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*ELEANOR RATHBONE MEMORIAL LECTURE*

**THE REALITIES  
OF A CARING  
COMMUNITY**

by

**OLIVE STEVENSON**

1980

## ELEANOR RATHBONE MEMORIAL LECTURES

The following Lectures have been delivered:

1. *Fear as a Deterrent* by Margaret Fry, J.P., M.A. (1948).
2. *Freer Migration and Western Security* by Sir Norman Angell (1950).
3. *The Philanthropist in a Changing World* by Mrs. J.L. Stock, B.SC. (ECON.), LL.D., LITT.D. (1952).
4. *Population Trends and the Social Services* by the Rt. Hon. Hugh Gaitskell, C.B.E., M.P. (1953).
5. *The Good Citizen* by the Rt. Hon. the Viscount Samuel, G.C.B., G.B.E. (1954).
6. *The Social Division of Welfare* by R.M. Titmuss (1955).
7. *The History of our Time : an Optimist's View* by K.R. Popper (1956).
8. *Natural Science and Social Science* by Sir Alexander Carr-Saunders (1957).
9. *The Equality of Women* by the Rt. Hon. the Lord Denning, Q.C. (1959).
10. *Penal Reform and Research* by the Rt. Hon. R.A. Butler (1960).
11. *Remuneration in a Welfare State* by the Baroness Wootton of Abinger, J.P., M.A., LL.D. (1961).
12. *The Disinherited Prisoner* by R.D. Fairn (1962).
13. *The Economic Rights of Women* by F. Le Gros Clark (1963).
14. *Social Purpose and Social Science* by T.S. Simey (1964).
15. *The Changing Pattern of Women's Employment* by Lady Williams, C.B.E. (1965).
16. *Philosophy and Politics* by A.J. Ayer (1967).
17. *Higher Education in the Stationary State* by John Vaizey, M.A. (1967).
18. *Race Relations and Education* by the Rt. Hon. Sir Edward Boyle, BART., M.P. (1970).
19. *The Politics of Pensions* by the Rt. Hon. Richard Crossman, O.B.E., M.A. (1971).
20. *Freedom and Order in a Liberal Society* by Shirley Williams, M.P. (1973).
21. *Blindness in Malnourished Children* by Antoinette Pirie, M.A. PH.D. (1974).
22. *Inequality, Hope and Progress* by Ralf Dahrendorf, PH.D., DR.PHIL. (1976).
23. *The Changing Face of Juvenile Justice* by Professor Winifred E. Cavanagh, B.SC.(ECON.), PH.D., D.P.A., J.P. (1976).
24. *Mothers and Children : Towards a Re-inherited Family* by the Rt. Hon. David Ennals, M.P. (1978).
25. *The Family Wage* by Hilary Land (1979).
26. *The Realities of a Caring Community* by Olive Stevenson (1980).

For Christie.

1981.

## ELEANOR RATHBONE MEMORIAL LECTURES

The Eleanor Rathbone Memorial Trust was established in 1948 to administer funds subscribed by friends and admirers of the late Miss Eleanor Rathbone (1872-1946) to perpetuate the memory of one of the outstanding English women of her generation, whose life was devoted to the defence of freedom and to the economic and social betterment of men and women of all nations.

Amongst the objects of the Trust is the provision of Eleanor Rathbone Memorial Lectures on subjects with which her name was particularly associated. The lectures are normally to be given in Somerville College, Oxford, where she was a student (from 1893 to 1896), or in one of the Universities (Birmingham, Bristol, Durham, Leeds, Liverpool, Manchester, Reading and Sheffield) which she represented as an Independent Member in the House of Commons from 1929 to 1946.

The 1980 Lecture was given at the University of Reading by Olive Stevenson, Professor of Social Policy and Social Work, University of Keele.

**THE REALITIES  
OF A CARING  
COMMUNITY**

The twenty-sixth Eleanor Rathbone Memorial Lecture  
delivered at the University of Reading  
on 4 November 1980

by

Olive Stevenson,  
Professor of Social Policy and Social Work,  
University of Keele

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This paper is in four parts. First, I shall pay some attention to definitions of the word 'community' and to the origins of, and meanings attached to, the phrase 'community care'. Secondly, I shall present some data concerning demographic trends, social structure, poverty and public expenditure in the personal social services. Thirdly, I shall examine some trends in two aspects of community care; those which relate to the support of individuals and families in their own homes and those which relate to the support of vulnerable and dependent people outside institutions but not in their own homes. In conclusion, I shall comment on the relationship of my theme to the views and policies of the present government.

It is customary at the beginning of a Memorial Lecture to pay tribute to the person for whom it was endowed. I prefer to reserve my tribute to Eleanor Rathbone until the end; I hope that the tone and content of this lecture will in themselves mirror, albeit inadequately, some of the values and issues about which she was so deeply concerned.

First, what does the word 'community' mean? At its widest, as defined by the Oxford Dictionary, it is 'a body of people organised into a political, municipal or social unity.' That is to say — the United Kingdom, Berkshire County Council, and this University may all be described as communities. Embedded in the word is a sense of belonging. We all belong to different communities for different purposes; such membership carries with it certain assumptions of reciprocity, of co-operation to mutual advantage. The word 'care' carries within it opposite meanings which stress our interdependence. 'Care' can mean both bearing burdens and taking responsibility for the burdens of others.

Although the phrase 'community care' is often used simply as an alternative to institutional care, it has nonetheless taken some colour from the meanings ascribed to the word 'community'. One sociologist has discovered ninety-four different definitions of 'community' which will not be rehearsed here. But the arguments are not merely semantic. There are some serious, indeed fundamental, issues about the word 'community' which have a direct bearing on any discussion of the development of social care.

For example, one of the most frequent confusions is between the idea of territory, of geographical space, and the alternative groupings which may legitimately be called communities. In research undertaken for the Royal Commission on Local Government in 1969<sup>1</sup> it was found that about one-fifth of the people in the sample did not acknowledge any

attachment to a home area and that those who did tended to perceive it in terms of physical appearance, the streets, etc., rather than 'mental distinctions in human terms.' This is a difficult phrase but the idea is very important for the planning of community care. As Cheetham and Hill<sup>2</sup> point out, the study did not address the more difficult question 'as to the extent to which residents of these small "home areas" agree in acknowledging the same area as each other. They suggest that

any attempt to map communities in this way might produce a very untidy collection of partially interlocking circles in any complex urban area.

But community is not only about geographical areas. It is about social networks and these are complex and varied. I am not a sociologist and am not competent to assess the current status of the debate about the nature of social networks which will no doubt be a continuing source of academic disagreement. However, even if the assessment made by Philip Abrams<sup>3</sup> is felt by some to be too extreme, his analysis of research evidence is of importance to our theme. He asserts:

In contemporary Britain . . . in almost every well-documented case the decisive context of care is not in fact community context in the territorial . . . sense. Rather the effective bases for community care are kinship, religions and race . . . Perhaps surprisingly, in view of all the talk there has been of the death of the family, kinship remains the strongest basis of attachment and the most reliable base of care that we have. This is especially true among women . . .

Abrams suggests that neighbours and more broadly based local communities come a very poor third to the ties of kinship and 'the moral communities' of religion, race and occupation. He suggests that we should be paying more attention to kinship and 'moral communities' as possible contexts for basic social care and less to the supposed 'communalities of location'.

Of course this does not mean that kinship ties are not on occasion territorially tight, especially when geographical mobility is low. Nor does it imply that nothing can or should be done to create community care which has the neighbourhood as its focus. It does, however, draw attention to the difficulties of such an enterprise. For, if Abrams is right, in many cases we would not be stimulating territorial networks which had become ineffective. We would be really starting from scratch. I shall return to this matter later in discussing trends in the personal social services.

What then of community care? What does the phrase really mean and whom does it embrace? There is no one right way of defining the term.

To the politician, community care is a useful piece of rhetoric; to the sociologist, it is a stick to beat institutional care with; to the civil servant it is a cheap alternative to institutional care which can be passed to the local authorities for action — or inaction; to the visionary, it is a dream of the new society in which people really do care; to social services departments, it is a nightmare of heightened public expectations and inadequate resources to meet them. We are only beginning to find out what it means to the old, the chronic sick and the handicapped.<sup>4</sup>

The title of this lecture was deliberately chosen to avoid the phrase in its familiar shape not only because it means different things to different people, but because it is too often used as a political slogan with little substance. Nonetheless, the term community care has popular currency and has its roots in an important principle. It rests on an ideal that individuals have a right to a life which is as 'natural' or 'normal' as possible in terms of the social context in which most of us have been born, reared and spent our adult lives. Some date its modern dawn from 1959 when the Mental Health Act was passed, which gave momentum to policies of rehabilitation of the mentally ill and mentally handicapped from the hospital to the community. Yet if one looks at different areas of social policy, it is apparent that this particular thrust was part of a wider movement. With the creation of Children's Departments in 1948 came increasing emphasis on the need and right of children to have experiences which would approximate as nearly as possible to normal family life. Large institutions were out of favour; fostering placements and the development of social work support to natural families were characteristic of the '50's, '60's and '70's.

It would be unrealistic to ignore the increasing concern about the financial cost of institutional care as a factor in the movement towards community care. But equally it would be cynical to suggest that the principle at stake was insignificant. Evidence of the deleterious effects of institutionalisation came from various directions and the combined effects were powerful.

However, even if community care is defined as social care outside institutions, that still leaves a need for further clarification. In this paper the term is used widely to cover all the means which we use or could use to support individuals and families outside institutions. This must take

account of the community as a political organisation and of its more intimate connotations. Its political context is crucial, for policies and programmes determined by the communities of both central and local government will greatly affect the quality of social care offered by other communities, whether they be territorial or the 'moral communities' to which Abrams refers. Two of the most important areas by which government affects social care are, of course, through income maintenance schemes and through those other elements in public expenditure which affect the personal social services. (One must also take into account some of the expenditure on health care, aspects of which are inseparable from social care as far as the well-being of individuals is concerned. However, this paper does not deal with that). One way of grasping the concept for the purposes of this discussion is to see the political unity, in this case the state, as providing the outer circle for community care, within which numerous other circles interlock and interact but are in some way connected to that outer circle.

Bayley<sup>5</sup>, in a study of the mentally handicapped and community care, drew a seemingly obvious distinction between care *in* the community and care *by* the community. It is one worth making, however, for it points to the gap between the rhetoric and the reality. The latter phrase carries with it a moral assumption of mutual responsibility and, in particular, of the support by the stronger of the weaker and more vulnerable members. Everything I have to say here is thus about care *by* the community. But that does not mean that the community should be considered solely as an informal system.

To whom, then, is this caring to be offered? The position of the family is central; as has been suggested, all available evidence shows us that the major support to the most vulnerable in our society is provided by the family. This applies not only to children but to the elderly, the handicapped and ill. For example, the White Paper of 1971 on the care of the mentally handicapped<sup>6</sup> estimated that 80% of these severely handicapped children and 40% of severely mentally handicapped adults lived at home. There has been much ill-informed comment about the breakdown of family support which is not substantiated by the facts. Nor has any effective alternative arisen to family care; amoebic-like, family structures alter in response to changing economic and social conditions but the family survives as a distinguishable entity against transient threats from alternative lifestyles such as kibbutz and communes.

Politicians of all colours are formally committed to its support;

indeed, they can hardly be otherwise since it provides the most extensive and least expensive form of social care for our vulnerable citizens. Caring for the carers thus becomes a central plank in community care. But this phrase merits careful examination. To be meaningful it must first take into account the implications of changing patterns of family life for the part which family members can play in care for their kith and kin. Secondly, it must examine the costs honestly. They are of two kinds. There are the personal costs, social, psychological and financial to those who care, and this includes all members of the family. There are the financial costs of providing domiciliary services to the primary caregivers. I return to these points later.

The family, then, remains the first line of defence. The implications for community care are many and various, not least because the family burden varies greatly in extent and duration. At one extreme, we see the parents of a severely mentally handicapped person who needs constant care as a child and as an adult. Both the extent and the duration combine to make heavy demands on the carers. At the other extreme, there is the family of a normal child subjected to a period of temporary stress, perhaps the severe illness of a parent. This family's need for support is limited in extent and in duration. Between the two lie many other examples; the years of struggle for a one-parent family in rearing normal children; perhaps a shorter period of decline when an old person deteriorates mentally and physically yet when the strain on the carers is by any standard grave.

In any consideration of community care, therefore, systems of family support are integral and I shall discuss aspects of this in the second part of my paper. But, of course, community care is also concerned with the support of those individuals who have no families available. These include those children in care, by no means all, who have tenuous or non-existent links with parents. Or they may be adults who are physically or mentally ill or handicapped; or they may be very old. The last group, the very old, raises some specific difficulties which merit particular attention. There is no evidence, as I have said, that families generally neglect their older relatives. But a study by Mark Abrams of the over seventy-fives in three parts of England<sup>7</sup> reveals something of what one might describe as family deficiency rather than family neglect. His conclusions, from a rigorous methodological study are:

- that two-thirds of the women aged 75 or more were widowed, divorced or separated and 18% had never married;

- that over one-third had either never had any children or else had outlived them. Among those living alone, as many as 45% were childless;
- but that of those with living offspring, nearly three-quarters saw them at least once a week;
- but that less than 30% of people aged 75 or more had had a visit from any family member during the weekend before the interview.

Abrams concludes that:

it would be erroneous to assume that family life (even if this includes "intimacy at a distance") is available to all elderly people; a substantial minority (over one-third) had no living offspring; for companionship these old people were entirely dependent on what was provided by friends and neighbours and the occasional contacts with statutory and voluntary social workers.

Whilst there will always be examples of family neglect, an analysis of the situations of old people, such as Abrams made, clearly shows that family deficiency is a much more complex notion, involving as it does childlessness, the death of children before their elderly parents, and geographical mobility.

Abrams asked the women over 75 about their feelings of loneliness. In a carefully constructed set of questions, it emerged that 28% of those living alone as compared with 14% of those not living alone expressed serious feelings of depression and isolation. One of the saddest findings was that 40% of the sample of those living alone said, 'I no longer do anything that is of real use to others.' This was an aspect of their loneliness. If one links this to the demographic trends which I shall describe later, it is clear that the single most important challenge to community care in the next twenty years will be in relation to the elderly. How do we mobilise alternative networks to those which family and kin supply, bearing in mind the evidence of the weakness of neighbourhood networks in comparison with 'moral communities'?

For a large section of our vulnerable population, mostly the very old, who have no available family, community care means support in living as independently as possible. But there is a third group (which can include all ages) for whom community care means the provision of substitute family life as its guiding principle. The most obvious examples are of fostering and hostels and small group homes for the handicapped and ill.

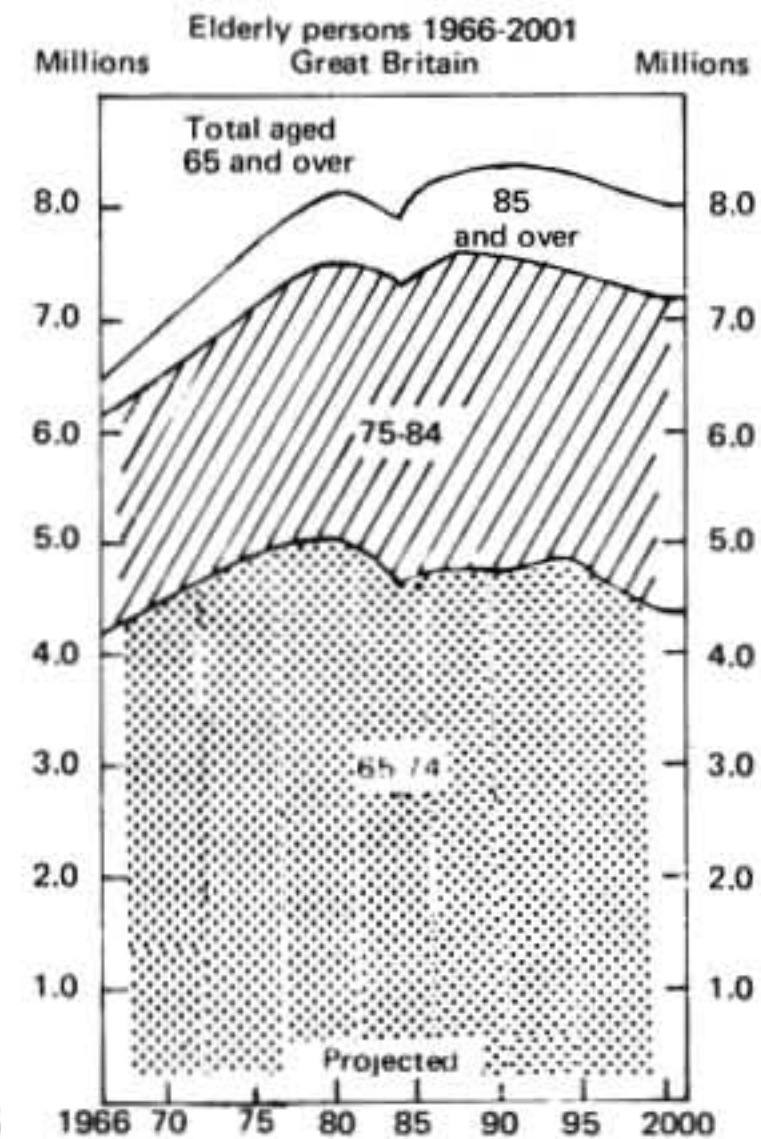
To summarise so far; first, albeit briefly, the definitional problems of the word community and the evidence of the strongest existing systems of community support in Britain today have been considered. It is suggested that the ideal of community care rests upon the conviction that all human beings have the right to live a life as near to that which is perceived to be normal by the society in question and that this is unlikely to be achieved in large institutions. I have outlined the importance of caring for the carers and pointed to some of the complexities if that is to be made a reality. Finally, I have pointed out the distinctions within the notion of community care which affect the type of support that is offered.

I turn now to look briefly at some demographic trends and other relevant factors concerning our social structure.

There can be no doubt that the rising proportion of the very old represents the major social challenge to an ideal of community care.

Table 1

**Elderly Persons 1966-2001**  
(p.8, *A Happier Old Age*, HMSO 1978)



Source: OPCS

This graph shows that the young elderly, though increasing somewhat in the middle of the period between 1966 and the year 2000, revert to about four and a quarter million by the end of that period. In contrast, the 75 — 84's increase from just over six million in 1966 to just over seven million in 2000 and the over 85's increase from six million to eight million.

**Table 2**  
**Home Population in England — millions**

Age	1973	1979	1985	Percentage change		Overall
				1971-73	1973-79	percentage change
0 — 4	3.5	2.8	3.4	-4	-19	0
5 — 15	8.1	7.9	6.8	+3	-3	-17
16 — 64	28.4	28.8	29.8	0	+1	+5
65 — 74	4.1	4.3	4.1	+4	+5	-1
75+	2.3	2.5	2.8	+3	+13	+25
Total:	46.4	46.4	47.0	+1	0	+1

*(Priorities for Health and Personal Social Services in England — a consultative document, HMSO, 1976)*

This table shows the balance of the population structure as a whole. The percentage of children between 1973 and 1979 has dropped in all by 22%, whereas the number of those over 75 has increased by 13%. The last column shows that between 1973 and 1985 we will see a stable child population but an increase of 25% in the over 75's.

Any consideration of our social structure must also take into account the changing patterns of marriage, divorce, and re-marriage. For example, there has been a fourfold increase in divorce over the past 20 years; of those divorcing now, one-third are likely to re-marry; of those under thirty when divorced, 80% are likely to re-marry; and women over thirty-five are least likely to re-marry.<sup>8</sup> To this must be linked trends in the employment of women. For example, in 1977, of women aged 25 — 34, 52% were working (about half full-time and half part-time); 67% aged 35 — 44 (28% full-time and 39% part-time); and 62% of those aged 45 — 59 were also in employment.<sup>9</sup> It remains to be seen, of course, how far the pattern and size of women's employment is affected

by the massive increase in unemployment generally which we are now seeing. What can be said with some certainty, however, is that very large numbers of women want to work, both for financial and social reasons and will return to it as soon as the opportunity presents itself.

The implications of these three trends put together are far-reaching and must be speculative although their general significance for policies of community care is immediately apparent. The tension between the traditional caring functions which women have performed and the demands of full- and part-time employment are obvious and have been much discussed. Less attention has been paid to the affects of marriage patterns on community care, in particular in relation to the elderly. Although most divorces take place when grandparents are relatively young and independent, the effect on the patterns of family interaction are often dramatically changed. We have yet to see how this affects systems of family support twenty years later. Bluntly, kinship ties which are formally broken and remade may alter the degree of responsibility felt for the well-being of the older generation. Concern and affection of course can exist independently of formal ties. But it would be foolish to ignore the force of such ties in maintaining support which involves considerable personal cost and strain. Furthermore, the way tensions and difficulties existing at the times of divorce and remarriage are managed by all the generations, including the oldest, is bound to have an effect on the subsequent willingness of the younger to care for the older. Remarkably little has been said about the impact on the family as a whole of patterns of family life which produce 'multiple grandparents'.

Divorce and remarriage, then, raise problems for the care of the very old, as indeed they do for the care of other vulnerable family members such as the mentally handicapped or ill. It is not only the *numbers* of the frail elderly in contemporary society which justify a particular emphasis on their position in relation to changes in the family structure.

Women's employment patterns are relevant because many women and some men will be 'one-parent families' for a period of time and for them employment will not be in any sense optional. However, the issue is more fundamental and far-reaching, since women in the last twenty years of the 20th century are most unlikely to retreat from their evident wish to be involved in paid employment. If one adds to that the finding that divorced women over 35 are least likely to re-marry, the whole issue of women's role in society in relation to their traditional function of informal community care must be called in question. In a hard hitting

article, Finch and Groves<sup>10</sup> put the feminist case most convincingly. They suggest that:

there is a very real possibility that women may be expected to, and may feel that, they have to give up work in order to provide care for a dependent relative . . . It is a situation which can be fraught with conflict, regardless of marital status.

They point out that because women are in general less well paid (and one might add also because of societal expectations) they are the more likely partner to give up work. However, this does not mean that the financial consequences are not serious; women's earnings are not pin money.

A survey in 1974 showed that out of 11 million couples with a husband under 65, 7 million wives contributed 25% to the family budget and the earnings of one-third of the wives constituted 30-35% of the family income. Moreover, three times as many families with working fathers would have incomes below supplementary benefits level if their wives were to stop working.

Finch and Groves go on to point out that

giving up work to care for a dependent relative may well be a prelude to poverty in old age for the carer,

since there may be considerable difficulty in getting back into the employment market and the interruption of earnings may have serious effects on occupational pensions. The authors dwell almost exclusively on the financial consequences of leaving the employment market but there can be no dodging the social and psychological implications. The benefit of work outside the home for certain groups of women has been demonstrated by careful empirical study by, amongst others, Brown and Harris.<sup>11</sup> This work has shown that clinical depression is more common among women who do not go out to work, if they lack close emotional support. The position of carers, usually, though not always women, in relation to their dependents has recently been described by the Equal Opportunities Commission.<sup>12</sup> Its use of case histories with quotation is poignant and vividly illustrates the circumstances in which many women find themselves:

Christine is 36. She cares for her 73 year old father, William, who has a blood complaint.

"I have been looking after my father since 1975. He lives in his own house and at the moment I am caring for him for two to three hours a day, and it's increasing all the time. I do it because I love him and there is no-one else. I do his cooking and washing, and I help him financially — every now and then I give him money to help with his budget, and I pay the bills for him. I don't think of them and total them — he's father and we do it. Yes, it has affected my family life, I'm torn between one and the other (husband and father). I have very little social life.

Over the past four years we haven't had a month without bother. It builds up, and you get to wonder what each day will bring. I'm constantly under the doctor."

Annie is 63. She cares for her 70 year old husband, Jack, who has bronchitis and asthma.

"My husband has chronic bronchitis and asthma. I've been caring for him for seven years. I have to do everything for him. In winter he can't stand the cold, in summer the dust, so he has asthma all the time. I worked up to being 50 years old, but gave it up because it got a bit too much. I have no pension. I would have a job if I could get one, it would help out.

We have extra heating costs in winter, I use more coal because he can't stand the cold. I have to change the beds every day and I clean every day, I do all the cooking, washing, and I fetch his medicines. We have a bath, but we haven't a toilet inside.

My family life hasn't been affected as such, but it does get on top of me. We haven't had a holiday for twenty years. He wouldn't go and I wouldn't go and leave him, so we don't go. I would like to, but we need all our money for heating and food."

This discussion is not meant to suggest that there are not emotional satisfactions for relatives in the provision of care for the dependent and vulnerable. Bayley's study of the mentally handicapped and their families illustrates this vividly.<sup>13</sup> Furthermore, for some, the decision to give up work will be made without great conflict. The purpose of drawing attention to these trends is to illustrate that we cannot take for

granted that patterns of family support should or will be available in the same form as heretofore. All patterns and structures in family life bring with them gains and losses for the individuals concerned. We have no right to assume that one particular pattern is, as it were, God-given and that a departure from it is to be deplored. The only rational way forward is to examine the implications of these changes for the provision of social care and to try to devise policies and programmes which take account of them. We ignore them at our peril.

Eleanor Rathbone did not mince her words about the position of women in family life. In 1924 she wrote:<sup>14</sup>

the development of this sense of sex grievance into a sense of sex solidarity and an articulate demand for the economic independence of women is, I believe, only a matter of time . . . the married working woman is apt to have a shrewd if a narrow mind. Her success in her particular job depends largely on humouring her household, especially its male members and getting her own way while seeming to give them their's . . .

She concludes: 'The movement for economic independence is still subterranean . . .' It would be unwise to dismiss these statements today, even if the emphasis has changed.

No consideration of the reality of a caring community can leave out of account the question of income support, both for those who look after the vulnerable and those to attempt to look after themselves. Townsend's<sup>15</sup> monumental *Poverty in the United Kingdom*, though contentious in some of its arguments, is remarkable in documenting and analysing the persisting problem of poverty in our midst. It is not appropriate to dwell on the detailed argument here but a few of the salient findings illustrate its relevance to community care. Townsend argues that:

- the poorest groups in our society are one-parent families and the elderly;
- about half one-parent families (a quarter of a million) are in, or on the margins of, poverty, compared with about a quarter of two-parent families;
- 20% (1.7 million) of the elderly are in poverty;
- 44% (3.7 million) of the elderly are on the margins of poverty;
- the elderly poor represent 36% of the poor.

He also suggests that of those appreciably or severely incapacitated, 43% of those between 40 and pensionable age and 52% of those of pensionable age are on the margins of poverty at the state standard.

This research was undertaken in a period of relative prosperity and takes no account of our present economic plight and, in particular, of the changes in government policies concerning aspects of social security. Townsend concluded that, on the state's own definition, 12 of our 50 million population are in or on the margins of poverty. Even if that figure were overestimated at the time of the survey, it is likely to be an underestimate for the first half of the 1980's. This gloomy finding has major implications for care by the community. For not only are some of the most vulnerable poor; so are a good many of their potential carers. That affects what one can afford to do for others. Even bus fares may deter the family of an unemployed man from visiting his parents.

As against these depressing facts concerning the extent and persistence of poverty amongst certain groups, one must acknowledge certain significant developments of principle in the social security scheme which are of particular value to those in the community who care for, or who are amongst, the most vulnerable and dependent. These include Attendance and Mobility Allowances and Invalidity Benefit. It is beyond the scope of this paper to consider the arguments concerning the structure of our social security system and the ways in which it cumulatively operates for the welfare or dis-welfare of certain groups. What has to be said is that, however laudable the intention behind various new elements in social security provision, the maintenance and increase of their real value in the next decade or so will be the test of their effectiveness. Furthermore, some would say — and I would agree — that the sheer complexity of the social security system, through the *ad hoc* development of various allowances has created a situation in which it is difficult for people to know their rights and to ensure that they have made, or been helped to make, the best use of available benefits. An example is the controversy, eventually taken to the courts, as to whether the parents of a mentally handicapped child suffering from Down's Syndrome were eligible for a Mobility Allowance. A similar case has recently been brought regarding an autistic child. Phrases like 'mobility' or 'constant attendance' when they are linchpins for eligibility for a particular benefit are bound to give rise to problems of interpretation. Interesting legal points they may be, but to the relatives the issues are not only of financial importance; they are often symbolic of the sympathy and support accorded, or not accorded, to them by the formal community, the state.

The persistence of poverty amongst our population means, quite simply, that many people cannot buy support by direct cash transactions. There are innumerable ways in which relatively small sums of money oil the wheels — freedom to order a taxi, pay to have your hair done at home, and so on. There are those who argue that we should work towards a system which encourages such direct transactions since it increases the dignity and independence of the individuals needing support. This sounds good but it can be used as a smoke screen to hide the deficiencies of the services essential to effective community care. True, if you are as rich as Elizabeth Taylor or Richard Burton, you can probably buy every service you need. But even for those who are comfortably off, certain services crucial for their well-being are, in this country, in very short supply. To take two very simple examples; first, there is a chronic shortage of chiropodists, with serious adverse consequences for the health and well-being of large numbers of frail elderly people living alone. Secondly, the provision of good quality day care for working mothers is, to put it mildly, patchy. Yet, as we have shown, there are and will continue to be, large numbers of one-parent families whose well-being is dependent upon there being adequate facilities for young children.

These are only illustrations of a more general point, that the model of the market place in which services are bought and sold is simply not adequate to deal with the needs of those of our citizens who, for one reason or another, need support to live in the community.

Finally, in this inevitably superficial discussion of social trends, I must point to another disturbing fact. The numbers of children committed to care by the courts has risen by nearly 100% in the twenty years 1956-76.<sup>16</sup> Contrary to popular impression, this is not primarily due to a rise in juvenile delinquency. Non-offenders have increased proportionately to offenders in this group of committed children. In 1976, of nearly 13,000 children committed to care, more than 50% were non-offenders, that is, the reason for their committal was not juvenile delinquency. Clearly, the interpretation of such a trend requires the utmost caution. It is all too easy to use such figures to support a particular moral or political stance. Parker is appropriately cautious, suggesting that:

the raising of the age of criminal responsibility from 8 to 10 (in 1969) hardly provides an adequate explanation. The increase in non-attendance at school may be a somewhat more important cause, as may be concern about non-accidental injury.

There is evidence to support the second point. After the Maria Colwell Inquiry<sup>17</sup> the numbers of Place of Safety Orders, made by magistrates at the request of social workers, to enable immediate removal from home of children considered to be at risk, rose dramatically.<sup>18</sup>

**Number of Place of Safety Orders made**

March 1972	204
March 1973	214
Colwell Inquiry sitting 1974	353
Publication of Report 1975	596
1976	759

But this further illustrates a dilemma in the interpretation of statistics. It would be absurd to conclude that the numbers of abused children rose so sharply immediately after the inquiry. Clearly, we are seeing a changing social response, embodied in the use of legislation by social services departments, to the social problem of children at risk in their own homes. The same point applies to the increase in care orders.

Be that as it may, it would be at least clear cut if one could say that the increase in the numbers of children committed to care means a similar increase in the numbers living away from their parents. But this is not so, for there has also been an increase of about 5% in the numbers of children who, though committed to the care of the local authority, are living with parents, guardians or friends. In 1976, about 35% of all these committed children were living in the community, mostly with their parents. But although these figures include children and young people committed for delinquency and then allowed home, the major increase in the ten year period of committed children living at home is to be found in those *NOT* committed for delinquency but for other reasons.

Behind these figures and the debate as to their interpretation, lie serious issues for social policy. There are deep divisions of opinion embodied in the latest government White Paper on Young Offenders<sup>19</sup> which proposes changes in the law relating to juvenile delinquency and in the reactions to this White Paper. I shall return to this point.

Before leaving facts and figures, a few points on social expenditure are appropriate so that some of the debate about community care can be put in a realistic context.

### Social Expenditure in 1975

	£ million	% of total
Social security	8918	33.8
Education	6626	25.1
NHS	5202	19.7
Housing	4291	16.2
Personal social services	990	3.7
School meals and welfare foods	390	1.5
Total:	£26417 million	

(CSO, *National Income and Expenditure, 1965-75*)

NB. Expenditure on personal social services consumed 1.9% of total public expenditure in 1976.

There is a sense in which all aspects of social expenditure can be said to be relevant to the practice of community care. However, this table shows that one key element, the personal social services, accounts for a very small percentage of the total. It is important to note this since the present government, in some of its pronouncements, may have led the general public to conclude that the personal social services have a much larger share of the cake than is in fact the case. One also notes that these services consumed less than 2% of the total public expenditure in 1976.

### Social Services Departments Revenue Expenditure 1976-77

	£ thousands	%
Total (net)	904678	
Fieldwork (including administration)	147384	16.3
Residential care (including admin.)	434805	48.0
Day care	106571	11.8
Community care	164566	18.2
Miscellaneous support services	5118	0.6
Administration — support services	41346	4.6
Research and development	4888	0.5

(*Health and Personal Social Services Statistics for England, 1978, DHSS, Table 2.10*)

This table shows that residential care takes up approximately 50% of the budget for personal social services. In the table, community care is

defined more narrowly to mean such services as home help and meals-on-wheels. But in the context in which the phrase is used in this paper, it is appropriate to put fieldwork, day care and community care together. When this is done, it can be seen that the total expenditure on community care is much the same as that on residential care. But the financial implications are very different. For the packages of community care vary greatly with individuals and there are many ways of exploring alternative support systems which give much greater flexibility for the same amount of money. In the case of residential care the cost per head, though varying between client groups, does not vary between individuals.

Thus, in this part of my paper, I have made some links between different kinds of data and indicated some of their implications for community care. I have pointed to the changes in population structure, mainly in respect of the projected increase in the frail elderly and to the relationship of this trend to patterns of divorce and remarriage and women's employment. I have suggested that no discussion of community care can leave out of account the persistence of extensive poverty amongst certain groups and that the structure of our social security system in some ways does not facilitate effective community care. The rise of children committed to care is a trend of major importance but its significance and therefore its implications for social policy are as yet little understood. Finally, I have sought to pin our discussion to the realities of expenditure and, in particular, to show how small a share of the national cake is given to the personal social services, whose responsibility it is not to provide all the social care which the dependent need but to ensure that it is provided. One of the greatest frustrations currently amongst social workers in both the statutory and voluntary sectors is that the resources are lacking to innovate in community care and to support and foster altruism by imaginative and efficient organisation. Even our 'free' blood transfusion service which Titmuss<sup>20</sup> used to exemplify social altruism, needs some resources for its effective working.

Thus far, I have painted with a broad brush; I have tried to indicate some of the issues and social trends which are integral to a realistic consideration of community care. In conclusion, I select from a massive array of particular problems only three, to demonstrate what is involved in the translation of ideals into practice. The three illustrate different facets of social policies and programmes.

The first concerns children and young people. I have already pointed

out that, from 1948, when sophisticated services to deprived children began to develop, there has been doubt concerning the effectiveness of residential care for the care and treatment of young people. This is in no way to denigrate the benign commitment of many who offered such care. Furthermore, efforts have been continuously made to move residential child care from what might be described as an 'institutional' to a 'family' model. Nonetheless, for reasons which have as much to do with roles and structures as with personalities, it has proved extraordinarily difficult to replicate family life in residential care, even when there has been a will to do so. Even more complex, however, has been the task of providing effective care to those who are removed from home because of their delinquent activities. A colleague and I recently completed a literature review for the Social Science Research Council on certain aspects of social policy, including substitute care for children and young people.<sup>21</sup> We concluded, after detailed study of the available research, that:

the overall picture of the effectiveness of residential treatment as a means of preventing juvenile delinquency is bleak.

It would be fair to say that this statement is widely accepted by informed persons of all political colours and is indeed acknowledged in the latest government White Paper.<sup>22</sup> It is interesting that the numbers and proportions of children and young persons in residential care for delinquents has changed very little in the twenty years 1956-76. As was pointed out earlier, in 1976 some 37% of committed children and young persons were at home and of these, rather less than half were juvenile delinquents. These bald facts give the background to a dispute between the judiciary and the social services which has found expression in the White Paper, in which it is proposed to give the courts new powers to make a residential care order, for a period of up to six months, in respect of a young offender who has been committed to care, has been living at home and commits another offence. In a sense, this move comes as no surprise to those who have listened to the rumblings of discontent and watched the growing disenchantment with the workings of the 1969 Children and Young Persons Act, which sought to develop new forms of community care for young people, which were described as 'intermediate treatment'. In fact, the proposals are more restrained than was at first rumoured. This is not the place to discuss the rising tide of anxiety concerning juvenile delinquency and the extent to which it is objectively justified or, indeed, the argument between the proponents of

the 'justice or welfare' models of juvenile justice. The point to stress is that there is no evidence that the residential treatment of delinquent children and young people is more effective than alternative forms of community treatment and that very few of the children and young persons in question need to be in custodial care because they are a significant danger to the community. Furthermore, there is at least a reasonable presumption, as with adult offenders, that their interaction with each other in the confines of institutional care may be actively harmful. There are also trends which are frankly alarming. This decade has seen the rapid development of closed units in community homes with education on the premises. Cawson and Martell<sup>23</sup>, in a rigorous analysis published by the DHSS of the characteristics of children who were sent to closed units show that there is no rationale for this. They conclude:

The selection of children for referral and admission (to closed units) bore little relationship to the reasons for which the unit was ostensibly provided. There was no evidence of a large increase in the number of violent or seriously disruptive children in care and, equally, no evidence that closed units were particularly effective in reducing violent or delinquent behaviour . . . In the past decade . . . the older more delinquent population has been creamed off by the Borstal system . . . Instead of reducing pressure on the child care service, this has increased it, leading to a definition of younger children, less delinquent and apparently less disturbed as unmanageable by the child care service . . .

Thus the likelihood of positive harm to children in institutional care is high.

The saddest part of the story is that children may have suffered and may continue to do so because of a breakdown in trust relations between the police and magistracy on the one hand and social services departments on the other. There are, needless to say, faults on both sides. However, in fairness to social services departments, it should be said that their statutory responsibility to implement the Children and Young Persons Act came at a time of major organisational upheaval when other pressing statutory duties were newly placed upon them. It is far too soon to declare unsuccessful the policies for the community treatment of delinquent young people which have generated considerable interest and probably more innovative projects than any other aspect of the personal social services in the past decade. To be fair,

the White Paper stresses the importance which the government attaches to non-custodial alternatives. But the inescapable impression of the Paper as a whole is that it will give encouragement to those who wish to retreat from professional policies, back to the tried and failed systems of institutional care, including the short, sharp shock which was tried and abandoned in the 1950's. It is to pander to the more primitive reactions, both punitive and fearful, which exist in all of us and which are so resistant to evidence, however carefully adduced. And if we do decide to pursue ineffective policies we might as well make them cheap.

The second illustration concerns the provision of substitute care in the community for the mentally handicapped who cannot live at home and for whom hostel care is provided. The comments refer only to the mentally handicapped and not to the mentally ill because comparable information on the latter group is hard to come by. However, one may note in passing that in 1977-78, *all* personal social services to the mentally ill accounted for under 1% of the budget as compared with 4.5% for the physically handicapped and 7.2% for the mentally handicapped. Furthermore, an analysis of hostel provision in eleven local authorities in 1975<sup>24</sup>, showed a far lower growth rate than for the mentally handicapped. There is clear evidence of serious neglect of the mentally ill.

Documentation on mental handicap is, however, much fuller. The government White Paper on mental handicap<sup>25</sup>, the Jay Committee<sup>26</sup> and a recent monograph from the Campaign for Mentally Handicapped People<sup>27</sup> give us much of value. This last document illustrates the gap between what they describe as 'the wealth of good advice in the 1970's' and the size of the problem which still confronts us.

The number of mentally handicapped patients in hospitals declined by some 5000 (from 65000 to 60000) in the last ten years and the number in hostels tripled — from 3000 to 9000. Since it is common ground that large numbers of such people need not be in hospital it is clear how far we have to go. Places for mentally handicapped children in hostels have increased much less rapidly and at the present rate would never reach the 1971 White Paper target; adult targets could be reached in 17 years' time, if the present rate of progress is maintained, which is unlikely. Even so, the mere creation of a hostel is no guarantee of good community care. For example, inappropriate nursing models of care can be used in the hostels so that the level of dependency among residents is unchanged. The crucial issue that emerges from the literature is the division between what Miller and Gwynne<sup>28</sup> describe as

'warehousing' and 'horticultural' models of care. Contrary to what most students infer from the phrase, Miller and Gwynne do not suggest that warehousing is wholly negative and horticulture wholly positive. Although their research refers primarily to the physically disabled, it is every bit as relevant to the care of the mentally handicapped and mentally ill. Briefly, the dilemma which faces those who care for such people concerns the extent to which change, development, progress, call it what you will, is possible. There are very real tensions in the provision of care which, on the one hand supports and sustains the individual and accepts his disability and, on the other, seeks to maximise his independence, often with a view ultimately to living outside the hostel. Assumptions which were made concerning the high dependency levels of some mentally handicapped people have been proved quite wrong. In innumerable ways institutional life can stunt the individual's development. Hostels, therefore, have many opportunities to promote growth, for example, in helping residents to choose for themselves what clothes to wear. But once the emotional fulfilment of the staff depends too greatly on such achievements, we are in dangerous waters for those who fail can be rejected or neglected. If hostel care becomes inseparable from some notion of fuller rehabilitation, its function in providing asylum, shelter for the weak, is downgraded.

However, slow as our progress may be, both in the extent and quality of such provision, it is an aspect of community care which has both profited by and contributed to the lessening of social stigma attached to these groups. And this is one of the crucial arguments for community care. It forces us to look at those who differ from the normal and in so doing, our stereotypes, our myths, and our fears are often dispelled. The power of these emotions is all too clearly seen in the predictable protests from local citizens when a hostel in their area is projected. The cry always goes up, 'our women and children are at risk', yet, interestingly, one is hard put to recall serious incidents involving hostel residents and the anxiety of the local community usually diminishes, especially if their involvement in the life of the hostel is fostered. This is being done in many parts of the country. This form of care is not dramatic yet it is in fact a microcosm of the ideal of community care.

The third and final illustration of issues in community care reverts to the first point of the paper, namely, to the need to know more about the social networks upon which the development of community care must rest. The present government lays much stress on the need to develop and foster informal caring systems. As I have suggested, these notions

of community are frequently confused with ideas of territory, of some geographical entity. Some social workers and academics, intentionally or unintentionally, are conspiring with politicians to confuse the issue. Speaking to the Association of Directors of Social Services<sup>29</sup>, the Secretary of State commended the notion of 'a patch system' for the delivery of social services. This idea is currently being developed with a kind of ideological fervour and represents an unfortunate coalition of the right and the left in politics. Briefly, for the uninitiated, the patch idea, at its purest, suggests that one social worker from an area team should be solely responsible for a small geographical area. The claim is made that this will enable an intimate knowledge of the local community and thus enable a more effective use of *very* local resources for community care. It often carries with it a dislike of the elitism assumed to be part of professionalism. Thus, the local friendly neighbourhood social worker is 'pedestrianised' and 'localised'; he is to be found in the pub, poking away at the grass roots. This suits the left, who dislike all professionals, and the right who are not yet willing to accept social work in the ranks of the doctors and lawyers.

I am being irreverent and of course unfair. It is perfectly proper that social workers should seek to find ways of mobilising territorial information networks. And it is true that they have not been particularly good at this heretofore. However, if Philip Abrams' arguments<sup>30</sup>, well supported by evidence, are correct, this can be only one way of stimulating social care in the community. For example, the idea of moral communities raises fascinating possibilities of linkages which are now much neglected by the statutory services, though less by the voluntary sector. What about the relationship between the churches and the statutory social workers? In any case, one can take the exposition of the moral benefits of informal care more seriously if it is not associated with a period of financial stringency. Some cynicism about the political rediscovery of informal care at such a time is inevitable. As chairman of Age Concern, a voluntary organisation, as well as one deeply involved over the years with the statutory services, it is my view that, given the demographic trends earlier described, it will take more resources, formal and informal, statutory and voluntary, to stay simply where we are. And, as has been shown, the gap between the reality and the rhetoric is still very wide. It is true that of those most dependent on community care, only the very elderly will increase dramatically in numbers, but those numbers have implications for all the others, in terms of resources available for the essential elements of community care, as for example, domiciliary services, day care with its

attendant need for effective transport and so on. It has been estimated that:

to maintain the 1973 proportion of the elderly population in residential care would involve an expansion of residential places of 32% by the year 2001.<sup>31</sup>

Clearly that will not happen. Since there is little evidence that those in residential care for the elderly need not be there, a heavy responsibility will fall on the community to care for its most vulnerable old people.

This realism does not only involve facing economic stringency. It involves facing what we are not prepared to do for the people who need care most.

Had I been giving this lecture in the '60's, or, indeed, the early '70's, it would have been easy to pay tribute to Eleanor Rathbone's achievement by reference to the continuance of her tradition of social reform. Yet it seems that we are not talking today about social reform in the sense in which it has been commonly used. We are talking about the maintenance of the fabric of the welfare state, of a structure created to defeat Beveridge's five giants. No government, of either colour, since the war, has seriously challenged that structure until now. And even now, probably partly because of concealed political divisions, partly from caution about adverse public reaction, it is extremely difficult to distinguish between the hard line of so-called *economic* reality — 'this is the only medicine to effect the economic cure' — and the hard line of *political philosophy* — 'this is the right medicine to effect greater independence and self-reliance'. The British tradition of gradualism works both ways. We reform slowly; do we also de-reform slowly? Are we witnessing shifts in emphasis, for example, as between the voluntary and statutory sectors, which in the long run may be seen to be beneficial, or are we seeing the very foundations of community care in a developed society being gradually undermined? It is not to be expected that an Act for the dissolution of the welfare state will be promulgated. Yet there are actions, including the enactment of laws and gnomic statements, which in aggregate at least point to the need for keen vigilance. One has the impression that this has been lacking, perhaps because the British public, since the war, has not seen such major changes in social policy. The lessons one can learn from Eleanor Rathbone are threefold: first, tenacity, which included a willingness to say things again and again until they were heard, even at the risk of being labelled as 'one-track minded' by those who do not wish to hear. The repeated message of this paper is that the realities of a caring community are costly in economic

and human terms and are complex in their design. Secondly, as Harold Nicholson<sup>32</sup> put it, 'her slings were weighted with pebbles of hard fact'. She was perhaps lucky in having slings rather than wheelbarrows full of hard facts, given that social science research was in its infancy. One of the difficulties in preparing this lecture has been the selection of a slingful! Thirdly, the controlled passion which Eleanor Rathbone exemplified remains the driving force which those in her tradition would wish to emulate.

But for us in Britain in the 1980's, given the subtleties of our political processes, vigilance must be the watchword. It is no good tending the trees if there has been planning permission to cut the forest down.

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