Guide, para. 4.12) This statement lies at the heart of individualised care planning. Separating the purchaser and providing functions ought in theory to free purchasers from conventional service provision and enable budgets to be used in creative ways. Early models of care management where care managers were provided with sums of money to maintain people in the community equivalent to the cost of residential care, were based on this premise. Indications from the SSI inspections, however, are that there is in practice little creativity around. The conservatism may be compounded by the inability of care managers to purchase outside lists of approved providers. The Practitioners' Guide recommends (para. 4.15) that 'where a practitioner is unable to accede to their preferences, users should receive a full explanation and be reminded of the complaints procedure' Similarly, where there is conflict in reconciling preferences and resources 'users may wish to avail themselves of independent representatives to promote their interests': Practitioners' Guide (para. 4.5).

### Establish preferences

The assessment of need and the provision of services are mediated not only by user choice, professional judgement and practical availability, but by the operation of eligibility criteria, as a means of prioritising who does and who does not have allocated to them a particular service. The Policy Guidance (1990, para. 3.24) lists service options in order of preference for 'preserving or restoring normal living' (as it is put). These are:

- support for the user in his or her own home
- a move to more suitable accommodation
- a move to another private household, e.g. to live with family
- residential care
- nursing home care
- long-stay care in hospital

Arguably, desiderata such as user choice were, from the inception of the new system of community care, never designed to take precedence within care planning. Price Waterhouse in their (1991) report for the Department of Health entitled 'Implementing Community care: Purchaser, Commissioner and Provider Roles' placed 'client choice' first on their list (para. 2) of reasons for favouring a purchaser provider split. The purchaser/provider split would 'facilitate increased client choice through the empowerment of care managers' (*not* the empowerment of users) (para. 10). They went on to say: 'It is important to remember that the empowerment of care managers on behalf of clients does not mean absolute client choice. Professional views, departmental policy, budgetary constraints and availability will all have a major impact on the package of care provided.' Operational and strategic imperatives may thus overcome both user choice and professional judgement. For example, cost efficiency in the provision of in-house day care may make that a preferred option over use of the independent sector. Departmental policy may determine who gets what type of resources within those available.

Eligibility criteria are used to target resources onto those deemed to be most in need of them, 'need' being seen as a cost-benefit concept. The question of who should be in the target groups is based on the valuation of outputs, for example keeping people out of residential care. Prioritising need in this way has led to a reduction or non-availability of services for some people. As resources become more limited, so people with lesser needs may find that they no longer qualify for a service, or a service previously provided such as domestic help, is no longer available. Discretion also remains in how to meet needs. For example, the provision of residential care for someone who would otherwise need 24-hour care at home, would be a proper use of discretion in the allocation of resources. However, rigid adherence to a policy that no more than a certain number of hours of home care would be provided at home, would be an unlawful fettering of discretion. Given the individualised nature of assessments, each case would still have to be dealt with on its merits.

The care plan itself is operational through the system of commissioning or contracting for care. It is one of the paradoxes of community care that where local authorities purchase care on behalf of service users, it is the local authority who is the customer or consumer with purchasing power, and not the service user himself or herself. An inevitable tension is thus created between the economic and social objectives of care

management: managing the budget versus advocacy for the best interests of the service user. Mares (1996) identifies a new range of business skills needed by care managers. These are handling contracts, costing care packages, negotiating prices with providers, monitoring the quality of service and sourcing suppliers. In addition, care managers should be aware of the 'cost' of their own time involved in such activities, as well as that of other professional colleagues such as occupational therapists or home care managers whose skills and resources they may wish to include in the assessment.

Care management fits in with the purchasing of services at the strategic level through the use of standardised service specifications and model contracts, so that the front-line worker negotiates only the details of the individual service to be provided to the user, based on the care plan. Thus the local authority may have a list of approved providers of, say, residential care or day care who are already contracted to provide a certain number of places for local authority nominees according to pre-set quality standards concerning, for example, staffing levels, size of accommodation and activities provided. Fine-tuning may then take place around the choice of particular room lay outs or activities to be provided.

There are three main types of contract that local authorities employ (DoH, 1993b):

- block contracts, where the purchaser buys access to a part of the whole of a service or facility for a specified price
- cost or volume contracts, where a volume of service and a total cost is agreed and any additional service is provided on an individual price basis
- individual or spot contracts where the purchaser contracts for a service for an individual user for a specified time at an agreed price

Each of these types of contract combines different risks for the provider, and varying degrees of flexibility for the user. Care managers need to know what type of contract is favoured by their local authority in what sort of circumstances.

Most local authorities have not devolved budgets down to the level of the individual care manager; the possibility of strategic planning is usually preserved by some centralisation of budgets at team manager level or above. Nevertheless, decisions made by individual care managers to choose a particular care provider will influence the pattern of future supply. Transaction costs involved in negotiating with a range

of different providers may militate against variety in provision and bulk purchasing of resources.

Mares (1996) sees purchasing decisions as being based upon the notion of 'best value' – a balance between quality and cost. Care managers remain accountable, in purchasing decisions, as elsewhere, for their professional judgement in making placements or providing services. Best value may not mean selecting the cheapest service, but balancing cost against quality of service provided. It is also useful for contracts to contain a degree of flexibility on such matters as, for example, the timing of visits in a contract for domiciliary care. This means that detail can be agreed between the provider and service user without having to involve the purchaser. It is good practice to append a copy of the care plan to the contract.

It was indeed one of the hopes of community care policy that innovative services would be developed, and Community Care Plans have to specify how independent providers have been linked in to planning for service development. Mares (1996) identifies a key task of care management as 'sourcing suppliers' where 'sourcing' is a business term which means identifying sources of supply. Thus a key difference between traditional social work and care management is seen as the activity of seeking out potential new resources and working out which will provide the best solution for the individual user within the budget available. Traditional social work, by contrast, involves co-ordinating existing services and liaising with other agencies.

### EXERCISE

Find out what services are available locally for supporting service users in their own home. Relevant sources may be the statutory sector, voluntary sector or private providers. Services may include domiciliary care, befriending schemes or recreational activities. You may wish to focus on one particular group of people such as older people, carers or people recently discharged from hospital. Information thus gathered could be put together in the form of a reference book to assist in care planning.

### A critique of the applicability of accounting practices within community care

Lapsley (1996) considers this new visibility for accounting measures and models as part of a much larger phenomenon within the public

service objectives a care plan is not a document fixed in time, and should contain within itself a date for its own review (often six or eight weeks hence depending upon administrative practice), or a statement of the contingency factors which would trigger an earlier review.

The basic question to ask is whether the service has been effective in the sense of achieving its objectives. The objectives of the service are the goals which the service seeks to achieve, such as retention in the community or a problem-free discharge from hospital. Describing social care services in terms of inputs, process, outputs and outcomes is an approach which has been adapted from business management. The advantage of specifying services in these terms is that it enables service planners to analyse more closely the way in which particular services achieve results (Mares, 1996). Review enables authorities to check that objectives are still relevant and are being achieved.

The personnel involved in the review may be different from those involved in the assessment. Some local authorities have appointed people specifically to work as 'reviewers', particularly of residential care, whilst others have delegated review functions to provider staff. There are practical difficulties, of course, in breaking continuity by allocating different functions to different personnel, particularly where review staff may be less well qualified than assessors, and where providers may have a financial interest in continuing services. More fundamental, however, is the presumption (or so it seems) in favour of short-term rather than long-term involvement by assessors and purchasers of service. Some of the dynamic nature of assessments (Coulshed, 1991) must inevitably be lost in this process, and the opportunity for methods of intervention such as the psychodynamic, which are based on a continuing and evolving relationship with the client, are lost. The problem has been particularly noted in mental health services (Huxley, 1993).

#### Co-ordinate the plan

The co-ordination and implementation of the care plan is the fifth stage of care management; 'the guiding principle of implementation should be to achieve the stated objectives of the care plan with the minimum intervention possible' (Practitioners' Guide, para. 5.1) Minimum intervention is defined however not in terms of values, such as self determination and empowerment, but in utilitarian terms minimising

the number of service providers involved. The example given is of introducing 'generic care workers who perform a range of tasks that have traditionally been divided between home care and auxiliary nursing staff'. (Practitioners' Guide, para. 5.1) This certainly has been a feature of some care management projects, most notably Darlington (Challis *et al.*, 1995) but is in itself not uncontentious, given that health care is that which is provided free at the point of delivery, although social care has to be paid for by financial assessment.

Implementation is viewed solely in terms of securing necessary resources or services, not in terms of targeting change within systems. The radical perspective on personal issues as consequences of structural deficits cannot be accommodated within this definition of implementation. The care plan is viewed as a closed system, individualistic in nature. The preferred role for the practitioner is that of social care planner, not service broker. The task is then to garner together the available services, within the limitations of a budget, during which process 'the practitioner is accountable to both the user and the agency'. (Practitioners' Guide para. 5.3)

The possibility of conflict between user and agency is not addressed. What the user seeks, the agency may not be able to give, or may disallow on the grounds of policy or cost. Alternatively the agency may be seeking to impose a service that the user does not want but which is deemed necessary for his or her protection, or to monitor her or his progress; supervised discharge from psychiatric care, is a case in point. Where legislation imposes protective duties upon the local authority, tension will inevitably exist between client empowerment and professional accountability.

Services contributing to a package of care may be nothing more than a listing of conventional service provision. Kathryn Ellis in her (1993) research into user and carer participation in needs assessment 'Squaring the Circle':

was continually struck by how marginal the support provided by social services or any other community-based services was to most people's lives; those needs which had not been addressed or even on the agenda were frequently the most significant. The fact that several people with disabilities were unable to get jobs, that a man with a progressive illness could not find suitable transport to get him to school where he had wanted for many years to do voluntary work, that several older people were isolated and housebound, that a

woman with learning disabilities did not have the support to live more independently, that many people were struggling to manage on low incomes, that several carers had to juggle work and caring to maintain the household income – these were priority issues. (Ellis, 1993, p. 41)

It is arguable that only a minority of these issues are the responsibility of social services departments as statutorily defined and thus within the proper purview of any system of care planning (Davies, 1994). However, by framing people's experience solely in terms of the limited context of community care, their aspirations about overall life-style are not considered, and an opportunity has been lost for the definitions of need used in assessment to be used to encompass a broader slice of people's lives (Ellis, 1993, p. 41). This should be what 'negotiating the scope of assessment' (Practitioners' Guide 1991, para. 3.3) really means, if as the guidance says, 'the individual's needs are to be seen in their proper social context'. Certainly, for a comprehensive assessment (to which people with disabilities are entitled), the Practitioners' Guide (1991, p. 58) suggests that all of the following issues are covered: self-perceived needs, abilities attitudes and life-style, race and culture, social network and support, housing, finance, transport and risk. One would expect then that care plans would mirror such agendas.

In the provision of resources to meet needs identified in the care plan, authorities should be free to use a variety of providers and should not be constrained by conventional patterns of service organisation. This is what needs led assessment really means. So a need for social stimulation will not necessarily be met by a day centre place; it may be met differently by the provision of transport and a facilitator to enable someone to visit family or friends. Prior to the introduction of community care, there used to be difficulties with 'out of authority' placements that local authorities would not fund. With the opening up of markets in social care, this should no longer be a barrier; however, a report from the local government Ombudsman (94/C/3690) into a complaint against Trafford Metropolitan Borough Council shows that this is not necessarily so. The case concerned the provision of day services for a young physically disabled man who had just left college; the only day centre for physically disabled people within the borough was unsuitable because it catered chiefly for older recently disabled people with better social skills. It was only when the man's parents took the initiative themselves that he was allocated a place at another centre

outside the borough. The local authority was criticised for not having a policy on how and when it would find services outside Trafford. Failure to consider provision elsewhere was maladministration.

### Identify unmet need

Care management was conceived as a cyclical process (see Figure 2 p. 13) in which feedback from the user of services was incorporated back into the planning stage. Important for the success of this process is how to identify and what to do about unmet need. The Practitioners' Guide (para. 4.35) acknowledges that need may remain unmet for a number of reasons:

- resources are unable to meet demand
- the quality and type of service is irrelevant to need, or unacceptable to users
- the conditions of service are inappropriate to need, for example, no weekend cover.

'There will continue to be situations in which there is a mismatch between the solutions provided by the existing services and the solutions identified by users, carers and practitioners. Care planning has a contribution to make in minimising this mismatch by defining the disparity and promoting the appropriate changes in service' (Practitioners' Guide, para. 4.36). Para. 4.33 of the Practitioners' Guide sees a benefit in differentiating between types of unmet need, including those that are:

- statutory obligations, for example, those included in the Disabled Persons Act 1986
- defined as entitlements under local policies, for example, failure to provide services within defined timescales
- current policies or criteria, for example, the emerging needs of those with HIV/AIDS.

There should also be a ready means of prioritising these unmet needs (para. 4.34). Certainly, the consequences of failing to meet these categories of need will be different. The identification of new needs is an issue to be raised for consideration when community care plans are revised. Failure to achieve internal targets, or those devised externally, for example by the Citizen's Charter, will attract the

attention of local authorities' own Inspection Units, but failure to fulfil statutory obligations is both a major cause for concern at an organisational level, as well as being open to challenge by individuals through litigation (see Chapter Six).

### Record the care plan

Fine-tuning the care plan against standard service specifications is thus one aspect of quality assurance. The translation of care plans drawn up by care managers in the community into care plans within day care and residential care has not been much considered. Even before the purchaser/provider split, the worlds of community and day/residential care were largely separate spheres of influence. The consequences of such demarcation is that evaluation of progress against goals set becomes more difficult. It is desirable therefore that the two systems are brought together with the care manager from the community being involved in the drawing up and review of the care plan in residential and day care.

When people move, as they frequently do, between the community and the hospital and residential care, it is essential that information travels with them: this may be biographical information, information on medical needs, or the care preferences of the individual – the food they like to eat, the time they like to get up in the morning. Recording of the care plan is an important final step in clarifying agreement between the care manager, service user and service providers on the objectives of the care plan and the means of achieving those objectives. Doel and Shardlow (1998) identify four specific purposes behind recording information. These are: procedural, investigative and speculative, personal, and providing continuity. As far as care plans are concerned the procedural aspect – the providing of an accessible account of past processes and agreements – is uppermost. The investigative and speculative function of recording will be important when complex situations are being explored, as in cases of suspected abuse. The personal aspect of recording underlines the value of life history and is linked to client access to files. Both this and the function of records in ensuring continuity of care are important in long-term work.

The local government Ombudsman has stressed the importance of operational policy for adult residential care, for which individual care plans are an important element. In investigating an allegation of neglect

in residential care (investigation 94/A/3636 against Lambeth London Borough Council) the Ombudsman said, referring to care plans in residential care: 'they are a necessary part of ensuring that each individual's needs are not lost once they are admitted to an establishment. They are vital for preventing institutionalisation . . . care plans are a continuous process'. It was also seen as important that problems should not be allowed to drift, and that any issues should be discussed at an early stage with residents and relatives. A care plan should facilitate an episode of residential care becoming a positive experience. Accordingly: 'An important factor in a care plan is to establish the resident's potential and areas of vulnerability so that full potential can be realised during their stay.' It goes without saying that any incidents (in this case, falls) should be recorded, and that a management system should be in place to allocate responsibility for asking for medical assistance.

### Social work interventions: risk and protection; support and care

The social worker as care manager will, by virtue of his or her professional role, be involved in the social work agendas of risk and protection as well as support and care. The care plan will be an important tool in risk assessment and risk management. Organisational constraints on purchasers may limit opportunities for further direct work to be undertaken with individuals once tasks have been identified for action within the care plan. Longer term therapeutic involvement may be seen as a provider service to be bought in, rather than as part of a holistic process. The relevance of both risk assessment and protection, and support and care, to the process of care planning are discussed below.

### Risk and protection

Care planning around issues of risk involves matters of judgement which are informed by cultural values and norms, as well as by professional accountability within a statutory framework. The Children Act 1989 quantifies risk in terms of significant harm as the threshold for statutory involvement, but there is no exact equivalent in adult care. Nor are there complex procedural arrangements for assessing risk,

## Monitoring and Review

The evaluation of outcomes, monitoring and review are essential components of the 'production of welfare' approach to care management exemplified by early research into community care in Kent and elsewhere (Payne, 1995). The successful evaluation of outcomes of course depends upon the clarity of objectives at the care planning stage, where clear goals are specified and strategic plans are worked out in order to achieve those goals. The monitoring process will then check that services are on target to meet those objectives. A review, however, is an opportunity for change by allowing participants to stand back and reconsider what those goals should be, adjusting interim plans accordingly. Any method of social work practice which fits this model will need to give as much emphasis to monitoring and review as to initial assessment. If a mechanistic approach is taken to case monitoring and review, the complexities of relationships involved in supporting people in the community can become stereotypical. Short-term pragmatic issues will also tend to predominate over long-term aspirations. Searching for Service (SSI/DoH, 1996a) identified this as a particular problem for young people with a learning disability, where 'getting through the week' took precedence over the longer-term evaluation of educational and social needs. Monitoring and review are thus essential tools for good social work practice. They also assume that the effectiveness of social work intervention can be evaluated. Proper monitoring and review means that care packages should be reviewed as a whole and not, as they often have been, by way of separate reviews, for example, in residential care and day care. The contribution of day care, home support services and residential care is however evaluated in this chapter in terms of their efficiency and effectiveness in supporting vulnerable people in the community, and in the recognition of their pivotal role in contributing to care packages.

### Monitoring

The Managers' Guide (1991, para. 2.29) makes it clear that systems of monitoring (and review) need not involve formal meetings, but can be undertaken in writing or by telephone. However, the important principle (para. 2.30) is that, wherever possible, monitoring and reviewing should be undertaken by someone who does not have a direct stake in the services provided. This enables quality issues to be effectively addressed, and services to remain needs-led. The regular reassessment of changing perspectives and priorities in progressing towards agreed aims and the effectiveness of arrangements with adults, carers and groups is one of the evidence indicators within the practice requirement 'sustain and maintain working relationships'. It emphasises the continuing nature of the responsibility for service delivery.

Some users of service may move in and out of the system. This is particularly true for people with mental health problems (Huxley, 1993). Huxley regards care management as failing people with long-term but fluctuating needs and attributes this to the choice of an inappropriate administrative rather than a clinical model of care management. In the clinical model direct face-to-face work is undertaken by the case manager which is not only more effective therapeutically, but also enables continuous monitoring of relapse to take place. Huxley also commends Quality of Life Assessment (QOL) as developed by Oliver (1991) as a systematic tool for social workers to assess outcomes for patients living in the community. Results of the application of quality of life assessment to community services show that community treatment is more popular with service users and (in terms of public accountability) can improve mental health and social relationships, though it also highlights deficiencies in regard to meaningful occupation, consistency in the quality of residential care and high levels of poverty. The application of Quality of Life Assessment is also empowering of service users insofar as it puts their views on community care at the centre of service provision and planning (Oliver, 1991).

Raiff and Shore (1993) emphasise the long-term nature of care management systems in the United States and their particular appropriateness for people with long-term chronic conditions. They discuss involving family members as active partners in the monitoring of services and as proactive 'case management extenders' in pulling in other resources. With regard to the monitoring function, consumers and family members should be specifically asked if they think that services

are making a difference, what they would like the next steps to be, and whether they are at this time feeling over-involved and burdened. The opportunity should also be taken to provide up-to-date information about new resources and issues. The valuable interventions are those that build on family strengths rather than correcting deficits, and those that support family decisions and consciously attribute successful outcomes to the family's, rather than the case manager's, efforts (Raiff and Shore, 1993).

### Review

Statutory reviews are familiar processes to social workers in child care, and intervals between reviews are fixed by regulations in the case of children looked after by the local authority. Reviews may be presented as important decision-making occasions, but Thoburn (1986) challenges the view that a review is predominantly a decision-making occasion, pointing out that it is often the 'small' decisions made in the intervals between reviews that alter the outcome of a case. The issue may be whether for example to spend money on supporting visits by the family, or whether to extend the child's network by involving other significant persons in the community. Reviews in community care are not statutory; there is nothing in the National Health Service and Community Care Act 1990 that requires reviews to be held. There has, however, been an administrative tradition of holding reviews for separate services such as day care and domiciliary care. As the Managers' Guide (1991) admits (para. 2.30), reviews have in the past been accorded low priority, so have either not taken place or have been subject to considerable delay. Preliminary findings from SSI inspections of community care services (1993) have referred to the 'review time bomb' as energies have been focused on assessment, rather than review. This can mean that services are being provided where there is no longer a need, or are not adapting to changed circumstances. The Policy Guidance (DoH, 1990a) reaffirms the importance of reviews in adapting services to changing needs of users and carers in a formal way.

Termination of social work involvement or of a particular service is an issue not much dealt with in the literature; much more attention has traditionally been focused on beginnings rather than endings. Raiff and Shore (1993) acknowledge that 'planned termination of advanced case management services to targeted high-risk clients is often an ethically

and politically difficult decision, implying a judgement that a client's gains have been maximised or that a prediction of risk warrants this decision' (p. 60). A number of different reasons for termination are identified by Raiff and Shore:

1. Spontaneous client-initiated requests for termination, or de facto 'drop out'. Either of these may signal incompatibility between the client and the worker or the programme and may require a good-faith demonstration of worker outreach to re-engage the client;
2. A request for termination as a healthy sign of client gains and growth in self-confidence;
3. There is some evidence that involuntary termination is occasionally used by the worker as a confrontational, last-resort tool to precipitate a crisis to re-engage 'uncooperative' clients.

More generally, the process of disengagement includes follow-up to ensure that a smooth transition is experienced and that achieved goals can be sustained, leaving the door open to possible return if a change of circumstances should occur. Making a more effective or expanded use of available networks is often a precursor of termination of involvement with formal services.

The ability to successfully disengage from relationships with children, young people, adults, carers and groups, is one of the evidence indicators within the practice requirement 'sustain and maintain working relationships' within the core competence 'intervene and provide services'. As such it links with an earlier evidence indicator under the same practice requirement 'identify and agree estimated time-scales for work and the conditions under which contact will end'. This shows the value respectively of being clear at the outset about the limits of involvement and the nature of the relationship, something which is especially important with students whose work on placement is necessarily time-limited. It also requires a criterion for success, or at least adequate progress, to be fixed at the outset; something which is fundamental to partnership and which enhances self esteem and confidence in the service user (Marsh and Fisher, 1992).

### What happens in practice?

There is evidence that in practice the tasks of monitoring and review are sometimes confused, to the detriment particularly of the monitoring



task. Mencap in their (1995) survey of service provision under community care noted the absence of clear local authority strategies for monitoring and attributed this partly to a paucity of government guidance on the issue. Only two out of thirty carers said that their care manager had told them about monitoring or how it is applied. Sometimes monitoring was substituted by review with little opportunity to discuss or alter service provision in the interim.

The purchaser/provider split may have attenuated the withdrawal of assessors from the monitoring task. An example of inadequate monitoring of a care plan, exacerbated by the purchaser's withdrawal from responsibility for this task, is seen in a report from the local government Ombudsman (complaint no. 94/A/0562) which led to a finding of maladministration against Newham London Borough Council. In this case a disabled woman with complex and rapidly changing needs was allocated predominantly a home care service for both cleaning and personal care. Once the original care plan was agreed, responsibility for monitoring was put on the provider team which, because it was a provider team, had difficulty accessing the assessment team when the care plan began to break down. It also appears that insufficient flexibility was built into the original plan to deal with contingencies such as the complainant suffering further ligament injury and needing additional care. The care manager was also not readily available to respond to queries from home care assistants about the tasks included in the care plan, and to be aware that the service received was sometimes erratic.

Close liaison between care managers and home carers who are closest to the day-to-day issues is easily lost if lines of communication are cut by the purchaser/provider split. It is also difficult to monitor a total package of care if provision is divided amongst a number of agencies. Evidence from Age Concern Scotland (Robertson, 1995) is that service users are keenly aware of the intimate and detailed knowledge that domiciliary workers have about their circumstances, and wish this information to be fed back directly into care management systems.

### Evaluation and effectiveness

How do we know that the work we do and the services we provide are worthwhile? It may be possible to measure the effectiveness of a service in achieving a certain outcome, whether that is an older person

### EXERCISE

Gary Lewis is 19 years old and has just begun a computer course at his local College of Further Education. Gary has cystic fibrosis and is a wheelchair user. He currently lives with his parents who assist with personal care and physiotherapy. The need for such assistance fluctuates from week to week; sometimes limited help is needed; at other times, a lot of assistance is required. Gary is talking about leaving home to live with his friend Jack, whom he has met at college. Jack would not be able to provide the kind of assistance that Gary's parents now provide. Gary approaches the local authority for assistance.

Assuming that a package of care could be set up, what arrangements would need to be put into place for such a package of care to be:

- (a) monitored,
- (b) reviewed.

remaining in the community rather than moving into residential care, or the achievement of funding for a carers' support project, but such 'effectiveness' is not the whole of the story. For some clients, process – the human value of being there and appearing interested and supportive – is as important as a tangible output, particularly for clients with chronic needs whose circumstances are not easily changed (Sainsbury, 1975). Cheetham *et al.* (1992) also urges us to differentiate effectiveness from evaluation. Evaluation judges the intrinsic worth of an activity, rather than its outcome. This acknowledges that social work can be about caring, not necessarily about helping, in the same sense as a medical model is about treatment and cure. With this in mind, we can evaluate the contribution of different sorts of service.

### Evaluating day care

Day care services have always played an important role in maintaining people in the community, but the advent of community care, with its emphasis on individual care planning, contracting and inter-agency co-operation provides an opportunity for a reappraisal of why such services exist, for whom and with what effect.

There are a number of different models of day centre functioning (Seed, 1988), but even though objectives may be stated in terms of only one or two models, the competing needs of users and service systems

Adams (1998) sees care management as changing the nature of social work practice towards proceduralism and away from theory-based and value-driven aspects of critically reflective practice. This is reflected in the competence based approach to student assessment which emphasises outcomes and performance rather than learning. The practice teacher will then have to mediate between the student's learning needs and the standards of service that the agency has to guarantee. Doel and Shardlow (1998) locate this firmly within the notion of accountability. They see the student's learning experience being underwritten in a number of ways within the agency. These underpinning factors may be subject to change in a system such as community care where there is increasing managerial control (Doel and Shardlow, 1998, p. 9).

- how much autonomy and responsibility do front-line workers have?
- do service users feel they are dealing with someone who can make decisions?
- how flat or deep are lines of accountability?
- how does the agency monitor the quality of service to users?
- what support systems are there for agency staff in terms of professional supervision, personal support or group support?
- who carries the can?
- who gets recognition?

### Working with other professions

Close liaison with other relevant professions – in education, in housing and in health care – has always been an important feature of social work, whether with children and families or with adults. The advent of community care has made the need for that liaison more apparent, whilst fudging the boundaries between different professional groupings. The resulting dilemmas are neatly summarised by Øvretveit *et al.* (1997) as: 'how to assess needs and work together with different professional languages, how to shift from profession-services to more interprofessional working, and how to combine team leadership with profession and agency management services' (p. 6). Øvretveit sees the key issue as defining the 'team' and its purpose. Managers must first of all clarify whether a team exists for client co-ordination (referring on to each other and working in parallel), or for a collective service (with

shared responsibility and authority). Teams vary on a continuum, from the highly integrated where the team's priorities are the strongest influence on the individual's work decisions to a network team which, though it may see the same 'type' of clients, is organised as a collection of disparate professional services each under its own management with its own policies, priorities and procedures. The former are multidisciplinary teams the latter are interdisciplinary. Examples of each can be found in services for people with disabilities and mental health problems. *Interagency* working, by contrast, is not dependent upon teamwork, places less emphasis on professionals working together, and concentrates rather on strategic issues and planning.

Øvretveit sees inter-professional working as valuable for a number of reasons (the first four of which draw upon work by Hallet and Birchall, (1992), in child care but which are relevant to the objectives of community care). These are:

1. Avoidance of duplication and overlap.
2. Reductions of gaps and discontinuities in services.
3. Clarification of roles and responsibilities.
4. The delivery of comprehensive, holistic services.
5. The promotion of a service driven by objectives and outcomes rather than by professional interests.
6. The potential for replacement of staff with closely supervised ancillaries.

On the other hand, Øvretveit sees some disadvantages in interprofessionalism:

1. A reduction of choice in the absence of a diversity of assessment and service.
2. The possibility of collusion against the client which is difficult to challenge.
3. A reluctance to pursue risky or novel solutions.
4. Inward-looking attitudes.

This greater emphasis on 'what gets done' rather than 'who does what' (Øvretveit) in multidisciplinary assumes a consensus model of working based on similar values and priorities. The major test of such co-operation is whether it can survive conflict. Dimond (1997) explores such conflicts in relation to legal rights and responsibilities. If a patient discharged from a psychiatric hospital, following involvement by a multidisciplinary team, commits a serious offence, who would be held

responsible for his or her discharge? The answer would be: the psychiatrist in charge of his or her case. Given this, it is not surprising that such a person would seek pre-eminence in decision-making and would suggest resources that are within his or her control. In the case of nurses working in a similar role to social workers, the nurse is bound by the UKCC not to work 'beyond the limits of her competence'; thus professionally-imposed limitations have the effect of restricting the transfer of skills. This has implications, of course, which favour the survival of distinct professional groupings in community care.

#### The status of social work within community care

Official statements on care management do little to clarify the status of social work within it. Neither the Griffiths report (1988) nor the White Paper (1989) nor the Policy Guidance addresses in any detail what the role of social work is intended to be. Bamford (1990 p. 159) was prepared to contemplate that this was because: 'the new role envisaged in designing, organising and purchasing services is so fundamentally different from that currently performed that a wholly different approach is required to which social work has a contribution to make.' Post-implementation surveys of social workers within a care management system have found major dissatisfactions with the bureaucratisation of the social work task. Both Macdonald and Myers (1995) and Petch *et al.* (1994) found widespread dissatisfaction with form-filling and the disempowering nature of the paperwork required to be completed. Lewis and Glennerster (1996) found that front-line workers were less enthusiastic than their managers about the community care changes and cited form-filling, hospital discharge procedures and the movement away from counselling as major sources of dissatisfaction. Managers themselves were showing a tendency (observed also by the SSI in 1993) (SSI, 1993c) to retreat from their professional role as 'supervisors' into a role as managers of budgets. Professional leadership in teams was thus being lost. The move from consensus management to general management not requiring professional qualifications for appointments which began in the NHS in the mid 1980s after the first Griffiths report is now being seen in SSDs (Simiç, 1996).

Lyons *et al.* (1995) in a survey conducted in 1993-4 of social workers' career patterns found that social workers' reactions to recent changes in their working patterns were closely related to their work

settings. Probation officers, for example were highly critical of national standards, which were seen as limiting professional freedom and supporting the control/policing role. Social workers in child care, however, were approving of changes introduced by the Children Act 1989, which were seen as clarifying the role of the social worker and as addressing power imbalances with families. Social workers in adult care were hostile to the introduction of market principles and felt that flexible and locally based responses were inhibited by rigid and bureaucratic structures. Hospital social workers felt estranged from the process of consultation being carried on in social services departments and were also affected by difficulties occurring in the NHS. Workers in fieldwork teams felt that they had less opportunity for casework; they were deskilled by dealing only with assessments of a very proscribed kind and felt that their jobs were being reduced by the bringing in of other occupational groups. A feeling that social work was being fragmented was widespread, and led to an inability on the part of social workers to define and have control over their work. The overall experience of change as positive was however related to membership of an autonomous and reasonably well-resourced team with a specific remit, such as HIV/AIDS, working in a local authority where political values were consistent with the worker's own values, working in a rural area where community links and networks were more easily developed and maintained, and either recent, relevant training or a background in finance or development work. A willingness to see oneself as a change agent and to push forward new ideas was a positive view of community care which was also related to job satisfaction.

An alternative to seeing care management as a new role in social work is to see it as a new task (Petch, 1997) or an innovative method of working to be used alongside other methods of working. Superficially, this argument might be attractive because there are many features which care management has in common with traditional social casework in its emphasis on assessment, care planning, implementing, monitoring and reviewing as part of an individual care plan. To equate care management with social casework is, however, to divorce both from their historical context. As Simiç (1996) points out: 'it is not the method that distinguishes care management from casework, it is the social and economic context in which it is employed and the way its resources, intellectual, emotional and material are developed' (p. 13). Biggs (1991) sees care management as ultimately unworkable because it views interpersonal relationships as unproblematic; it is therefore

fatally dismissive of a major method in social work practice – the psychodynamic. Anyone who has worked with carers under stress against a background of difficult family relationships going back over a number of years knows this to be true. It is the focus of Hughes' (1993) work on the assessment of elderly people in the community, and Parker's (1993) study of disability in marriage. To regard such problems of living as purely practical is to throw expensive resources at problems which they will not be able to resolve. Yet it is a common fault of social work practice, particularly in assessment, to oversimplify problems in this way (Ellis, 1993).

#### Skills training in community care

The skills required of social workers in community care are a mixture of the old and the new. Smale and Tuson (1993) begin from the premise that there are particular skills that social workers need if their goal is not to be 'expert professionals' but facilitators of full participation in the way in which assessments are carried out. This includes skills in the process of assessment involving complex negotiations based on:

- expertise in facilitating people's attempts to articulate and identify their own needs and clarify what they want;
- sensitivity to language, cultural, racial and gender differences;
- the ability to help people through major transitions involving loss;
- the ability to negotiate and conciliate between people who have different perceptions, values, attitudes, expectations, wants and needs.

All of these things are of course major attributes of the social work task, and this has led Sheppard (1995) to see social workers as particularly well-suited to carrying out the tasks of care management. Challis (1992) challenges the view that community care is concerned simply with the efficiency of systems and looking back over the historical development of community care projects, notes that:

The experimental inputs of the most successful projects were ideational as well as structural. They were substantially about commitments, values and skills. What the structures (including the resources) were intended to do was to enable and encourage people

to apply the commitments, values and skills of the new community care philosophy; that is, provide the incentives and rewards which harness individual motivations to achieve the equity and efficiency goals of public policy. (p. 118)

CCETSW (Best, 1994) offers guidance on training for purchasing and contracting skills, probably the most technical of care management skills, which at the same time incorporates ethical practice into an understanding of roles and tasks:

Students who have successfully completed qualifying training in social work can be expected to understand the nature of health and local authority enabling/purchasing role, the characteristics and composition of the statutory, voluntary, private and not-for-profit sectors. Students should be expected to engage with the inequalities arising in purchasing through competent ethical practice. They should know how to make a contribution in the purchasing and contracting of social care services – with supervisor support in collaboration with other disciplines, service users, carers and relevant representatives. (p. 41)

Students should be able to evaluate whether services take into account ethnically sensitive and cultural considerations, whether they recognise users' and carers' rights of choice, and whether they provide opportunities for those aggrieved to seek representation through advocacy, complaint or legal redress.

#### Social casework in community care

The medium through which services are to be delivered within community care is 'the package of care'. To what extent is this also an innovation?

Smale and Tuson (1993, p. 26) emphasise that in care management as elsewhere, 'social services and social work intervention are a response to the nature of a person's social relationships'; thus the relevant assessment is not that of individuals, but of social relationships. They point out that for most people the rudiments of a package of care already exist in the form of support provided by family, neighbours and involved professionals such as the GP. The basic task

predicated upon the labour of women, particularly as women are also assumed to have the major responsibility for the care of children. Suggestions of a return to communal or institutional care are however resisted by Morris (1993a) who sees such a movement as divisive and discriminatory against disabled women. Less emphasis on 'care' and more on 'enabling' would seek to remove the negative connotations of exploitation and dependency. 'Caring about' as a replacement for the notion of 'caring for' humanises the situation being described and gives it dignity. The situation of children who care for adults in the same household is, for example, often interpreted narrowly as 'caring for', with concerns focused on the appropriateness, or otherwise, of the tasks that the child is undertaking, and on abrogation of the parental role. A more positive approach is to discuss each of the participants' feelings about the situation: there may be a good deal of 'caring about' going on, with the child wishing to contribute to the household, and the parent concerned for and involved in the emotional development of the child (SSI, 1996b).

The task for the social worker is to perceive how the system itself works: what sustains the carer/cared-for relationship, and what undermines it. Qureshi et al (1989) predicate that helping in its widest sense is characterised by exchange theory; in other words, people will calculate (consciously or not) whether what they gain from the relationship, in terms of satisfaction or reward, is worth the physical or emotional effort they put into it. As the balance will be different for each individual, and will change over time, exchanges need to be carefully monitored and, where necessary, supported. The Carers National Association has evolved a 10 Point Plan for Carers which seeks to quantify what most carers would want. These are:

1. Recognition of their contribution and of their own needs as individuals in their own right.
2. Services tailored to their individual circumstances, needs and views.
3. Services which reflect an awareness of differing racial, cultural and religious backgrounds.
4. Opportunities for a break, to relax and have time to themselves.
5. Practical help.
6. Someone to talk to about their own emotional needs.
7. Information about available benefits and services.
8. An income which covers the cost of caring.

9. Opportunities to explore alternatives to family care.
10. Services designed through consultation with carers, at all levels of policy and planning.

The Carers (Recognition and Services) Act 1995 gives carers who provide a substantial amount of care on a regular basis a right to assessment of their needs as carers. It is important that social workers bring this provision to the attention of carers, and that local authority eligibility criteria are designed with the needs of carers in mind.

Breakdown in the caring/supporting relationship is a more potent factor than level of disability in precipitating admission to residential care (Warburton, 1989). Research by Levin *et al.* (1989) has found that day care and respite care are services which are highly valued by carers of elderly people, and which enable them to carry on caring for longer. Nevertheless, social workers must be sensitive to a desire by carers to use such services to begin the process of disengagement from caring; not to be explicit about the purpose for which such services are being used means that social workers and carers may be working to different agendas.

### Community responses

The interlocking nature of individual and collective responses to the problem of need was identified in the Barclay report (1982). Social Services Departments were seen as having failed to come up with strategies for linking statutory and non-statutory sources of care provision into a coherent plan. Community care planning enables, indeed requires, such a strategy to take place. It is the responsibility not only of departments but also of individual social workers to develop skills in 'exploring communities of interest which may be important to a particular client' (para. 3.30). For care management to operate properly it is important not only that individual's needs are understood, but that individuals, groups and organisations within communities are prepared and able to provide the facilities needed (Coulshed and Orme, 1998). The theoretical base is close to that of radical social work with its emphasis on collective action and a perception of individual problems as political issues. This is not to deny, however, that networks may have a therapeutic role to play as change agents in finding solutions to the problems of individuals and families.

Seed (1990) sees individuals as having networks which comprise layers of close, or more distant social involvement. This may be represented diagrammatically:

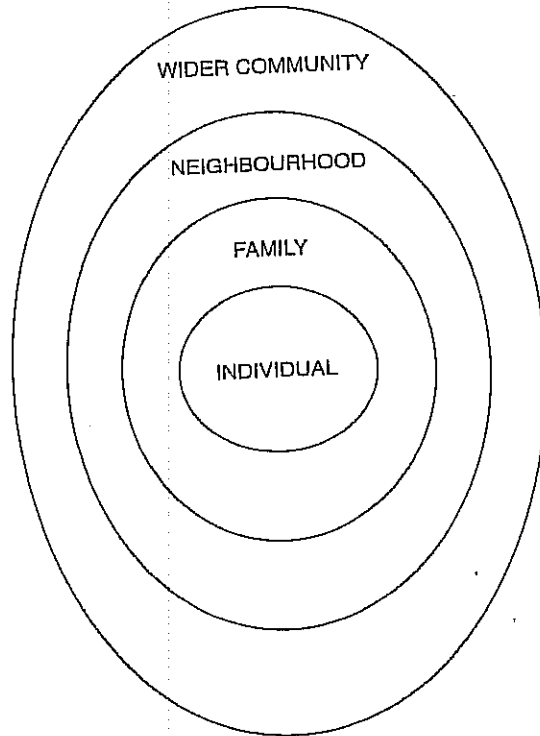


Figure 3 Social networks

The analysis of networking in social support systems has developed from systems theory, and offers a way of exploring how people's social networks operate in ways that help or hamper their ability to cope in the community. Network analysis has been successfully used to assist people with learning disabilities to move out of hospital care into the community; the role of the social worker being variously that of counsellor, mediator, planner or advocate (Atkinson, 1986). Its value to social workers is as a tool for understanding the social experiences of

clients and of composing a picture of the informal support systems that may need to be mobilised or even created (Reigate, 1997). A network might include close relatives, neighbours and friends, voluntary helpers, people with similar problems coming together in a self-help group, and members of formal organisations like churches or trade unions. Seed (1990) suggests that the keeping of a networking diary is a useful tool for keeping the client as the focus of planning, and illustrating the client's own ability to form networks in the community.

### EXERCISE

Construct a diagram to illustrate the social network of a person that you know (or of your own social network). What are the significant individuals and organisations within this network?

Smale and Tuson (1993) see social workers as being proactive in making community resources available: 'Care managers will have to work in partnership with local people to negotiate the need for, plan, initiate, support, sustain and maintain local groups, voluntary organisations and schemes for meeting certain people's needs' (p. 40). The core competence 'communicate and engage with organisations and people within communities to promote opportunities for adults, their families and groups, at risk or in need, to function, participate and develop in society' explicitly recognises this community development aspect as a competence. This is backed up by the evidence indicator: 'identify and evaluate the roles, responsibilities, policies and potential contributions of agencies, community resources, volunteers and other professionals.'

This echoes Goldberg and Warburton's (1979) conclusions from their study of social work in the aftermath of the Seebohm reorganisation in the early 1970s. With regard to work with older people, they concluded from an examination of case review records that local authority social services departments could only hope to provide very basic services for what was even then the growing number of very elderly clients. There was a major demand for information and advice, for example, on welfare benefits, which probably could be more rationally supplied through citizens advice bureaux or neighbourhood advice centres; there was need for specialist social work involvement in dealing with issues relating to grief and loss, or major life changes such as admission to residential care, and there was a need for heavy-end

domiciliary care and the provision of aids and adaptations. However, beyond this, occasional routine visiting by social workers was rarely an appropriate or effective means of support or anticipating approaching crises. 'Relief of isolation and loneliness, help with small chores, emotional and practical support to informal carers' would, they concluded, need to be provided by volunteers or 'good neighbours' under the sponsorship of either the statutory or voluntary sector. Similar convictions as to the appropriateness and a capacity for developing community support systems were behind the innovatory Kent Community Care Project (Davies and Challis, 1986) which provided the research evidence for the development of Community Care (see Chapter Two). In this project, local people with no previous caring experience were recruited to perform routine domiciliary tasks for frail elderly people and their main carers. Overall the project was seen to increase the likelihood of people remaining at home with an improved quality of life and at lower cost than conventional services. However, one difficulty within the project, and a reason for the later collapse of the community aspect of the scheme, was the low rate of pay given to helpers.

Finding, supporting and sustaining networks within a community can be a major part of the social work task. Also acknowledged is the fact that individuals, agencies, volunteers, community resources and other professionals within a network may have differing perspectives. Working with Difference (Home Office, 1995) is thus an important aspect of working within a community; structural factors such as gender, race and class may be more powerful in themselves than the inclusive idea of community. It is also necessary to acknowledge that people may have different motivations on a personal level for giving time, money and expertise to assist others, and that these need to be supported (Qureshi *et al.*, 1983). Some people may need time from the worker; some may need financial reward; some may simply need acknowledgement that they are doing a good job. Smale and Tuson's (1993) description of a package of care as 'a fluid set of human relationships' rather than 'a basket of goods and services' indicates the sort of social work skills in negotiation and counselling that may be needed here.

'Working Alongside Volunteers' (SSI, 1996a) seeks to emphasise the importance of clarity and commitment, co-ordination, equal opportunities and contract specifications in work with volunteers for Social Services Departments. However, this is very much a review of systems

and does not explore client perspectives on volunteering, or the community development potential of the role. Though volunteering is often seen as an individual activity, it can also be organised collectively through self help organisations and community groups (Payne, 1995), and may include people who are service users in their own right. Again, social workers will have to contribute positively to exchanges in the relationship, not simply take the benefit of the volunteer's time.

Payne (1995) explores the difference between community development work and community work. Community development work is based upon pluralism – the idea that formal authorities, though they have an important role in providing services and taking a lead in planning, are not the only bodies concerned with public welfare. Voluntary organisations and neighbourhood groups will play a significant role in developing a truly local response to need. The basic tenets of community development are therefore highly congruent with those of community care, though as Payne points out (p. 169):

The central conflict within community development is that between developing services and projects which respond to social services requirements, and promoting involvement in processes for community decision-making among people in particular areas or with shared interests, which may not reflect or may conflict with social services priorities. The evidence is that a degree of involvement in services and much better community responsiveness on the part of agencies can be developed. Genuine community influence or, to go further, control, may be much harder to achieve, even if it is desired. A distinction must also be drawn between the interests of the community as a whole and those of users and carers. There may be no interest in the particular needs of groups of users of community care services; priorities with other people may lie elsewhere.

Community development work is essentially proactive in developing community awareness as well as services or facilities, such as luncheon clubs or sitting services, so that carers can meet together. The role of the paid worker becomes one of a facilitator rather than a leader. Local groups, based around a common interest, can be helped to grow, enabled to use community facilities such as village halls or be given help in developing business-like tasks such as running a meeting or organising a budget. The most famous account of community social work in action is the 'patch' system in Normanton, Wakefield described by Hadley and McGrath (1984). Social workers working

on a 'patch' within a closely defined geographical area would acquire 'on the ground' information about the local area, would develop an accessibility to local people and forge strong personal links with other professionals in the area such as GPs, community nurses, representatives of voluntary organisations and churches. Community social work was endorsed in the Barclay report (1982) but is currently out of fashion. Payne (1995) would judge the effectiveness of community social work in terms of its major objectives of involving local people in decision-making and making locally-sensitive services available.

Community work per se is outside the ambit of social work insofar as community workers have their own distinctive qualification separate from the Dip. SW, and do not work to statutory requirements. Community work mobilises the resources of the community itself to change. Mayo (1994) sees that there are two different perspectives on community work: the *technicist* and the *transformational*. The *technicist* promotes community initiatives within the framework of existing social relations, whereas the *transformational* seeks to develop strategies and build alliances for social change. Transformational community work is inherently political in that it challenges the location of power within officially sanctioned groups. Structural inequalities, poverty and racism are all confronted by community work. In so doing, it exposes the benign assumptions of community care policy that society is based on consensus and that formal and informal care can easily be interwoven.

The 'community' basis of community care is challenged from a different perspective by Bulmer (1987). Bulmer develops the idea of a community of 'limited liability' based upon temporary and highly focused alliances between people who have a common interest, for example in the provision of good quality education for their children at the local school, or the building of a bypass to alleviate traffic congestion locally. It cannot be assumed that this community of interest will extend to other matters, particularly as people's major ties remain kinship ties, which survive despite greater social mobility. The isolation and rejection of people with mental health problems or learning disabilities is seen as underlining the point that in many people's minds community care means care by the families (if any) of those in need of care, and not some wider conception of social responsibility. The consequence is that formal (statutory) sector involvement is necessary to support people who are without family ties. Yet, at the same time, informal care by families alone is not adequate, largely due to the

absence of a proper family policy to compensate financially those family members who provide care. Community care policies which ignore these infrastructure issues are therefore built on shaky foundations.

### CASE STUDY

Polly Richards is 35 years old and lives alone in her flat on a local authority housing estate. She has a diagnosis of schizophrenia and receives fortnightly visits from a community psychiatric nurse. Polly rarely leaves her flat, except to visit the local shops and café. The CPN has become concerned that local youths are visiting Polly's flat when they are supposed to be at school. Small amounts of money and some possessions have gone missing. Polly has said that she enjoyed their company at first, but now she feels harassed by them. She has asked them to stay away, but they have not done so.

The CPN asks your advice on what to do about this situation. What would you advise?



- Anti-Discriminatory and Anti-Oppressive Practice positively promote differences as part of an agenda for change.

Thus the historical development of the value base of social work from the individual to the structural can be seen to come together within community care, as long as the practitioner remains aware of the different sources upon which such practice is based.

### Participation

Participation by service users in the design and delivery of services was heralded in the foreword to the Griffiths report as a basic cornerstone of community care policy: 'The whole thrust of my work has been to ensure a move from an administered paternalistic provision of service to a managed system of meeting consumer needs in a way which will provide a quality of service economically and effectively delivered and involving and motivating both the consumer and the staff' (Griffiths, 1988, foreword).

Croft and Beresford (1990) in their first enquiry into user involvement in Social Services Departments identified two vital components for effective user participation: a voice in the agency, and personal support to express it. Neither was sufficient without the other. Also of importance was the encouragement given to direct involvement by front-line staff from the agency; imposing participatory schemes top-down was likely to dilute their effect. Involving people in the planning of services was also found to take more time, skills and resources than expected. However, it also saved time and money resulting from ill-informed decisions.

Croft and Beresford also identified two competing philosophies underpinning user involvement: consumerism and self-advocacy. Consumerism was defined as the seeking of information from users by agencies that wish to improve their efficiency, economy and effectiveness. Agencies do this primarily in order to find solutions to their own problems, such as, is their product the one that the consumer wants? Self-advocacy, is by contrast user-driven, and here the aim is empowerment. Service users seek a direct say in agencies and services to gain greater control over their lives; their motivation is not the narrow one of wishing to be involved in the administration of services. An example of consumerism would be advisory committees set up under the Regis-

tered Homes Act 1984 to comment upon the registration process; an example of self-advocacy would be the setting up of Carers Forums specifically to raise awareness of the needs and rights of carers. Agencies should therefore clarify from the beginning what kind of involvement is being sought and what commitment can be given to act on what people say they want.

### Empowerment

Shardlow (1998) observes the term 'empowerment' as being used in the literature in two different ways. He sees Stevenson and Parsloe's (1993) definition of empowerment in community care as being centred upon the articulation and meeting of social care needs. Braye and Preston-Shoot (1995) however emphasise both the developmental nature of empowerment – extending one's ability to take effective decisions – and its role in maximising people's quality of life by enabling disempowered people to have a greater voice in institutions, services and situations which affect them in the attainment of their own goals.

Hoyes *et al.* (1993) have produced a 'ladder of empowerment' to measure the extent to which users both individually and collectively have the power to take decisions or influence the decision making process. The 'top' of the ladder reflects the highest level of empowerment, and the bottom of the ladder is the lowest (Hoyes *et al.*, 1993).

#### THE LADDER OF EMPOWERMENT

HIGH	Users have the authority to take all decisions
	Users have the authority to take selected decisions
	Users' views are sought before decisions are finalised
	Users may take the initiative to influence decisions
LOW	Decisions are publicised and explained before implementation
	Information is given about decisions made

Jack (1995) however is sceptical of claims that empowerment can be achieved through participation in service planning: he poses the

question (p. 6): 'Do participation and involvement 'empower' service users or is their involvement itself potentially disempowering through absorption, colonisation or the bureaucratic dissipation of legitimate protest?' Real empowerment involves control – over money and over resources – and is essentially a political activity. It is not something which is in the gift of professionals; it is something which arises from the demands of individuals or groups to have their needs met. The model of care management which best fits the idea of empowerment is that of service brokerage (Brandon and Towell, 1989). In this model, the care manager acts as agent of the service user and/or their family to commission services from a variety of sources which fit the agenda which he is given. The care manager has no resources of his or her own, but negotiates for individualised funding to obtain services that the user needs and wants. Thus it is the service user and not the professional who sets the agenda.

Jack contrasts empowerment and enablement; terms which are often confused in social work parlance. Empowerment involves establishing the legitimacy of user-determined goals as an attribute of citizenship. Enablement, however, is not a political concept, but a professional skill. In the context of community care, the professional may involve a user in the assessment process for a service; the worker may thus 'enable' the user to develop self-confidence, self-esteem and negotiation skills through this process. However, the power to purchase that service and to withdraw it is retained by the professional who has given over none of the power to control the process or its outcome (Jack, 1995, p. 11):

The new Diploma in Social Work does not in fact use the language of empowerment but uses that of enablement and opportunity. Core competence 2 is to 'promote opportunities for people to use their own strengths and expertise to enable them to meet responsibilities, secure rights and achieve change'. The emphasis is thus on 'New Right' values of individual responsibility for (non-radical) change. The practice requirements emphasise this ultimate personal responsibility. The practice requirement 'provide opportunities for learning and development to enable children and adults to function and participate' emphasises for example, the giving of *assistance* to children and adult service users and carers to *participate* in decision-making about arrangements for daily living and personal care. It does not locate the power to make such decisions within the province of service users and carers themselves.

Empowerment in its proper sense has not only a substantive but a strong procedural aspect insofar as it is about having access to decision-making processes. An interesting practice example of a well-meaning but oppressive system which was criticised in terms of its failure to empower service users is contained in a report from the local government Ombudsman (Report 95/B/0166 against Cornwall County Council). The complainant had been excluded from a day centre for people with mental health problems for alleged abusive behaviour. From the reading of the report it appears that the day centre was operating in an unstructured way akin to a therapeutic community. There was no clear guidance on how to manage or record difficult events and thus no channel of representation or complaint short of using the local authority complaints procedure. The absence of any provision for making independent enquiries effectively gave all power to the centre manager. In addition, no work was undertaken with the user to facilitate her eventual return. The laxness of the regime therefore meant that users effectively had no voice in the process of terminating attendance or its outcome. Empowerment therefore is dependent upon clear procedural provisions being made for decision-making which have the rights of users at their centre.

### Advocacy

'Promoting the rights of children and adults at risk or in need in the community' is one of the practice requirements within the core competence 'promote and enable'. An evidence indicator for this is direct advocacy with, and on behalf of, children and adults. How feasible is such a form of advocacy within an administrative or entrepreneurial system of care management? Advocacy is 'speaking on behalf of' another, usually in a formal, and often in a quasi-legal, context. In contrast with empowerment, advocacy does not give power; it gives the right to make representations to those (others) who have the power. It implies partisanship; a sense of belonging to the person on whose behalf the advocacy is taking place. It is unlikely then that anyone who is an employee of the agency which makes the final decision on the granting of resources or the settlement of a dispute concerning property, money or even individual liberty, can properly be said to be acting as an advocate. The Practitioners' Guide (1991, para. 74) recognises this: 'the devolution of responsibility to allocate resources, changes the nature of