authority is the main purchaser of community services —for example, in services for mental health, particularly in those for people with long term and severe mental illness and complex needs. For such patients decisions by care managers to commit resources will have to be integrated with the decisions about the deployment of health resources made by doctors, usually consultant community psychiatrists with specific responsibilities for discharge and aftercare under the Mental Health Act and care programme approach working in mental health multidisciplinary teams.

Mechanisms must be set up to ensure that commissioners in both health and social services receive feedback about needs assessment. This will be necessary if services in the NHS and those bought by care managers are to relate more closely to individual needs. This feedback will be particularly necessary in districts where care managers do not hold their own budgets.

New perverse incentives

The implementation of care management in April could rapidly illustrate how the admirable intentions of the government's community care policy might founder on the unintended consequences of more powerful forces and contradictions. Firstly, although the transfer of social security funds will allow more needs driven services, it will also cash limit expenditure. Secondly, this transfer punishes local authorities with few residential care homes and cuts off money for future expansion. Thirdly, the directive that care managers should not themselves give direct care runs counter to the core of good social work practice and creates a new corps of care administrators, thereby reducing the number of staff available to give direct care. Fourthly, no central guidance has emerged on how to coordinate at the local level, care management,[14 16] the care programme approach,[15 17] and hospital discharge procedures, thus inviting triplication of planning effort.

Fifthly, conflicting central guidance is emerging about the statutory requirements to provide services for people whose assessments show up unmet needs, or even to inform people about the results of assessment.[18] Finally, the distinction between health and social care is proving much less clear in practice than in concept, and long running boundary disputes between agencies could erupt unless the problem is considered specifically in joint planning forums. Such joint planning is taking place now in Southwark.

Managing care management carefully

There is the ever present danger that insufficient overall funding will drown the potential benefit of the community care reforms.[19 20] And, for the current volleys of reforms to hit their targets, several extra initiatives will be required. When needs assessment information is fed into discussions on commissioning and planning it will probably highlight the need for district health authorities and local authorities (and, increasingly, general practitioner fundholders) to commission many community services jointly. Joint commissioning arrangements will allow specific gaps in service provision to be filled. Variations in joint commissioning practice between social services and health services will have to be piloted and monitored carefully.

Agencies will have to agree on definitions of needs and how people with different degrees of need will be prioritised when services are rationed. The division between health and social needs can be narrowed by joint training. Agreed procedures for appeals, complaints, and arbitration should be set up for users, and for authorities in dispute. Finally, models of care management must be tracked carefully and evaluated to show whether brokerage is the hub or the rub of community care.

We are pleased to acknowledge the helpful contributions of Matt Muijen and Peter Ryan of Research and Development for Psychiatry and of Geraldine Strathdee of the Maudsley Hospital in preparing this paper.

1 Braun P, Kochansky G, Shapiro R, Greenberg S, Gudeman JE, Johnson S, *et al.* Overview: deinstitutionalisation of psychiatric patients, a critical review of outcome studies. *Am J Psychiatry* 1981;138:736-74.
2 Kiesler C. Mental hospitals and alternative care. *Am Psychol* 1982;4:354-60.
3 Tessler R, Goldman H. *The chronic mentally ill: assessing the community support program.* Cambridge, Massachusetts: Ballinger, 1982.
4 Anthony W, Cohen M, Farkas M, Cohen B. The chronically mentally ill and case management—more than a response to a dysfunctional system. *Community Ment Health J* 1988;24:219-28.
5 Thornicroft G. The concept of case management for long-term mental illness. *Int Rev Psychiatry* 1991;3:125-32.
6 Torrey F. Continuous treatment teams in the care of the chronic mentally ill. *Hospital Community Psychiatry* 1986;37:1243-7.
7 Patmore C, Weaver T. *Community mental health teams. Lessons for planners and managers.* London: Good Practices in Mental Health, 1991.
8 Renshaw J, Hampson R, Thomason C, Darton R, Judge K, Knapp M. *Care in the community: the first steps.* Aldershot: Gower, 1988.
9 Intagliata J. Improving the quality of care for the chronic mentally disabled: the role of case management. *Schizophrenia Bulletin* 1982;8:655-74.
10 Challis D. *Case management in community care.* Aldershot: Gower, 1986.
11 House of Commons. Social Services Committee. *Second report. Session 1984-85. Community care.* London: HMSO, 1985:paragraph 181.
12 Griffiths R. *Community care: an agenda for action.* London: HMSO, 1988:v.
13 Secretaries of State for Health, Social Security, Wales, and Scotland. *Caring for people. Community care in the next decade and beyond.* London: HMSO, 1989:21. (Cm 849.)
14 House of Commons. *The National Health Service and community care act.* London: HMSO, 1990.
15 Department of Health. *The care programme approach for people with a mental illness referred to as the specialist psychiatric services 1990.* London: Department of Health, 1990. (HC(90)23/LASSL(90)11.)
16 Onyett S. *Case management in mental health.* London: Chapman and Hall, 1992.
17 Department of Health, Social Services Inspectorate. *Care management and assessment. Summary of practice guidance.* London: HMSO, 1991.
18 Laming H. *Implementing caring for people. Assessment.* London: Department of Health, 1992.
19 British Medical Association. *Priorities for community care.* London: BMA, 1992.
20 Blom-Cooper L, Murphy E. Mental health services and resources. *Psychiatric Bulletin* 1991;15:665-8.

Correction

What proportion of congenital abnormalities can be prevented?

Several authors' errors occurred in this paper by Andrew E Czeizel and others (20 February, pp 499-503). Firstly, in the second paragraph of the methods section common congenital abnormalities are defined as those with a frequency of ≥1/10 000; this should be ≥1/1000. Secondly, in table I the entries for cleft palate and cleft lip with or without cleft palate are wrong: these lines should read:

749.0 Cleft palate	110	229	46	0·42	0·097	8·9
749.1-2 Cleft lip with or without cleft palate	110	229	114	1·03	0·067	8·9

Finally, several of the references are incorrect. the references at the end of the first sentence of the fourth paragraph, and the first sentence of the sixth paragraph, of the methods section should be 3a, not 4. The reference at the end of the first sentence of the ninth paragraph of the methods section should be 4a, not 5. The reference at the end of the third sentence of the first paragraph of the discussion should be 8, not 10, and the next sentence should end with reference 9. Finally, the references at the end of the second paragraph of the discussion should be 6 and 7, not 8 and 9.

The two new references are:

3a Czeizel A, Telegdi L, Tusnády G. *Multiple congenital abnormalities.* Budapest: Akadémiai Kiadó, 1988.
4a Czeizel A, Sankaranarayanan K. The load of genetic and partially genetic disorders in man. 1. Congenital anomalies: estimates of detriment in terms of years of life lost and years of impaired life. *Mutat Res* 1984;128:73-109.