

AN EMPOWERING APPROACH TO MEASURING QUALITY IN SOCIAL CARE SERVICES IN ENGLAND

Dr Monica Dowling – Royal Holloway, University of London

Abstract

Social care services in the UK are services that are provided in the community to help individuals with a variety of social problems. They include: care after discharge from hospital, care for people with mental health problems and learning disabilities, care for children with disabilities and children who are suffering from abuse or teenagers who are beyond care and control, and care for older people. This paper intends to understand and measure the quality of care provided from the perspective of social service users and carers. This is an innovative project in that measures of quality in social care services in the UK have generally been concerned with measuring performance in terms of Quality Indicators or Best Value reports. Indicators can measure for example how many times the telephone rings before it is answered by social care services, while Best Value reports measure the outcomes of a service from a managerial perspective. Although these quality measures quite often involve user surveys, the methodology does not allow for the user to give a wholistic response about the service they have received. Postal survey questions have a very low response rate with users and carers who have more pressing issues to deal with and if the surveys are administered by individual callers, they can confuse and mislead users and carers if the set questions are not appropriate.

What is not measured is process and outcome from a consumer viewpoint utilising a qualitative methodology that enables users and carers to tell their own story. This three year study of users' and carers' experiences of community care interviewed over 200 individuals utilising an approach that allowed them to explain their experiences of the public care sector from their own perspective. In the follow up study, parents of children with disabilities designed the research tool and have been involved in disseminating the findings from the research to social care organisations and the Social Care Institute for Excellence which is a new government research organisation to promote innovative research that involves users and carers.

The paper suggests a theoretical framework which is also innovative in identifying three perspectives in analysing quality measurements in welfare organisations – scientific/empirical, managerial and empowering.

The quality of social care services is considered in relation to three crucial issues: How can quality be measured? How can social service users and carers contribute to a quality service? How can the quality of services be improved as a result of explorative research with users and carers?

Users of welfare services are not a powerful group in their interaction with professional groups in social care services. However their contributions have the potential to create an innovative, effective and practical measurement of quality in social care organisations.

Paper presented by:

1. Monica Dowling

Department of Social and Political Science, Royal Holloway, University of London, Egham, Surrey, TW20 OEX, 01784 443674 phone, Email m.dowling@rhul.ac.uk

Introduction

Quality...you know what it is, yet you don't know what it is. But that's self contradictory. But some things *are* better than others that is they have more quality. But when you try to say what the quality is, apart from the things that have it, it all goes *poof!* There's nothing to talk about. But if you can't say what Quality is, how do you know what it is or how do you know it even exists? If no one knows what it is then for all practical purposes it doesn't exist at all. But for all practical purposes it really *does* exist. What else are grades based on? Why else would people pay fortunes for some things and throw others in the trash pile? Obviously some things are better than others.....but what's the "betterness"?.....So round and round you go, spinning mental wheels and nowhere finding anyplace to get traction. What the hell is Quality? What *is* it? (Pirsig, 1974).

This paper intends to get some traction on the concept of quality by investigating ways in which it can be measured in relation to social care policies and practice in England. Spinning mental wheels around the idea of quality will consider three crucial issues: How can quality be measured? How can users and carers of social care services contribute to a quality service? How can the quality of services be improved within a social care framework? Fieldwork findings from qualitative research studies with social service users and carers from 1992 to the present will be integrated into the discussion where appropriate.

For the purposes of this study, but bearing in mind the debate surrounding who are users and carers as far as social services care is concerned (Barnes et al, 1996), "Users" are defined as individuals receiving social care services. "Carers" are defined as individuals who have, are or will provide family and community care for individual users. These definitions are necessarily broad because social service users and carers are not a static population. Birth, accidents, illness and the ageing process will mean that family members may suddenly or gradually require care in the community. Death, recovery from illness and teenagers growing older may mean that social care services are no longer needed. Targeting policies of many social services departments can mean that potential users and carers are denied services unless they are in high need due to financial constraints. However the geography of where the individual lives and the timing of when they require services will determine whether they are defined as a social service user or carer by their social services department.

How can Quality be measured?

The dictionary definition of quality relates to degree of goodness or worth - a subjective description which underlines Pirsig's view that quality is difficult to define and thus measure.

If we are concerned with means as well as ends in providing social care, it will be important to evaluate the ongoing attributes of a day care or a night sitting service. Outcomes such as whether social care recipients have a Care Plan or have been satisfied with the promptness of response to telephone enquiries are one important factor in the measurement of quality and are well represented in quality indicator documentation and Best Value reports. However they measure facts and produce statistics that can never be the whole story in a social care environment where interaction and engagement are equally important. This scientific/empirical approach while

useful needs to be combined with qualitative approaches that focus in depth on individual's views on how quality can be achieved in social care services.

Four approaches to Quality which have been imported from the commercial world highlight the way social care services in the UK have developed in the direction of 'Benchmarking' and Best Value.

- ◆ The Traditional Approach – an approach which conveys a definition of quality in the commercial world through establishing prestige and positional advantage for example 'status' names such as Rolls Royce or Harrods would maintain they offer better quality services and products than more 'run of the mill' companies. This approach is not easily transferable to social care services in that public welfare services are not regarded as high status in the first place. The Government has recently launched a £2 million recruitment campaign to develop a public relations exercise for the social care professions. However this is a far smaller budget than the recruitment campaigns for police officers, teachers and nurses.
- ◆ The 'Scientific' Approach – an approach which defines quality in terms a series of standards set by experts (for example in the business world ISO 9000/EN 29000). These quality measurements have been wholeheartedly applied to social care systems and developed through central government driven initiatives such as *Modernising Social Services* (Department of Health 1998), *Modernising Government* (Cabinet Office, 1999) and the *National Health Service Plan* (Department of Health 2000). However these standards are often seen as a bureaucratic nightmare by social care professionals and are not demonstrably transparent or understood by users, carers or social care workers.
- ◆ The 'Managerial' or Excellence Approach – an approach which stresses continuous improvement (for example Total Quality management – TQM in a commercial environment). This approach has been applied in a top down approach from Senior management in public welfare services in combination with the Scientific approach. However it is difficult to motivate welfare staff to improve in line with the social services 'mission statement' if there is low morale and 40% staff vacancies in some authorities. This approach also assumes commitment to improvement by staff whereas the commitment of users in working with public welfare officials cannot be guaranteed – especially if they are on probation or subject to compulsory mental health or child care legislation
- ◆ The Consumerist Approach – an approach which would evaluate quality through understanding the consumer perspective. Government policies are keen to apply this approach to users of public welfare services but the practice is not innovative or sensitive enough at present to have made a significant difference to social care services. John Hutton, Minister of State commented in a keynote conference speech (NISW 2000), 'I want us to think about how quality can be defined ..A good place to begin is with users' and carers' experiences of social services. Their knowledge is key to what constitutes good social services. I want us to listen, and then apply the lessons learned from them...Users' views are a crucial way of testing and assessing for quality in services'.

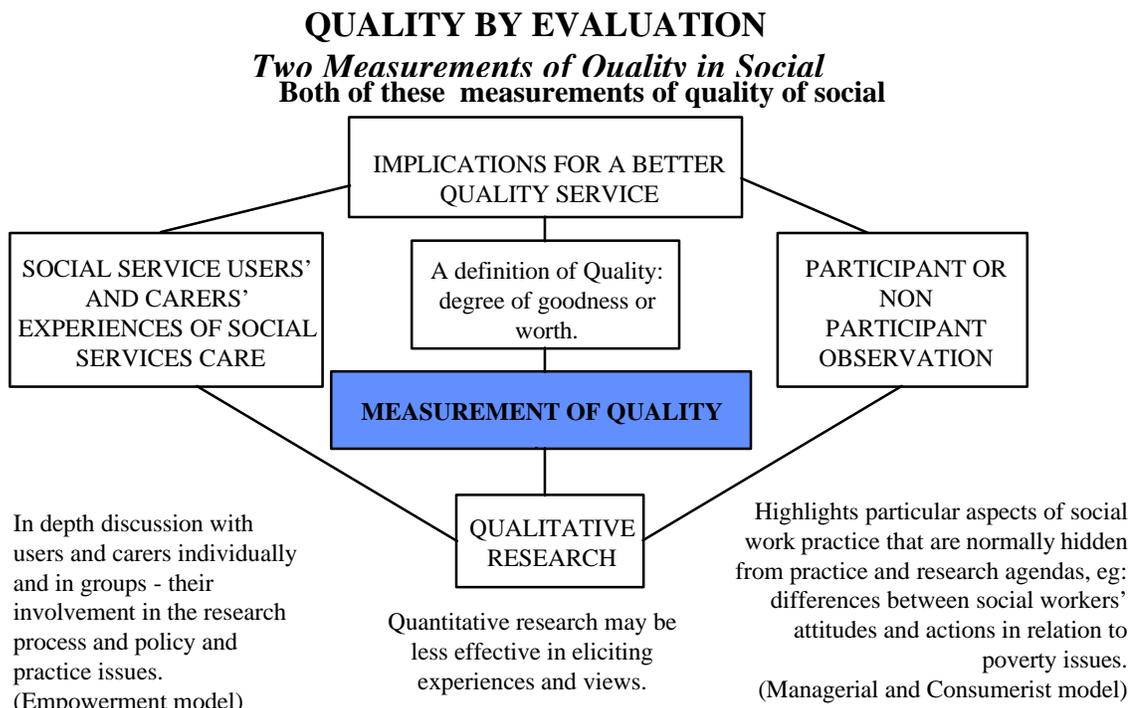
How can Quality be Measured from a User and Carer Perspective?

The first important issue in terms of measuring quality concerns how users and carers are listened to. The attached diagram makes the point that users and carers have stories to tell which often do not fit into a questionnaire or quality standards format. Thus the measurement of quality on the right of the diagram is concerned with a methodology that understands process and interaction rather than merely outcomes. Participant and non participant observation are ethnographic

methods which are particularly useful for understanding the interactions between professional workers, the management hierarchy and social service users and carers. Such methods can explain why particular processes are unsatisfactory for users and carers, professionals and management by analysing prevailing attitudes and actions, the culture of the organisation and the wider social policy environment (Satyamurti, 1981; Dowling, 1999). Participant observation offers a surprisingly realistic and valuable method with which to understand for example how poverty impacts on social service users, and what role social workers play in this process. It may be equally useful for similar studies which seek to discover how individuals translate attitudes into actions (Burgess, 1982, 1988) and it appears relatively unacknowledged as a research methodology that can lead to action research and the development of policy initiatives in measuring quality. As a method of evaluating quality in social services, it is useful from a managerial and consumerist perspective because it allows purchasers and providers of services to understand how the organisation operates at different hierarchical levels (Whyte, 1984).

In depth interviews and group discussions with users and carers as an evaluative method on the left of the diagram are part of a larger tradition of emancipatory qualitative research (Rogers and Pilgrim, 1996). They aim to give individuals power to define their own research agendas and to have a say in the research process. Such research is now commonly connected with the idea of empowerment. Whether such research is ever really empowering for users and carers is a difficult question to answer. However users and carers particularly those who had a poor experience of community care or child protection policies did often thank the interviewers for their help and in talking through the experience appeared to regain some personal power (Dowling 1997).

Mrs Q: *I am quite pleased that you came to see me because I feel I know a little bit more of what I should be asking for and that you have reinforced me to say it. Because I think I don't know how much I should really be saying because I feel helpless.*



Int: *Please be assured that you have every right to express your ongoing concern as Keith's parent and to be critical of the services and demanding of them to ensure that he comes out of this sorted out. You don't want to lose your son in care for years and find that at the end of it he is no better, or worse than when he went in.*

Each user and carer interviewed in the research programme in Surrey was provided with a copy of the report for their client group. This allowed them to see that their views were part of a wider agenda and would hopefully promote discussion with other users and carers who were not part of the research process. User and carer research monitoring groups were developed with active members of user and carer groups. The principal aim of the groups was to discuss with the activists whether and in what ways the social care issues presented to them from individual interviews were illustrative of the wider concerns of users and carers in their client group. In the ten research monitoring groups - one for users and one for carers in each of the five client groups - the process of discussing issues concerned with social care and feeding back comments on drafts of each report appeared empowering. For example users and carers in the groups would feedback information on further steps they had taken to regain power in the social care arena. Users on the mental health service monitoring group formed themselves into a consortium to offer training on user issues to social services departments and are developing research as user academics. One of the users on the older people's research monitoring group who is a resident in a home applied to be an assessor of Surrey residential homes after his participation in the group and his attendance as a guest speaker at a Social Service User conference. He asked me for a reference for the part time post which I gladly gave him. He succeeded in his application.

Consumerist Approaches

User and carer opinions are sought from both a consumerist and empowerment perspective. The consumerist perspective would tend to organise user and carer feedback to benefit the care organisation but also to improve the efficiency of the service provided for users and carers. This could be in the form of a survey with questions such as "how many times did the phone ring before it was answered when you phoned social services?" Asking these sort of questions *appears* to promote action. For example if the results of the survey show that the average response from users and carers was 20 rings then staff can be told that they must answer the phone before it rings 10 times. While having a superficially beneficial approach for the consumer, many users interviewed using a qualitative approach found these sort of questions meaningless, not relevant to their everyday lives nor to what they wanted from social services. For example one lady of 75 who had rung social services when she had fallen over, had been hospitalised and was now back at home. She said she had no idea how many times the phone had rung when she first contacted them four months previously.

On the other hand some mental health service users were happy that a quality standard existed that meant that they were able to get through to someone when they needed to in an emergency. They had had experiences where the telephone was not answered at all. Thus such a standard can be effective in promoting quality but it is not a complete answer to the question – what is quality?

Complaints procedures are also part of the consumerist approach in that they are able to give individual users and carers a voice. However welfare organisations do not necessarily respond effectively to the complaints nor can such individual complaints generally make a difference to the policies and practices of the organisation. The consumerist approach can be seen to be tokenistic as although it consults with users and carers there is no real attempt to share power with them.

The Empowerment Approach

The empowerment approach is consistent with the dictionary definition of “empower” - to authorise or enable. It has a fundamental aim of ensuring that users and carers not only have more say but more power in the policy making process. As Michael Turner from the user led network ‘Shaping our Lives’ notes, ‘ service users and their organisations are encouraged by the new emphasis on quality and the stated (government) aim to ensure that users play a central role in defining quality. Their reservations are about the current gap between this rhetoric and the realities of life for user groups.’ (NISW,2000)

Participants who took part in the research process can only be empowered if they feel their discussions and perspectives are taken into account at the local welfare practice and policy level. They also need to be consulted by policy makers, elected officials and professional officers as well as researchers for longer term policy objectives so that the confidence and power that they have achieved can continue to be developed.

Research Findings

More than 250 social service users and carers in Surrey have been involved in discussing social care provision. They have included older people, individuals with mental health difficulties, learning disabilities or physical disabilities, parents of children with special needs and young people defined as “beyond care and control” or in need of protection. Most social service users and carers interviewed and involved in group discussion were clear and forthright in voicing their satisfactions, dissatisfactions and suggestions regarding how social care could be improved. From their perspective they understood the concept of quality and what could be defined as a quality service. The government’s ideal of a seamless provision of social care services is typified by this parent’s view of how he would organise a social care network for his learning disabled son.

Mr E: *I would like to see the Social Services more obvious at school level and information facts available to parents. There is an annual review of the child's Statement. I don't think it's beyond anyone's ability as part of the Statement for there to be Social Services involvement a little box on the Statement to the effect that this child is now or may be moving on to higher education. Parents feel that there will be a housing issue and Social Services should get a copy of that and pick up on these bits, then to contact the parents, make their own assessments using their own skills as to how able the parents are to look after the child over the next few years and then look at long term decisions. To educate the parents, to give sufficient facts for them to then be able to start asking sensible questions about the child's options, the parent's options, what is part of the infra structure. If there are charitable trusts which you should get in touch with now who may provide a house which can transfer to the local authority, who they are, what they are. Have you made a will? You have a child with problems, may we respectfully suggest you look in our direction. So you cover two things, your child and possible extra funding for Social Services. OK this will be directed at your child but so what? If it means buying a house and your child is one of four in that house, well..... We want Edward to have as fuller life as possible, and we want him to get out there and start doing it as quickly as possible. We don't want the situation of him living at home with us when he is still 30 as he won't have any social life, - he'll be lost in this house.*

Users and carers felt that a quality service needed to be **flexible, responsive, collaborative and imaginative.**

Nevertheless as this parent points out, however well or badly quality standards are developed in a particular welfare authority, if the resources for the core services and recruitment of staff are poor, there cannot be a quality service provided.

Mr RG: *My opinion is that the Health Service should have a requirement to contact Social Services when anybody is diagnosed with whatever. Our experience was that our daughter was diagnosed as autistic at two years old, we went away, my wife was suicidal, it's one of the worst things that can happen to you. We wrote to Social Services they didn't even bother to reply to the letter. The reason was they didn't have a case manager in the Frankam area. That is totally inexcusable, if there is not a case manager in Frankam, those letters should be sent somewhere else for a reply. They are understaffed, these Managers keep changing from one office to another there is no continuity - nobody is taking responsibility. We were very upset with social services. We had no help at all.*

Mrs D had experiences of social care services that showed insensitivity to the carer and child's needs. If publicly available transparent quality standards (both within and between authorities), and the new star ratings (Coote, 2002) had been in place which Mrs D could have accessed, she would have at least had more knowledge before she moved to a different authority.

Mrs D was fostering a child with severe learning and physical disabilities. Marie was initially diagnosed as having a limited life span but was now a teenager. The foster mother compares after her move from one authority to another, the two authorities' approaches and recognises that one authority valued carer input in providing a higher quality service for the child in need and the family who were looking after her while the other did not

Mrs D: *Because of her bed wetting we go through an awful lot of bed linen and we have been through two mattresses in four years. City authority was always aware of these sort of things. Surrey have never said to us once "do we need anything?." There were things that were standard with City. Marie has allergies, she is allergic to anything just about except for meat and two veg. She can start vomiting and get diarrhoea. It can go on for three or four days at a time. We have had it where she cannot control it, projectile vomit. City used to say to us, "every four months we will have your carpets cleaned for you." They would clean her bedroom, the bathroom and the living room and that was done automatically. I never asked Surrey, it wasn't worth it - I knew I would never get it.*

Mrs D did not complain about this particular issue with Surrey because she had complained about the loss of her special allowance for caring for a severely disabled child when she moved from City to the Surrey area. The allowance was not reinstated and as can be seen from the above quotation, she is not satisfied with the quality of other services provided to support her. It is not surprising that she chose after much discussion with Surrey to "exit" the foster care arrangement. Marie was taken into long term residential care which is likely to affect the quality of her life while Surrey would be facing a far greater residential care cost than paying Mrs D the special allowance she had received in City authority.

As Coote (2002) comments, 'The case for rigorous performance management is unanswerable. Social services are publicly owned, financed by our taxes and intended to meet the needs of the most vulnerable members of society. Why should we put up with anything less than consistently high standards? And is there any justification for keeping the quality of performance a secret?

Surely people have a right to know whether their local social services department is better or worse than others?’

How can the Quality of Services be improved within a Social Care framework?

Defining a quality service and then improving it from a user and carer perspective will have different flavours depending on the service required and the type of care provided. For example young people in residential or foster care (both individual interviewees and the research monitoring group) had different perspectives regarding a quality service to those receiving mental health services.

Theresa at 14 had absconded from school regularly for two years. She had been staying with foster parents because she was sleeping rough and her parents were concerned about her whereabouts in relation to possible criminal activities and her sexual behaviour. At the time of this interview, she had returned home to live. Quality of care for her was being settled in a school she liked, while an improvement in care would have been for the whole process to have been speeded up.

T: *..... in Year 10 and 11 we are all put in the same class, and there are two teachers for seven pupils - so we get a lot of attention - all the teachers are like social workers - you can talk to them - they don't have favourites we are all treated the same which is good not like at a larger school, where they have favourites - I was never a favourite of any teacher.....Social Services sent me there so that was one good thing they did for me, it took me three months to get into that school.*

A very different approach was recommended by a user member of the research monitoring group for mental health service users and carers who felt that the quality of social care services for mental health service users was about providing a safety net for those discharged from hospital.

Mr C: *I think still largely with mental health the problem is loneliness and isolation. They're in their bedsits, they don't see anybody, they've got no money to go anywhere and in some ways it's quite nice for them, usually it's the social worker, then they lowered the salary and called it Community Support Worker. They would come along and knock on their door and say 'Put the kettle on ' or 'I'll put the kettle on, you sit down and we'll have a chat for a minute'. To some extent that's what a lot of them wanted. It's almost buying company, the government paying for their company. There probably is a better way of doing it than that but that's what they see the social worker as I think.*

Improvement in the service would have meant employing a larger number of community support workers preferably ex-users to support individuals with mental health difficulties in the community.

Although users and carers in different social care groups had varied satisfactions, dissatisfactions and recommendations for a better quality service, there were some strongly held opinions which transcended all user and carer groups. These were mainly concerned with **the value and necessity of clear and accessible information in order that users and carers can make informed choices about the care provided.** Although quality cannot be ensured because customers cannot choose what they buy in an open market (unlike the commercial world), people

can make choices that are meaningful to them, if they have information regarding the alternatives open to them (Pfeffer and Coote, 1991).

Even if users and carers of social care services were generally satisfied with actual services provided, there was a significant level of dissatisfaction about such matters as lack of information about care options and the right of access to care plans, review notes and procedures, case records and complaints' procedures.

Conclusion

From an empowerment perspective, four key issues would improve the measurement of quality:

- ◆ For user and carer organisations to be able to produce the evidence sought on their perspectives, they need to be supported with adequate resources. Without this support, the infrastructure for user involvement at a local and national level either does not exist or cannot function effectively
- ◆ User and carer involvement and user and carer evidence needs to be valued. Valuing this input as an essential component in ensuring quality services means respecting qualitative and ethnographic research studies and user led research. Evidence from statistical and organisational forms of quality measurement at present takes precedence over any other measurement of quality.
- ◆ Users and Carers need to be encouraged and paid for their time in becoming involved in user and carer research. They need to feel that their input will make a difference when they may struggle to contribute. At present many are cynical about research and talk about 'research fatigue' because they have seen so little benefit from it.
- ◆ Welfare services need to be resourced and staffed at a level at which it is possible to measure quality. If funding and staffing are not sufficient, then whatever measure of quality is utilised, the results will be disappointing.

This paper is mainly concerned with the establishment of a "voice" (Hirschman cited Pfeffer and Coote, 1991) for social service users and carers in concepts of quality. The market option of "exit" in relation to local authority community care services is only available to:

- C users and carers with resources,
- C those who are carers paid by the local authority (for example foster parents)
- C users and carers who are so dissatisfied they would rather do without social care services altogether.

Perhaps the most important issue in relation to the measurement of quality of care is that social service users and carers are keen to have more of a say in the way social care services are provided for them. Not all users or carers will wish to be involved, but the networking approach organised as part of these research studies, indicates that users and carers felt less isolated in the community when they had user and carer group contact telephone numbers and the numbers of telephone information / support lines. As Alan Walker noted in 1993 (p221/2), '...the user centred or empowerment approach would aim to involve users in the development, management and operation of services as well as in the assessment of need. The intention would be to provide users and potential users with a range of realisable opportunities to define their own needs and the sorts of services they require to meet them. Both carers and cared for would be regarded as potential service users. Services would be organised to respect user's rights to self determination

and dignitythus user involvement must be built into the structure and operation of Social Services Departments and not bolted on.’

There is at present in the United Kingdom an ideological drive which assumes: standards are the absolute measure of quality; that there is no other way of measuring quality; that the standards produced are understandable to the general public and what they want; and that they are achievable by the workforce at the current resource level.

For measurements of quality to be innovative and useful, they need to involve users and carers in a wider range of ways. Qualitative research needs to be promoted so that users and carers have meaningful opportunities to have their say on practice and policy changes to the social care system. As recipients of social care services, they are also able to monitor the effects of improvements in the quality of the social care system over time.

This final story illustrates by taking the orchestra as the welfare world – which includes users and carers, social care workers and their management, government organisations and elected officials – the danger of trying to achieve and measure quality from one (business) perspective rather than from a number of different perspectives that combine to create a unique whole.

Schubert’s Productivity

A company Chairman was given a ticket for a performance of Schubert’s unfinished symphony. Since he was unable to go, he passed the invitation to the company’s Quality Assurance Manager. The next morning, the Chairman asked him how he enjoyed it, and instead of a few plausible observations, he was handed a memorandum, which read as follows:

1. For a considerable period, the oboe players had nothing to do. Their number should be reduced, and their work spread over the whole orchestra. Thus avoiding peaks of inactivity.
2. All twelve violins were playing identical notes. This seems unnecessary duplication, and the staff of this section should be drastically cut. If a large volume of sound is really required, this could be obtained through the use of an amplifier.
3. Much effort was involved in playing the demi- semi quavers. This seems an excessive refinement and it is recommended that all notes should be rounded up to the nearest semiquaver. If this were done, it would be possible to use trainees instead of craftsmen.
4. No useful purpose is served by repeating with horns the passage that has already been handled by strings. If all such redundant passages were eliminated, the concert could be reduced from two hours to twenty minutes.

In the light of the above, one can only conclude that had Schubert given attention to these matters, he would have had time to finish his symphony (Roseland, 2000).

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