

Only Connect: Client, Carer and Professional Perspectives on Community Care Assessment Processes

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Abstract

Differences in perspective between clients, carers and practitioners are familiar from the literature. Findings from two research projects are reported here, which identify mismatched perspectives and appear to question the foundations on which community care policy and practice rest. The article discusses features of the policy and practice context that contribute to the likelihood of divergent views about need and appropriate or effective service provision within community care. In concluding with a review of the modernising agenda and the legal mandate, it questions whether a closer alignment between client, carer and professional perspectives can be achieved.

Key words: assessment, community care, user perspectives, need

Introduction

Differences in perspective between clients and social workers about problem definition and required services are not unknown. Disabled people and carers may hold wider definitions of risk, which practitioners appear reluctant to recognise or respond to (Davis et al, 1998). Learning disabled people have expressed different views from social services departments about what constitutes a valued respite service (Joseph Rowntree Foundation, 1996). They have emphasised greater freedom and improved social life, and concentrated on emotional and practical experiences that would promote a sense of inclusion and quality of life, whilst staff have stressed the importance of living skills and training (Jahoda and Cattermole, 1995). Rogers and Pilgrim (1995) found that what survivors of psychiatry wanted was not necessarily what they received from care managers.

Different perspectives are though problematic when the effectiveness of policy and practice is based on assessment informed by the concept of need and services designed to individual requirements. Findings from two research projects, chosen because they explicitly contrast the perspectives of clients, carers and social workers, are presented to illustrate the complexity behind divergent perspectives and to review the 'modernised' pillars on which community care policy rests.

Both projects used triangulation to compare client, carer and social worker perspectives on processes and outcomes in community care. Clients were asked about their perceptions of their needs and the

extent to which provided or available services met those needs. They were asked about their levels of satisfaction with assessment, service provision and the degree of involvement experienced or choice offered. Carers were asked these questions in relation to both the person for whom they provided care and themselves. Social workers were asked these questions in relation to both clients and carers. This approach enabled the factors contributing to effectiveness, disagreements or dissatisfaction to be explored case by case and across each of the client, carer and social worker samples.

There are difficulties with concepts like satisfaction and appropriateness (Huxley and Mohamad, 1991-92; Wilson, 1995), the latter meaning the degree of 'fit' between the identification of individual needs and service provision. Perspectives may be influenced by knowledge of services or limited expectations, help received in past encounters or difficulty distinguishing between satisfaction with how services are given from whether they are perceived as actually meeting need. People may feel uneasy expressing criticism. They may feel wary of power relations between researchers and respondents or deterred by having to comment within frameworks set by professionals.

To counteract these difficulties the projects discussed in this article investigated key domains widely used in research designed to elicit client and carer views (Huxley and Mohamad, 1991-92; Donnelly and Mays, 1995). These domains are living environment, daily activities and personal well being, social contacts and relationships, physical and emotional needs, access to help, the effects of help received, and the characteristics of workers. They appear in the single assessment framework for older people (Department of Health, 2002b) and in practice guidance on carers'

assessments (Department of Health, 2001b). Levels of satisfaction with specific aspects of services were examined rather than adopting a global measure (Cullen et al, 1997). The projects asked about perceptions of needs and the extent to which services provided adequately met them. They asked about levels of satisfaction with assessment, forms of service provision, and involvement in decision-making.

Focus groups of clients, carers and social workers were consulted to ensure that this topic guide addressed accurately areas seen as relevant by them and to pilot the resulting questionnaire. In both projects, see Table 1, the sample comprised clients who had recently received a comprehensive assessment and the social workers responsible. Project 1 only sampled cases where a carer was also present. In both projects contact with clients was made after the social workers had screened out those who were judged too disabled to participate. In project 2 carers and social workers were interviewed in these cases in order that some perspective would be available in relation to older people who, otherwise, could easily be marginalised and their stories ‘silenced’. Each client and carer completed the questionnaire in an interview with a researcher. Social workers completed their questionnaires by post. Each questionnaire contained comment boxes to allow for inclusion of information to amplify a person’s answer. They could be used flexibly therefore to respond to ideas raised by participants and to

capture as far as possible their experiences.

Choice and Partnership

One pillar of community care policy is client and carer empowerment (Department of Health, 1991), reconfiguring the balance of power with providers through involvement in assessment, and separating this from service provision in order to extend choice. In project 1, 39 per cent of clients and half of carers said that the former had no choice about the provision of services. Forty-eight per cent of carers felt that they had no choice about services for themselves. Social workers thought that this was the case for only eight per cent of clients and nine per cent of carers. Clients and carers complained that they did not know what services were available and were, therefore, unable to make informed choices about which options would best meet their needs. They also complained about hurried interviews. Encouraging levels of satisfaction with overall contact with social services were found but much less satisfaction with levels of involvement. Twenty-one per cent of clients and 28 per cent of carers felt that the level of user involvement was unsatisfactory. Twenty-nine per cent of carers felt taken for granted and considered their own involvement as unsatisfactory. Disabled people and their carers were especially dissatisfied. Social workers were almost unanimous in being satisfied, at least to some extent, with the level of involvement achieved.

Table One: Research studies sampling people’s experiences of community care

Project	Commissioner	client group	Triangles	Methodology
1. Buckley et al (1995)	Local authority, Metropolitan Borough Council in North West England	Older people, disabled people and clients with mental health issues	76 – sample proportionately sub-divided into client groups according to number of assessments	Interviews with clients, their carers and social workers
2. Preston-Shoot and Wigley (1999)	Government department, social services division	Older people in the community and in care homes	46 – random sample drawn from records of completed comprehensive assessments	Interviews with clients, carers and workers (16); clients and workers only (25); with carers and social workers only (5)

In project 2 social workers also reported higher levels of client and carer involvement in the assessment process than either clients or carers themselves. Fifty-six per cent of clients felt that they had been involved at least to some extent. Social workers thought that this was the case for 83 per cent of clients. In this project too they were more optimistic about the degree of choice experienced by clients and carers. The degree to which they felt that information was provided, that services were within their locality and available, and they were able to influence or determine the type of service provided, shaped perceptions about choice. Carers, especially, seemed uncertain for whom services, such as respite care, were intended. The complexity of community care was also illustrated by the finding that clients and carers may express satisfaction whilst believing themselves to have no choice about the provision received, perhaps because services improved their quality of life.

Information

In project 1 social workers were much more likely to be satisfied with the information they provided than clients and carers were with the information they received about how needs are assessed, how decisions are made, and about their rights. Clients and carers wanted more information and found that given was too brief, confusing and occasionally unreliable. They bemoaned the absence of leaflets. Physically disabled people were least likely to be satisfied. Clients and carers were concerned with how information was given, highlighting the importance of professional skills in checking that information has been understood and retained.

Table Two: Project 1 (n=76) – satisfaction with information given

	Client	Carer	Social worker on client	Social worker on carer
On needs assessment	34%	32%	87%	82%
On decision-making	24%	28%	79%	82%
On services available	33%	35%	89%	89%
On rights	22%	20%	79%	72%

Information giving should be a process over time, not a one-off procedure.

The same picture emerged in project 2.

Table Three: Project 2 (n=16) – satisfaction with information given (figures rounded down)

	Client	Carer	Social worker on client	Social worker on carer
On needs assessment	37%	25%	81%	81%
On decision-making	25%	12%	81%	81%
On services available	25%	25%	87%	81%
On rights	Nil	Nil	56%	50%

Table Four: Project 2 (n = 25) – satisfaction with information given

	Client	Social worker on client
On needs assessment	28%	80%
On decision-making	24%	80%
On services available	24%	80%
On rights	8%	48%

There were complaints about the lack of information concerning care homes and other services, and about the difficulty of recalling information that had only been given once and verbally. Written information could, however, prove difficult to read. Several clients who did not believe that they had been given any information appeared not to know that their needs had been assessed. Carers were critical of the reactive nature of practice, feeling that information was made available only when requested. Carers also wanted more information about how clients were responding to medical and other interventions.

Fifty-six per cent of clients said that no information had been given about rights. Sixty-two per cent of carers reported likewise. This data may reflect social workers' uncertainty about the legal position or a belief that clients have few rights in

comparison with the powers and duties delegated to local authorities within welfare legislation. This lack of information, especially when coupled with a failure to provide details about complaints procedures, may effectively restrict the ability of clients and carers to hold agencies accountable (Preston-Shoot, 2001).

Assessment

Assessment is central to effective service delivery (Department of Health, 2002a) but is complicated by knowledge about the availability of resources, willingness to express needs, and communication difficulties. Tables 5 and 6 detail the needs surveyed.

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Table Five: practical needs

Practical assistance	Household tasks
Mobility inside and outside the home	Communication
Cleaning	Managing finances and medication
Difficulties seeing/hearing	Difficulties picking up/holding objects
Unsuitable accommodation	Poor condition of accommodation
Problems claiming benefits	

Table Six: socio/emotional needs (*in project 2 only)

Feeling lonely	Worries about illness/disability
Relationship problems with family or friends	Worries about mental health/growing older
Feeling marginalised*	Intellectual stimulation*
Sexual relationships*	Feeling depressed

In project 1 carers were more likely to suggest that clients needed a lot of help than were clients themselves, except concerning the condition of accommodation and worries about health/disability. This mismatch was especially striking with depression, managing medication, and managing finances. For example, 28 per cent of clients but 45 per cent of carers thought that the former needed a lot of help with feeling depressed.

Clients were more likely than carers to say that they needed some help, except in areas of managing medication, housing problems, loneliness, worries about health/disability, and family relationship problems.

Social workers reported fewer clients who required a lot of help, particularly relating to mobility outside the home, household tasks, managing money, managing medication, claiming benefits and feeling depressed. For example, 17 per cent of social workers thought that clients needed a lot of help with feeling depressed (see client and carer figures above). They suggested however that a greater number of clients needed some help. Even so, they still reported fewer needs concerning mobility at home, help with communication, difficulties seeing and hearing, housing problems and depression. If the categories of needing a lot of help and needing some help are aggregated, social workers still identified fewer clients as needing help in seven categories of need compared to service users - mobility at home, household tasks, communication, difficulties seeing/hearing, housing problems, claiming benefits, and feeling depressed.

Social workers similarly reported fewer carers who thought that clients needed help in 11 categories of need - personal help, mobility at home, household tasks, communication, managing finances, managing medication, difficulties seeing/hearing, housing problems, claiming benefits, worries about health/disability, and feeling depressed. Carers were more likely than social workers to agree with clients on perceptions of client needs in 16 of the 18 categories of need, the two exceptions being difficulties seeing/hearing and feeling depressed. There were significant levels of disagreement between clients and social workers about the former's need for help, particularly concerning loneliness, claiming benefits, worries about health/disability, family relationship problems and housing.

When asked to prioritise three most important needs social workers were more likely to emphasise personal assistance, communication, management of medication and work on family relationship problems. Clients and carers tended to prioritise cleaning and household tasks.

Throughout, the client group where there was the highest level of agreement was mental health.

In project 2 carers were more likely to report clients as needing 'a lot' or 'some help' in the areas of socio/emotional needs than clients themselves, perhaps indicating older people under-reporting need and being tentative in their requests for help, and carers acting as advocates for effective care packages. Social workers identified that clients could be anxious about the availability of future support and could become depressed because of isolation, bereavement, admission of a partner into care, or loss of health and activity. They were more likely than clients or carers to identify the difficulties that can sometimes follow from partners having to renegotiate their relationship because of the need of one person for care and support. They were also more likely to highlight the frustration that clients or carers can experience when others do not acknowledge their situation.

Social workers appeared less likely to assess clients as needing 'a lot of help' with practical needs, such as personal assistance, cleaning, household tasks, and financial management, but more likely to assess them as needing 'some help' in these areas. They were more likely to assess clients as needing 'a lot of help' with some socio/emotional needs. When the categories of 'a lot of help' and 'some help' are combined, social workers were more likely than clients to identify some level of need in most areas, the difference being particularly striking in respect of socio/emotional needs.

Social workers were less likely than carers to say that clients needed 'a lot of help' with socio/emotional problems but were more likely to say that clients needed 'some help'. In few areas of practical need were they more likely than clients, where carers were also available, to identify some level of need. In these cases social workers were more likely than carers to identify socio/emotional need in respect of loneliness, worries the client may have in growing older, family relationship problems and depression. The picture in relation to practical needs was variable. For instance, social workers were more likely than carers to identify some level of client need for personal assistance and for help claiming benefits but less likely in respect of managing finances.

In the 16 cases involving clients, carers and social workers, carers' perceptions of client need were more likely to correspond with views expressed by clients than social workers in 13 of the 21 categories of need. In five instances social workers were more likely than carers to agree with clients, namely on personal assistance, mobility outside the home, cleaning, suitability of housing, and the need for intellectual stimulation. In three instances there was no difference, namely needs relating to mobility within the home, loneliness, and managing medication.

When asked to identify what they thought were the three most important needs for the client, some trends emerged. Where clients, carers and social workers were all involved (n=16), social workers were more likely than either clients or carers to prioritise claiming benefits, the unsuitability of accommodation, relationship difficulties within a family and respite care. Carers and social workers together were more likely to prioritise intellectual stimulation, whilst clients and social workers were more likely than carers to be concerned about mobility inside the home. Clients and carers were much more likely than social workers to give some priority to household tasks and cleaning. Rankings given to personal assistance and mobility outside home corresponded more closely.

In cases involving only clients and social workers (n=25) similar divergence emerged:

- 14 social workers ranked personal assistance as a priority, 11 giving it top ranking, whilst only six clients gave this item as a priority, five ranking it first.
- 12 social workers were concerned about the unsuitability of accommodation, two giving this highest priority, whilst only three clients were concerned about this item, each rating it third.
- 11 social workers were concerned about depression, two giving it highest priority. Only one client ranked this item, indeed as their highest priority.
- 10 clients were concerned about mobility outside the home, six giving this item as their highest priority. Only three social workers referred to this item, with only one giving it the highest ranking.

- 10 clients were concerned about household tasks, with two giving this item their highest priority. Only five social workers referred to this item, one giving it the highest ranking. A similar picture emerged in relation to cleaning.
- clients and social workers expressed similar levels of concern about loneliness, marginalisation, and mobility inside the home, but these issues did not feature as priorities in many cases.
- Across all categories of need, there was disagreement in over half the cases in relation to thirteen needs (personal assistance, mobility indoors, cleaning, household tasks, managing money, housing, claiming benefits, loneliness, worries about ageing, marginalisation, stimulation, family relationships, depression). Clients reported the need for more help than social workers in respect of personal assistance, cleaning, and household tasks.

Unmet Need

Respondents were asked to identify services that had actually been provided for clients and to indicate whether these were meeting needs or were insufficient. They were also asked to identify where clients were not receiving a service that they considered necessary. In project 1 carers were more likely than clients to state that services were insufficient. Disagreement between clients, carers and social workers concerning how far services met client needs related to flexibility, quality, the experience and attitudes of providers, reliability and consistency. For example, changes in paid carers do not enable a client to build up a relationship, which can create distress and isolation. The most significant findings on services were that:

- clients were sometimes confused about who provided services, especially the distinction between social services, voluntary agencies and private organisations;
- whilst levels of service were generally thought to be sufficient, the highest levels of dissatisfaction with sufficiency concerned domiciliary care (12% of users, 20% of carers), aids and adaptations, chiropody and respite care (12% of carers);
- social workers appeared to be more concerned

with levels of sufficiency than either users or carers;

- the most often mentioned 'missing' services were counselling provided by social workers (23 clients [30%] and 27 carers [36%]), informal visitors (26 clients [34%] and 35 carers [46%]), and chiropody, followed by respite care, transport, recreational services, day care, and aids and adaptations;
- service users and carers were more likely to identify missing services than social workers, and carers more likely than service users;
- night sitters and day carers were criticised for their lack of skill and experience.

In project 2 clients identified services that would improve their quality of life. These included provision of telephones to overcome isolation, support after bereavement or major illness, social opportunities and support to make the transition into a care home. Carers were critical of the lack of activities in day centres and care homes, and of the difficulty obtaining aids and adaptations that would enable the client to remain at home. They expressed difficulty accessing support groups because of transport problems, and advice about illness and disabilities.

The most important missing services from the carers' perspective were informal visits, physiotherapy, respite care and recreation. Social workers emphasised day care and night sitters. Clients emphasised transport, followed by physiotherapy and informal visits. The most significant insufficient services were aids and adaptations, reported by social workers and clients; chiropody and home care, emphasised by clients; counselling, stressed by social workers; and day care, home care and respite care, most frequently mentioned by carers.

Carers

Community care policy has placed increasing significance on meeting carers' needs. In project 1, six practical needs were surveyed: free time, handling emergencies/crises, immediate access to social workers, information, travelling, and money. Six emotional needs were also surveyed: feeling lonely/isolated, worries about the client growing older/disability/ mental health, worries about own

ability to continue caring, relationship problems with family or friends, feeling depressed. In contradistinction to the findings for clients, social workers assessed more carers as needing a lot or some help with practical needs compared to carers' own views. However, they reported less need for help with social/emotional needs, especially depression, worries about the client's disability, and worries about their ability to continue to care. For example, 21 carers (28%) said that they needed 'a lot of help' with worries about the client's disability/growing older/mental health, while social workers assessed only 12 (16%) as requiring this degree of help. The comparable figures relating to the ability to continue caring were identical; whilst those for feeling depressed were 13 carers (17%) and four social workers. As with clients (reported above), social workers reported fewer carers as needing a lot of help but more as requiring some help with social/emotional needs. This can have an eroding effect on carers' willingness and ability to care. Where carers perceived themselves as needing no help, there was a relatively high level of agreement with social workers' perceptions. Agreement diminished the more carers expressed a need for help. It was not reached in half of cases across different practical and social/emotional needs except for management of money and relationship problems with family and friends, where in most cases everyone was agreed that no help was required.

Practitioners' ability to provide practical services may (be used to) deflect attention from carers' social/emotional needs. Support, understanding and time to discuss their worries and fears, were important for carers who also prioritised different needs, dependent on whether they are caring for an older and/or disabled person. Carers of disabled people especially stood out as expressing a need for help with socio/emotional problems, such as depression and concern about the ability to continue caring. Those looking after older people stressed the need for free time. However, social workers did not identify these same perspectives. When asked to rank in order of importance their three most important needs, social workers and carers mentioned some free time most often as falling within the latter's three most important needs. Carers were more likely to emphasise handling crises and worries about their ability to

continue caring. Social workers were more likely to emphasise carers' worries about the client and concern about their ability to continue caring. Social workers continued to assess fewer carers for whom feeling depressed was significant. Twenty-six per cent of carers but only five per cent of social workers included this within their ranking of the carer's three most important needs.

Services that carers identified as most significant in meeting their needs were counselling (to share feelings and worries), day care, domiciliary care, night sitting, respite care and transport. Social workers were more likely than carers to assess that received services met their needs. They also thought that fewer carers required a service, which they were not receiving, than did carers themselves, for example transport, night sitting, respite care, domiciliary care, or counselling.

Project 2 surveyed seven practical and six social/emotional needs. These were block free time, free time at intervals, handling emergencies/crises, immediate access to social workers, information, travelling, financial advice; feeling lonely/isolated, worries about the client growing older, worries about own ability to continue caring, relationship problems with family or friends, feeling depressed/angry. Carers and social workers were asked to prioritise these needs in order of importance. Both groups ranked block free time as most important and information as the third most important need. Carers ranked second the need for free time at intervals whilst social workers ranked here worries about being able to continue caring.

Not all carers saw themselves as having needs whereas social workers were more likely to identify carers as having needs in their own right. Some carers received support from family and friends and from people with similar experiences and, therefore, did not identify themselves as having a need for services. Thus, for each area of practical need and in three areas of social and emotional need, social workers thought that more carers needed both 'a lot of help' and 'some help' than did carers themselves.

This could be an overestimate of need by social workers or, rather, an underestimate of need by carers. If the latter, this may be the result of not

Table Seven: Identification of need – perceptions of carers (n=21)

Need	Respondent	A lot of help	Some help	No help	Don't know
Block of free time	Carer SW	4 12	6 4	11 3	2
Free time at intervals	Carer SW	2 7	4 8	15 2	4
Handling crises	Carer SW	4 3	2 8	15 6	4
Depression	Carer SW	1 1	2 9	18 9	2
Worries – caring role	Carer SW	2 5	7 7	12 7	2

knowing that support can be made available, a lack of confidence in service providers, and/or a reluctance to admit that support is required.

Those carers who could identify services that they wanted to meet their needs mentioned respite care, day care, home care and night sitting services. It was not unusual for carers to report reliance on taxis in order to keep appointments or to do shopping and to request more assistance in the home, for instance with providing clients with personal care. Carers were critical of the inadequacy of respite care provision, especially in the person's own home where the environment is familiar, and a perceived lack of professional expertise in caring for older people. Social workers shared similar perspectives on missing or insufficient services but also referred to counselling, recreational activities and informal support for carers.

Discussion

Client and carer perspectives on valued features and shortcomings of community care practice have proved consistent, as reviews illustrate (Preston-Shoot, 2000b; Wilson, 1995). Although community care policy aims to facilitate mutual understanding about clients' needs in order to provide appropriate and effective services, structural problems have underpinned the divergence of views (Myers and MacDonald, 1996) – the complexity of interpersonal relations, an imbalance of power and the policy context

(Biggs, 1994). However, government has accepted that serious problems have affected services (Department of Health, 1998) – eligibility criteria excluding people who need help; decisions service-driven not needs-led; variable services for carers. The drive now is for flexible and quality services, supported by frameworks and standards that improve the effectiveness of planning and provision, and safeguard people against poor practice. What are the prospects?

The Legal Mandate

The National Service Framework for Mental Health (Department of Health, 1999) creates standards designed to ensure that clients and carers have access to the full range of services that they need. That for older people (Department of Health, 2001a) aims to promote their physical and mental health and independence. Its standard of person centred care seeks to enable them to make choices about their own care. It acknowledges that older people and their carers have not always been treated with respect nor been able to make informed decisions through proper provision of information about care. It accepts that organisational structures have impeded the provision of care coordinated around the older person's needs.

However, there remains a reluctance to place social rights centre-stage in community care policy, an indication that the limits of the welfare state have been reached (Salter, 1994). Whilst disabled people and (some) carers have a right to assessment and to information about services, the legal mandate continues to embody a needs-led rather than rights-based approach (Drewett, 1999). Vaguely constructed discretionary duties largely provide the mandate for practice, allowing professional judgement and available resources to determine the scope of responsibility. Indeed, Rummery and Glendinning (1999) argue that professional and managerial gatekeeping compromises people's citizenship status and legal rights and rations provision. Service criteria linked to resource and budget considerations influence access to (Davis et al, 1998) and the content of assessed need (Biehal, 1993). Wells (1997) forthrightly asserts that insufficient resources compromise assessment. Perceptions of need, then, are shaped to match available resources.

Information is sought for, and assessment aims to meet the needs of the service (Social Services Inspectorate, 1997a) rather than the 'client's' felt needs.

Policy guidance, to which local authorities must adhere and which embellishes the duties contained in primary legislation, is often unknown to practitioners and to clients (Preston-Shoot, 2001). This ignorance of policy guidance and its weakness in holding practitioners and managers to what is lawful undermines good intentions to promote high standards of care, such as to ensure fair access to social care based on assessed needs and similar care outcomes whatever services are provided in response to risks (Department of Health, 2002a). Accountability to clients becomes compromised by accountability to an employer's procedures. Structured financial controls and procedures that limit the time which can be allocated to individual cases, for example, dominate over the legal rules and the professional values and knowledge that outline good practice. Sometimes practitioners complain of their inability to turn the community care policy of empowerment, needs-led assessment and holistic care plans into reality; sometimes they are angry at their compliance in a duplicity with managers about unmet need (Syrett et al, 1997). Equally worrying is the potential for collusion between organisations and care managers against clients, where unlawful and even abusive practice is condoned rather than challenged (Preston-Shoot, 2000a). The relationship between clients and social services departments remains fundamentally unequal (Rummery and Glendinning, 1999). Guidance requires services to better recognise and respond to carers' needs and sets standards for information giving, making representations, breaks, their emotional support and support to care and maintain their health (Department of Health, 2000). It requires councils to disseminate information about access, eligibility and services and to prioritise services according to risks to people's independence (Department of Health 2002a). More effective would be primary legislation that created rights for clients and carers or absolute duties on service providers, for example, to enforceable service standards.

Assessment

Clients and carers can find assessment encounters confusing, fragmentary, and irrelevant to their own concerns and priorities (Davis et al, 1998). In these reported projects they complained of inadequate time with social workers and lack of feedback about proposed care plans. They felt anxious and powerless, and did not know what services were available. They were unable, therefore, to make informed choices about what services would best meet their needs. Their experience, expertise and knowledge were undervalued. These accounts are not atypical (Preston-Shoot, 2000b). Yet assessment is one cornerstone of community care policy, with clients and carers supposedly centrally involved in identifying desired outcomes so as to redress the balance of power and improve services (Department of Health, 1991).

One source within assessment of a clash of perspective is the status of perceptions about need. Policy guidance (Department of Health, 1990), in recognising the potential for clients and carers to hold divergent opinions, privileges the client's view. However, in any disagreement between client and care manager, it privileges the latter's opinion, thereby allowing practitioners to use normative (standards set by professionals) and comparative (relative to others and to eligibility criteria) rather than client definitions of need (Tanner, 1998). Rather than an empowering process, assessment then becomes competitive since the volume of demand against budget effectively means that one person's resource is another person's unmet need.

Client and carer status is being reconfigured. Their views about their experiences must now be systematically sought (Department of Health, 2001a). They should be active partners in the assessment of their needs because of their expertise. They should be helped to prepare for the assessment process, which should find the best way for each individual to state their views (Department of Health, 2002a). Guidance on the single assessment framework (Department of Health, 2002b) notes that older people are the most important participants because they are the greatest experts on the nature of their difficulties and potential solutions. Thus assessment must in future

begin with their perspective and keep their account of their needs to the fore throughout assessment, care planning and service delivery.

Assessment should take account of whether carers have needs in their own right (Department of Health, 2002b). Indeed, care managers are exhorted to provide services focused on outcomes that carers want to see (Department of Health, 2001b). These are emotional support, support to care and to maintain their own health, having a break and a voice, and information, provided with sensitivity to need and in recognition of carers as partners (Department of Health, 2000). The new prominence given to advocacy for learning disabled people and clients experiencing mental distress is similarly a welcome corrective to professional power over information and decision-making.

However, these policy developments operate within the familiar hierarchy of relationships, such that the clash of perspective remains institutionalised within policy. Guidance (Department of Health, 1990) remains in force that the care manager's view ultimately prevails. The only reference to divergent perspectives appears in guidance on carers' assessments (Department of Health, 2001b) where care managers are advised to record differences between clients, carers and themselves.

A second source, inextricably linked to resources, is a narrow interpretation of care management as a bureaucratic rather than an empowerment and/or clinical (direct work) approach (Huxley, 1993; Nocon and Qureshi, 1996). A procedural rather than an exchange model of assessment (Smale et al, 1993) results. This explains why clients and carers complain about the absence of mutuality and recognition of their expertise on their own needs, and why researchers (for example, Wilson, 1995; Nocon and Qureshi, 1996; Stanley, 1999) find that assessment minimises some needs, such as emotional support, significant relationships, and life history. It may explain why in project 1 agreement between carers and assessors diminished the more the former expressed a need for help.

Guidance appears to reinforce the importance of an exchange model and partnership approach to

assessment. It notes (Department of Health, 2002b) that historically assessments may have been done to older people and services planned without considering their wishes and views. When working with carers (Department of Health, 2001b) purchasers and providers must listen carefully to what carers see as services able to deliver the outcomes most likely to help them and the cared-for person. However, councils may take resources into account when setting eligibility criteria (Department of Health, 2002a), which is likely to undermine the goal of similar care outcomes for similar assessed needs.

Limited assessment frameworks and skills comprise a third source. The importance of practice skills, such as communication, engagement and relationship building cannot be over-emphasised, especially when clients downplay their felt needs or distrust services. Administrative rather than relationship-based assessment models render it more difficult for clients and carers to speak their experience to authority and to challenge how practitioners judge their competence. Government inspectors (Social Services Inspectorate, 1997b; 1998) have articulated a need for systematic and targeted assessments, which do not make assumptions about needs but are informed by research on what people value.

Guidance is available on what assessment of clients (Department of Health, 1991; 2002a; 2002b) and carers (Department of Health, 2001b) should cover. This includes the nature of presenting need and its significance for the client. Guidance stresses the importance of information to informed choices, and of time since not everyone will be able to state from the outset what they want to happen or to identify their own needs. However, what is needed to achieve, maintain or restore an acceptable level of independence or quality of life is still defined by the agency (Department of Health, 1991).

Finally, role strain creates anxiety against which practitioners may defend by distancing themselves from clients and their needs. The impact of eligibility criteria, driven by agency resources, negates the policy requirements for accurate assessment of needs and services that promote and maintain people's quality of life. The policy also

portrays clients and carers as consumers with voice and the power of exit (Syrett et al, 1997). In fact, relationships remain fundamentally unchanged.

Triangles

The potential for conflict is threaded throughout assessment and care planning. How it is resolved depends on the 'client's' perceived ability, who disagrees with whom and the substance of the disagreements. Where clients and carers disagree, practitioners may arbitrate to enable each to appreciate the other's viewpoint but may override clients in order to avoid a crisis. Where clients and social workers disagree on how to meet need, negotiation and compromise may result (Myers and MacDonald, 1996). Clients and carers may exclude practitioners in emphasising family solidarity; clients and workers may exclude carers in maintaining independence despite risk; carers and workers may combine to exclude clients (Biggs, 1994; 1998). It is more helpful, however, to connect each apex of the triangle to appreciate different priorities and perspectives, to acknowledge the potential each can give to the encounter, and to hold in mind complex dynamics. Such an approach would illuminate the different levels of need expressed by carers in the two projects.

The complex triangular dynamics in the projects reported here differ – clients appear reluctant to admit their need for a lot of help; carers either more accurately estimate need and/or act as advocates for a lot of help to ensure that sufficient is provided. This may reflect the operation of another triangle (Braye and Preston-Shoot, 1995), namely needs, rights and resources, where the conflict centres around who or what controls the provision and quality of services.

The final triangle is agency, worker and client, where one dilemma is to whom the worker is ultimately accountable. This triangle carries the same danger of dyadic collusion, where one 'party' is recruited by another to endorse its position against the third or where one part is split off to defend against anxiety, contradiction or complexity within the task.

Conclusion

A perception audit challenges the assumptions and rhetoric on which policy and practice are built. The projects reported here expose the limitations of such principles as empowerment and choice as implemented in procedures and practice. They challenge providers about how they conduct assessments and offer services. In the current clamour for evidence-based practice, they offer further supporting data for why care managers are pessimistic about outcomes for clients within the present system (Syrett et al, 1997; Stanley, 1999). Whether the clear signposts, which they offer, will be followed to make the principles of community care more meaningful for clients, carers and practitioners alike is another question.

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References

- Biehal, N. (1993) 'Changing Practice: Participation, Rights and Community Care', *British Journal of Social Work*, 23(5): 443-58.
- Biggs, S. (1994) 'Failed Individualism in Community Care: An Example from Elder Abuse', *Journal of Social Work Practice*, 8(2): 137-49.
- Biggs, S. (1998) 'Carers, Clients and Workers: on the Relationship Between Policy and Collusion', in A. Foster and V. Zagier Roberts (eds) *Managing Mental Health in the Community: Chaos and Containment*. London: Routledge.
- Braye, S. and Preston-Shoot, M. (1995) *Empowering Practice in Social Care*, Buckingham: Open University Press.

Buckley, J., Preston-Shoot, M. and Smith, C. (1995) *Community Care Reforms: The Views of Users and Carers – Research Findings*, Manchester: University of Manchester School of Social Work.

Cullen, D., Waite, A., Oliver, N., Carson, J. and Holloway, F. (1997) 'Case Management for the Mentally Ill: A Comparative Evaluation of Client Satisfaction', *Health and Social Care in the Community* 5(2): 106-15.

Davis, A., Ellis, K. and Rummery, K. (1998) *Access to Assessment: Perspectives of Practitioners, Disabled People and Carers*, Bristol: Joseph Rowntree Foundation/Policy Press.

Department of Health (1990) *Community Care in the Next Decade and Beyond. Policy Guidance*. London: HMSO.

Department of Health (1991) *Care Management and Assessment: Practitioners' Guide*. London: HMSO.

Department of Health (1998) *Modernising Social Services*, London: The Stationery Office.

Department of Health (1999) *National Service Framework for Mental Health (LAC(1999)34)*. London: Department of Health.

Department of Health (2000) *Quality Standards for Local Carer Support Services*, London: Department of Health.

Department of Health (2001a) *National Service Framework for Older People: Executive Summary*, London: Department of Health.

Department of Health (2001b) *A Practitioners' Guide to Carers' Assessments under the Carers and Disabled Children Act 2000*, London: Department of Health.

Department of Health (2002a) *Fair Access to Care Services. Guidance on Eligibility Criteria for Adult Social Care (LAC(2002)13)*, London: Department of Health.

Department of Health (2002b) *Guidance on the Single Assessment Process for Older People (LAC(2002)1)*, London: Department of Health.

Donnelly, M. and Mays, N. (1995) 'Users' Views of Care in the Community Six Months after Discharge from Long-Stay Psychiatric Care', in G. Wilson (ed) *Community Care: Asking the User*, London: Chapman and Hall.

Drewett, A. (1999) 'Social Rights and Disability: the Language of 'rights' in Community Care Policies', *Disability and Society*, 14(1): 115-28.

Huxley, P. (1993) 'Case Management and Care Management in Community Care', *British Journal of Social Work*, 23(4): 365-81.

Huxley, P. and Mohamad, H. (1991/92) 'The Development of a General Satisfaction Questionnaire for use in Programme Evaluation', *Social Work and Social Sciences Review*, 3(1): 63-74.

Jahoda, A. and Cattermole, M. (1995) 'Leaving Home: A Real Choice for People with Learning Difficulties?', in G. Wilson (ed) *Community Care: Asking the User*, London: Chapman and Hall.

Joseph Rowntree Foundation (1996) *Respite Services for Adults with Learning Difficulties*, York: Joseph Rowntree Foundation.

Myers, F. and MacDonald, C. (1996) 'Power to the People? Involving Users and Carers in Needs Assessments and Care Planning – Views from the Practitioner', *Health and Social Care in the Community*, 4(2): 86-95.

Nocon, A. and Qureshi, H. (1996) *Outcomes of Community Care for Users and Carers*, Buckingham: Open University Press.

Preston-Shoot, M. and Wigley, V. (1999) *The Needs of People Aged 65 and Over on the Isle of Man. A Report to the Social Services Division, Isle of Man Government*. Liverpool John Moores University.

- Preston-Shoot, M. (2000a) 'What if? Using the Law to Uphold Practice Values and Standards', *Practice*, 12(4): 49-63.
- Preston-Shoot, M. (2000b) 'Clear Voices for Change: Messages from Disability Research for Law, Policy and Practice', in J. Copper (ed) *Law, Rights and Disability*, London: Jessica Kingsley Publishers.
- Preston-Shoot, M. (2001) 'A Triumph of Hope Over Experience? Modernizing Accountability: The Case of Complaints Procedures in Community Care', *Social Policy and Administration*, 35(6): 701-15.
- Rogers, A. and Pilgrim, D. (1995) 'Experiencing Psychiatry: an Example of Emancipatory Research', in G. Wilson (ed) *Community Care: Asking the User*, London: Chapman and Hall.
- Rummery, K. and Glendinning, C. (1999) 'Negotiating Needs, Access and Gatekeeping: Developments in Health and Community Care Policies in the UK and the Rights of Disabled and Older Citizens', *Critical Social Policy*, 19(3): 335-51.
- Salter, B. (1994) 'The Politics of Community Care: Social Rights and Welfare Limits', *Policy and Politics*, 22(2): 119-31.
- Smale, G. and Tuson, G. with Biehal, N. and Marsh, P. (1993) *Empowerment, Assessment, Care Management and the Skilled Worker*, London: NISW/HMSO.
- Social Services Inspectorate (1997a) *Caring for People at Home. An Overview of the National Inspection of Social Services Department Arrangements for the Assessment and Delivery of Home Care Services*, London: Department of Health.
- Social Services Inspectorate (1997b) *A Service on the Edge. Services for People who are Deaf or Hard of Hearing*, London: Department of Health.
- Social Services Inspectorate (1998) *A Sharper Focus. Inspection of Services for Adults who are Visually Impaired or Blind*, London: Department of Health.
- Stanley, N. (1999) 'User-Practitioner Transactions in the New Culture of Community Care', *British Journal of Social Work*, 29(3): 417-35.
- Syrett, V., Jones, M. and Sercombe, N. (1997) 'Implementing community care: the congruence of manager and practitioner cultures', *Social Work and Social Sciences Review* 7(3): 154-69.
- Tanner, D. (1998) 'Empowerment and Care Management: Swimming Against the Tide', *Health and Social Care in the Community*, 6(6): 447-57.
- Wells, J. (1997) 'Priorities, 'Street Level Bureaucracy' and the Community Mental Health Team', *Health and Social Care in the Community*, 5(5): 333-42.
- Wilson, G. (ed) (1995) *Community Care: Asking the User*, London: Chapman and Hall.

