Housing and community care in Scotland

Paul Spicker

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1. Community care and housing

The Griffiths report on community care[1] has led to major changes in the way community care is organised. This, in turn, has important implications for housing organisations, which have a major role to play in community care provision. But some important issues were not considered in the Griffiths report, and it is difficult to tell what effect the reforms should have, or even what the effects are likely to be. The first problem was that Griffiths was concerned with England and Wales; the policy was addressed to a slightly different set of problems. The second problem is that Griffiths had almost nothing to say about housing, suggesting that community care need not much be considered with the issues of `bricks and mortar'. Perhaps unsurprisingly, then, the policies which are being made for housing and community care in Scotland are something of a hotchpotch, based on various approaches, often with varying aims. This paper is the report of a survey which attempts at least to describe some of the things which are going on, in the hope that it will help to make sense of current policy and clarify at least some of the options.

Community care

The idea of `community care' has been around for a long time now; the Ministry of Health produced the first community care plans nearly thirty years ago. However, it has never been very clear just what it is supposed to mean. Initially, the main concern was to deal with people who were discharged from psychiatric institutions; Enoch Powell, as Minister of Health, looked forward to a time when there would be no more institutions. The arguments for closing institutions were strong. In the first place, institutions were seen as very undesirable places to live in; critical literature was reinforced by a series of scandals. [2] Secondly, it had become possible during the 1950s to keep psychiatric patients on drugs while they were not in an institution. Thirdly, and perhaps most important, the

institutions had become expensive to maintain; `community care', care that was not in an institution, seemed to be a much cheaper alternative. [3]

Where people were discharged from institutions, it soon became apparent that they were going to need considerable support in the world outside. Often, that support was not available, leading to problems when people's circumstances broke down. If Scotland escaped the worst of this, it was simply because people tended to stay in the institutions instead; the discharge of people from institutions in Scotland has never really matched the pace of discharge in England and Wales[4]. But this has a down side, as well; there has never really been, in Scotland, the sort of pressure which rose elsewhere to provide more extensive community facilities. The resulting pattern of services in England and Wales is patchy enough (though Wales has the claim to be furthest ahead); in Scotland, provision outside institutions is often limited and ad hoc. Many people, for want of anything better, have to live in institutions who would be capable of coping outside[5].

Community care has to be much more than care that is not in an institution. Bayley, in a famous text, distinguished care `in' the community - that is, people being put into a particular location - from care `by' the community, where community services are able to provide an appropriate level of support.[6] That is the kind of care which Scotland now has to develop. The dominance of the health service in Scotland has meant that relatively little has been done, up to the present, by Social Work departments. There are some important contributions from the voluntary sector, but at the same time they fall far short of a comprehensive framework of services.

The management of community care

The Griffiths report was intended to address a range of problems which have come out of the provision of community care. Many different services are involved in the process, and they have to be co-ordinated to be effective. The problems which occur are first, institutional: agencies have different aims, and different criteria by which to measure success or failure. Second, there are professional problems; the different professions involved have different methods of work, language, and standards of professional practice. Third, there are financial problems. Community care is managed by several different authorities, most importantly health, personal social services, housing and social security.

Griffiths proposed to remove many of these problems by appointing someone to be in charge, an idea from which the current concept of the `care manager' has grown. There are reasons to be sceptical about the success of this approach[7]. Many of the problems of co-operation and co-ordination remain. The role of care managers itself is still unclear, with many different interpretations about the locus of authority for planning, budgeting and case management. And

the total effect depends crucially on the budget which is available. What has emerged is a system in which plans are made by the Social Work Department, but many responsibilities for provision remain with other agencies.

The role of social work departments envisaged in the Griffiths report is in important ways very different from the provision of community care in the past. The most fundamental change proposed has been a movement away from planning and direct provision to something more like a `market', in which social work authorities purchase services and adopt an `enabling' role. The model of provision which Griffiths seemed to favour was one in which decisions about purchasing should be made as far as possible at or near the level of the consumer, so that the constraints on providers would become more like the constraints on private firms. The task of the SWD, by this model, is partly to allocate initial budgets between priority groups, and partly to foster the development of a range of alternative provisions. Although some authorities do use the language of contract or `commissioning' (and one reply to the survey came from a `Contracts Manager'), the way that arrangements are being made in practice is not necessarily what Griffiths had in mind. There are boundaries to be negotiated between different services, and co-operation rather than `management' seems in order. What Social Work Departments seem to have done in the process of preparing for community care is to plan - to collate information, explain priorities and negotiate means of implementation; and despite Griffiths' concern to shift Social Work departments away from the provider role, it seems clear that the provision of service remains an important part of the role of the departments.

Joint planning and implementation is much more typical of the dominant approach in Scotland. Where Social Work Departments have acted as if they were `purchasers', it seems often to have been to the consternation of those with whom they come into contact, who expect a much more co-operative stance; so, for example, when regional councils have made decisions in isolation, or even pulled the plug on developments undertaken in conjunction with Housing Associations (which is fully consistent with the `purchaser' function) it has attracted complaints from housing organisations, not unreasonably, that developments could hardly be planned on this basis. The concern of Scottish policy has more usually been to promote a dialogue and co-operation between the different agencies involved in the process of community care.

Housing and community care

The role of housing services is central to much `community care'. In the first place, accommodation is a significant need in itself. Many of the clients of special housing are in one sense or another especially vulnerable; they are liable in a competitive market to find themselves in inferior housing on unfavourable terms.

Second, accommodation provides a secure basis for the development of social relationships. Physically disabled people need not only internal mobility, but access to communal facilities. For people with learning disabilities, one of the primary considerations is support for families, in which location can play a significant part. People recovering from mental illness may be at risk of a relapse, particularly if the mental illness is social in origin, a reaction to stress or isolation. In each case, the provision of adequate and appropriate accommodation is likely to be a major part of any care plan.

Third, accommodation is a precondition for the delivery of other care services. This may be true simply because the accommodation is the setting in which care is in practice delivered, but it is equally important within `community care', where the development of a treatment plan and maintenance of support within the community often depend crucially on the availability and location of accommodation. This may reflect social needs; it may equally be true because people are unable to receive appropriate physical care if they do not have appropriately situated accommodation. In the case of discharged psychiatric patients, the maintenance of a care plan often depends on the delivery of medication either at home, or at a location near to the home; and a patient who does not receive medication is liable to suffer, not simply a psychiatric breakdown, but at the same time a breakdown of social relationships. One of the most obvious failures of community care has been the incidence of homelessness among psychiatric patients.

As time has gone on, the role of housing in community care has been redefined in terms of supported accommodation. The Wagner report identifies many different types of supported residential accommodation: they include

- long term care. This is the most commonly recognised pattern, including many old people's homes, children's homes, and so on.
- respite care. These homes give carers a break.
- assessment. A number of homes - particularly for children - are designed as temporary stages, during which a person's needs can be assessed and a suitable placement found.
- rehabilitation. Some homes - like probation hostels or hostels for former psychiatric patients - are concerned with enabling someone to return to the community.
- therapy or treatment. Examples are hostels for people with drug dependencies, and some hostels for mentally ill people.
- training. There are homes and hostels of this type, e.g., for people with learning disabilities, mothers with young children.
- convalescence, e.g. nursing homes for the elderly or for some psychiatric patients.
- crisis or emergencies.

- shared care or flexible care - arrangements which are increasingly being made for elderly or physically disabled people. [8]

This kind of arrangement is clearly an important element in community care; and the report comes to the conclusion that, in practice, there is no clear distinction to make between the different forms of care. Residential care should not be seen as care that is different in kind from other types of provision, but as a pattern of care provided with accommodation. It is a form of `supported housing'. The report includes, as a result, examples like sheltered housing, group living or core and cluster homes, as forms of `residential care', and argues that "housing and social services will need to agree and administer jointly policies for the allocation of supported housing"[9]. This implies a major role for housing services.

There are, however, some reservations to make about the approach endorsed by Wagner. There are important differences between services provided to someone within ordinary housing, and services which are only delivered in practice within a specially designated residential setting. And the distinction between accommodation and support legitimates a fairly widespread view that housing and accommodation can be considered quite separately from other forms of support, which is what the Griffiths report attempted to do. Griffiths argued that "the responsibility of public housing authorities should be limited to arranging and sometimes financing and managing the `bricks and mortar' of housing needed for community care purposes." This is based in a major misunderstanding on the role of housing services; it underestimates the significance of housing in people's lives, the importance of housing as a basis for provision of all kinds, and the role played by housing officers as part of a multi-disciplinary team. Griffiths later retracted, stating that the important issue was to provide an appropriate administrative framework[10]; but there was little suggestion of this in the government's white paper, which moved away from models of co-ordination and liaison, and scarcely considered the contribution of housing at all.[11]

2. Community care in Scotland

Central government policy in Scotland has paid more attention to housing than the Griffiths model seems to imply. I have already commented that in Scotland the emphasis has fallen much less on `purchasing' than on planning, liaison and co-ordination, with the concern being to ensure the appropriate provision of services from a variety of sources. The role of housing organisations, in this model, is not only to provide bricks and mortar, but to engage in the process of planning in order to achieve the aims of community care in conjunction with other agencies. The Scottish Office has published a circular on `Housing and Community Care', which defines a number of functions which local authorities should carry out. They include

- taking part in community care planning
- considering community care requirements as part of the housing plan
- participating in the assessment of the community care needs of individuals
- planning to meet identified demands, and
- considering how their stock can best be used to meet the aims of community care in their areas.[12]

This makes housing an integral part of community care planning, and it helps to establish some of the grounds on which the policies pursued by housing organisations might be judged.

The survey

The material which follows is based on a survey of leading agencies in Scotland. Social Work departments, Health Boards, Housing Departments and Housing Associations were all asked about the role of housing in community care. Replies were received, in total, from 9 Social Work Departments (out of 12), 12 Health Boards (out of 16), 44 Housing Departments (out of 56) and 46 Housing Associations.

The basic questions to Social Work Departments and Health Boards were as follows:

1. What arrangements have you been able to make up to the present to make housing available for community care purposes?
2. What plans do you have for the future which affect or include housing provision?

3. Are there any problems you have had in ensuring the adequate provision of housing for community care purposes?

The reason for asking Social Work Departments should be clear enough; the Social Work Department is the lead authority in the process of planning for community care, which means that Social Work planning documents should cover the whole process. The role of Health Boards, by comparison, requires some clarification. Some Social Work plans have been produced jointly with Health Boards (e.g. Highland, Grampian), and in other cases (e.g. Borders and Tayside) the Social Work Department replied for the Health Board. Two Health Boards seemed to find it strange that I should have written to ask them about housing: one commented that `you will be aware that we do not have any direct responsibility for housing, for which reason I felt unable to answer your questions'; another commented that the questions seemed to be about housing rather than health. Another made it very clear that they did not really think my questions appropriate: the response, in full, was "1. Nil. 2. Nil. 3. Not applicable."

The reason for circulating Health Boards separately is not only that they have played an important role in Scotland up to the present, but that they still have important powers in this area. Health Boards retain responsibility for identifying and planning to meet health care needs, which implies some overlap of the functions when community care needs are related to health care. Like Social Work departments, they have the power to make contracts with providers (like housing associations), and can fund resettlement of people out of long-stay hospitals into the community. The responsibilities for providing accommodation which Health Boards have maintained include long stay accommodation, terminal care, and some respite care. There is, then, some residential provision: Forth Valley commented that they sometimes buy on the open market. [One return from a Health Board commented that they had no housing stock, but did have community based residential units, including some with `domestic environments'. This rather convoluted way of describing accommodation might be a response to the Scottish Home and Health Department's policy: since 1987 it has required Health Boards to sell housing which is `surplus' (by which is meant all housing which is not actually in a hospital site, or needed for staff in training).] Part of the importance of Health Boards, too, is that a decision to vary provision of different kinds is often the major impetus to changes in community care provisions elsewhere.

At the same time as Social Work Departments and Health Boards were asked about their plans, housing departments and housing associations were asked:

1. What arrangements has your organisation currently made to provide housing for community care?
2. What plans do you have to provide housing for community care?
3. Are there any problems your organisation has had in helping to provide and plan for community care?

Clearly, there was some overlap between the replies given here and those given by other agencies - given the role of Social Work Departments in taking an overview, it would have been strange if there were not. But it seemed unwise to suppose that Social Work Departments and housing organisations would have exactly the same view of the process, and in the event there are some striking differences in perception.

The community care plans

The information which came in reply to the survey was very uneven in quantity and quality. Many of the respondents did not try to address the questions asked directly, but referred me to documentation from which I had to try to abstract the relevant answers. The documents do not all use the same categories for planning, and the criteria are often unclear. There seem to be few if any standards which the success or failure of policies might be judged, other than the number of units of housing provided: criteria like cost-effectiveness, flexibility, or consumer satisfaction hardly feature. Many of the plans do not refer to any criteria at all; they simply state what is being done, and what will be done next.

Many plans are still in their infancy. In principle, plans should contain several elements, including a statement of aims, consideration of means of achieving them, and a programme for implementation. Where aims are presented, they are often couched in wide-ranging and fairly general terms; it is sometimes difficult to see everything which is written as a `plan', because not all are not linked to specific means of implementation. One reads, for example, that services for people with learning disabilities `should be designed to accommodate individuals, and not primarily concerned with their own organisational ends' (Central RC), or that people with mental health problems need `easier access to local authority housing and housing association premises including supported accommodation and sheltered housing' (Borders HB). These are very worthy objectives, but it is not always clear how they are going to be realised in practice.

The plans are not very clear about priorities, either. This is probably deliberate; there are so many problems that any opportunities for development offered by co-operation with other agencies are likely to be seized on. However, the generalised approach does cause problems for organisations who are hoping for some guidance; Hillcrest HA complains that the local community care plan "is so all encompassing and written in such a general way that it gives little or no

attention to establishing concrete objectives and priorities. This has left something of a planning gap ... which creates uncertainty and confusion over what kind of projects are desirable and whether they will be supported." The Scottish Association for Mental Health, on the basis of a review of policies for psychiatric patients, comments that

> "the term `strategic planning' is perhaps something of a misnomer ... The risk is that small, piecemeal additions will be appended to existing provision in an ad hoc fashion and real innovation hampered unless a major resource input is secured."[13]

Assessing needs

The planning process depends on the compilation of information about the current situation, a task which has been given to all the main agencies involved (even to Housing Associations, which have the requirement as part of their Business Plans). The best information which is available on community care is probably that provided by the Social Work Services Group, which has figures for residential provision provided through health and personal social services, as well statistics for sheltered housing.[14] This does have gaps, though, because `supported housing' which is provided does not necessarily come within the remit of the SWSG; one comment in the survey (from Dumfries and Galloway Health Board) was that a number of private `hostels' are not registered, and not supervised, because they do not seem to fit the criteria for residential care. Strathclyde RC also has fairly good basic information, though at the time of writing it exists only in draft form, and it has not been made available more generally.

The Scottish Office asks housing authorities to identify, for each of the main client groups,

> "a. the number of people in the local authority area and their geographical distribution;
> b. their age range;
> c. the level and extent of any disabilities;
> d. the range of types of accommodation required;
> e. the preferences of people themselves for the housing option that best meets their needs;
> f. other support facilities in the area ..." [15]

This seems to have proved problematic in practice; the information is often incomplete, and it does not always exist in any usable form. Tayside and Fife Social Work departments both commented on the lack of information available

about housing needs, while Perth (in Tayside) complained about the `lack of information on the level of housing need for each of the client groups considered.' (Perth argues, with some justification, that funding has to be made available to undertake the research that is needed.) In some cases, there was irritation at refusal to share such information as was available:

> 'For some time there was great difficulty in extracting any form of statistical information from either the Health Board or Regional Council with regard to proven need ...';
> '[The Health Board] is reticent in providing information - e.g. a recent survey of needs for mental handicap was carried out recently and the Health Board are resisting requests to share this information.'

It is perhaps worth noting that even if the core information was available, it would be difficult to understand the impact of a shortfall in provision without knowing a great deal more. Problems do not simply go away because the provision has not been made; people have to make the best of their situation; the agencies help as best they can. Where there are no formal arrangements for helping people, it may still happen that district councils or housing associations allocate housing on an informal or ad hoc basis. Where there are formal arrangements for some services and not others, people will use the alternatives available; so, for example, it may well happen that an old person who might have best been helped in extra care housing will move into residential care because of the lack of alternatives. And where there are gaps in provision, there may be arrangements to try to get around those gaps: so, although Highland has no `very sheltered' housing, `it is considered that some individuals are supported in sheltered housing to a degree that would meet `very sheltered' classification'.[16]

Formal arrangements

The direct contribution of housing organisations to the plans is limited. Although the Scottish Office has considerable expectations of local authority housing departments, it seems clear that a number of them hadn't got started yet, while others (notably in Highland Region) referred me on to Social Work departments rather than outlining their own contribution. There are many reasons for the delays in the process; some authorities are still waiting for a lead from someone, while others seem to feel that once they have made their contribution to the planning process, the matter is out of their hands.

A number of plans (e.g. Central and Fife) did refer to `contracts' with particular housing providers, and gave examples. It might be argued that if the purpose of community care reforms was to bring about a clear distinction between purchaser and provider, then housing organisations would not directly

be involved in community care planning; all they would need to know is what the purchasers were asking for, and how much they were prepared to pay. There are two problems with this. One is that although there are agencies which seem to be waiting for requests from planning bodies, there do not seem to be many proposals for action (a position explicitly referred to by Cumbernauld and Kilsyth DC, and implicitly by those who comment that since planning is at an early stage no specific plans have been formulated.) The second problem is that housing organisations also have strategic responsibilities, and have to balance various conflicting priorities. Overall, then, the emphasis has tended to fall more on liaison and co-ordination between authorities.

The most common pattern of liaison is the establishment of some kind of body at which discussion of housing issues can take place. Tayside and Fife have established housing `forums', with representation from all the District Councils, the Scottish Federation of Housing Associations, and Scottish Homes; Central and Strathclyde seem to be on the same course. Highland has a similar working group, which is a sub-group of the Joint Officer Group. Grampian has specifically considered housing issues and agreed a number of (small) initiatives; their approach seems to have been to approach each district council separately rather than jointly. Few of these arrangements, however, have yielded much at this early stage. Lothian has adopted a different approach, for which it claims some degree of success (the response has been different for different client groups). Housing is represented both at a strategic level, in the 'Co-ordination and Strategic' functions of the Joint Planning Structure, and within Client Group Joint Planning Teams. 'Housing', they state, 'is recognised as being a central feature within all Community Care developments.'

Part of the formal process of developing community care plans is that housing organisations are supposed to be consulted, a function which forums and joint working groups generally fulfil. The process has not been well received by housing agencies, many of whom feel that their role is marginal and that consultations have been desultory. This is a selection:

> "Housing Associations have not been consulted in any serious manner with regard to the provision and planning for community care in this area. ... At the last meeting (of the Special Needs Liaison Group) the only representatives attending were from the Housing Department and this Association!" (Cloch HA)
>
> "This authority has not been consulted adequately in my view ... there may very well be problems due to the delay in arranging meetings with the Health Board and Social Work Department." (Lochaber DC).
>
> "This association has never adequately been involved, not through its own choice, in the planning of community care projects in respect of funding and staffing issues" (Langstane HA).

> "The biggest single problem for housing association providers ... is simply that we collectively have no clear idea of the role that we will play under [the] Region's Community Care Plan despite the existence of the housing forum, which is theoretically there to consult and conform various participating organisations ..." (Hillcrest HA)
> "So far as the most recent Care Plans of the various Regional Social Work departments are concerned there has been insufficient involvement at the planning stage although we have been `consulted' by four regions once the care plans had been drafted" (Hanover (Scotland) HA).

A couple of associations (Servite and Gowrie), while generally concerned about lack of participation, were approving of Fife Region's efforts. The test seems to be not only that the appropriate forums are created, but that they are used.

One interesting exception to the usual pattern is Shetland, which is - unlike most Scottish authorities - a unitary authority, in which Housing and Social Work are part of the same organisational structure. The SWD reports its `delight' in having strong housing representation. There is other evidence of strong links: the Director of Social Work can give points for priority in housing allocations, and housing is allowing Social Work to `bid' for uses of new developments. But it is difficult to generalise, not least because of problems in the other Island authorities. The Western Isles are reeling from a major financial crisis. Orkney has been so bound up with the Clyde inquiry that little has been done in relation to community care, and the process is only just beginning now. The Housing Department comments that besides "we are struggling to meet our statutory obligations to rehouse the homeless and we are one of only 8 Scottish housing authorities to have been given a negative capital consent figure". At the same time, there is considerable evidence of co-operation and goodwill, and their record compares favourably with some authorities four or five times their size.

The role of housing organisations in the planning process

Housing organisations seemed concerned that their role was undervalued, and that housing issues featured insufficiently in the community care plans. A number of organisations felt they had little role in the provision of community care: Nairn DC, for example, said that it had no provision and no plans; Stewartry DC wrote that "due to the fact that there is no indication of the numbers of people likely to be in need of housing, no action has yet been taken to make special provision for this." This seems to mean, not that there is no relevant activity, but rather than there have not been any initiatives as part of community care planning, and so no new housing is likely to come on stream. One of the most striking examples of this was Nithsdale DC, from whose reply I might have supposed that not very much was happening; their efforts seemed to be confined

to participation in a forum which had just been set up. By contrast, a letter from Dumfries and Galloway Health Board describes them as `particularly helpful' when dealing with hospital discharges, despite the absence of formal arrangements (and the arrangements made by the hospital concerned, Crichton Royal, are cited as an example of good practice in a report by the Scottish Council for Single Homeless[17]). Kirkcaldy DC's response similarly referred to special allocations, co-operation with agencies, leases to specialist agencies, adaptations to housing and heating schemes, but had nothing about `community care' in the narrow, official sense. Where housing organisations did refer to a significant contribution to community care, it usually referred to cumulative efforts over a long period of time. Argyll and Bute DC, in one of the most positive responses, was able to point to fifteen years' development for different groups; their provision in most areas is among the fullest in Strathclyde, and possibly the fullest in the country.

Many housing organisations felt that they had a marginal role in community care planning.

> "the arrangements being pursued by the local Social Work authority, as the leading player, for planning in respect of implementation of the community care provisions, [are] not entirely clear. This authority has been involved in joint discussions on the arrangements for community care planning only at a very general level and, it seems, around the fringes. This is despite strong intimations from the District Council that this Authority wishes to be closely involved in the planning process at all stages ... " (Cumnock and Doon DC)
>
> "Liaison between the Social Work, Health Board and Housing is still very limited and it is our worry that decisions might still be taken in the Community Care field with an unrealistic assumption as to what housing input can be." (Kilmarnock and Loudon DC.)
>
> "[There is] an apparent reticence on the part of the Social Work Department and Health Board to recognise the importance of housing to the success of community care." (Dundee DC)
>
> "We have tried to discuss ... future requirements ... Their responses have been pretty lukewarm to say the least. I do not believe Housing Associations in this area are being seen in any strategic way as possible providers of new housing within Care in the Community planning." (Cloch HA).

There was some evidence, too, of marginalisation of housing organisations in the replies from Health Boards, if only because those boards who do not see housing issues as part of their spheres of interest had no reason to discuss the

issues with other agencies. At the other end of the spectrum, Greater Glasgow Health Board was strongly committed in this area:

> "Our plans are almost completely dependent upon housing as our mode of community care has been to negotiate contracts with provider organisations to established supported accommodation which offers the ability to maximise residents abilities and quality of life in as normal a community setting as possible."

This Health Board has, in its own phase, `undertaken a trawl' around housing organisations in order to explain its work and to identify sources of housing. But, like all the agencies involved in planning they are limited in what they are able to achieve, because they depend on help from other agencies.

By contrast, the view from the Social Work departments seemed altogether more positive about the role of housing: Strathclyde acknowledges the past contribution of housing organisations, which they comment "have been the source of some of the most imaginative and progressive responses to a range of different community care needs". The importance of housing seems to be generally agreed, which perhaps reflects the work done by the housing bodies themselves to argue for a larger role. Clydesdale DC referred to representations made over several months about their not being involved in planning, which have since led to the formation of a housing forum. Albyn HA commented:

> "Up until recently housing has been given a low profile in the concept and planning of Community Care.. This has meant that a lot of time has been taken up in lobbying for housing issues to be given their rightful place within Community Care planning and provision."

The contribution made by housing organisations

The argument that housing organisations must be involved does not clarify just what the nature of the involvement should be. There are four main roles: planning, enabling, providing accommodation, and providing components of care. Involvement in planning requires participation in the assessment of needs and establishment of priorities. This has long been part of the functions of housing organisations. Dundee DC set up a committee to give special attention to disabled people fifteen years ago, and another for special needs, including psychiatric patients and people with learning disabilities, in 1987. It has just turned its attention to the community care needs of people using the night shelter and rehabilitation units; the plan covers the next five years.

There are those who feel that they have had to cut their own path through the maze: one HA commented that "The Association's existing housing has been

planned and developed in the absence of any planning input from the Social Work Department." A District Council comments that local inter-agency groups have made much more contribution to the planning and development of particular projects than the formal mechanisms established by the Region:

> "To some people it has appeared that certain projects have appeared DESPITE formal joint planning rather than as a result of it."

There is a sense in which this has to be true; providing housing is a long-term enterprise, and the provision which exists now has often been developed over a period of years. For the same reason, it is difficult to say what the long-term effects of community care planning are likely to be.

Enabling, the role which the government favours for district councils, involves planning, negotiation and brokerage, sometimes coupled with a funding role. Motherwell DC reports that it has actively "promoted" projects for recovering mentally ill people and people with learning disabilities, attracting investment from Scottish Homes and Lanarkshire Health Board. Some local authorities regretted the lack of a more direct involvement:

> "While the authority appreciates the great assistance provided by housing associations, it would obviously be much easier and more convenient to be in a position to make direct provisions ourselves." (Argyll and Bute DC)
> "in carrying through the project in a bricks and mortar sense, projects would be brought to a quicker conclusion if the Housing Department had funding to develop the project". (Dumbarton DC)
> "The role of the District Council as an enabler is constrained and priorities for investment through social housing agencies such as Housing Associations are effectively being driven by Central Government ... " (Dunfermline DC).

Kyle and Carrick DC combined this role with the provision of property:

> "The District is concentrating on its `enabling' role to provide the `bricks and mortar' for community care housing".

Several developments had been provided or were under way. Although I have reservations about this approach, it deserves some credit; identification of a clear role, in collaboration with others, helps to make future work possible. This is surely preferable to the numbers of authorities which have not been able to work out a position, and have taken no action.

The role of housing organisations as providers might be seen either in terms of the provision of accommodation, or of accommodation with support.

A number of organisations have adopted the former stance, though the separation of accommodation and support has meant that there have been problems with revenue funding (the costs of running the service), which then has to come from a different agency. Other organisations have adopted a role confined to factoring, leaving support and other management issues to other groups with specialised skills. The practice is probably more widespread than the survey showed, because a number of district councils let properties to voluntary and statutory agencies. Key HA, which specialises in housing for people with learning disabilities, has developed a series of arrangements with different housing organisations in which it provides management services in their properties. Currently, it has drawn on property from thirteen different housing associations and four District Councils, most of which didn't think it appropriate to include the developments as a reply to the survey in their own right, though clearly their co-operation is essential.

The provision of support by housing managers is clearly an important part of the role of many housing organisations, particularly the more specialised housing associations but also including many `mainstream' agencies. For most housing managers, contact with issues in community care is unavoidable, if only because (as Edinburgh's return pointed out) most people needing community care are already in mainstream housing. This kind of work is management intensive: Dunfermline DC argued

> "The housing management implications of Care in the Community will demand more and more housing staff time and this will be at the expense of work more closely identified with the landlord role of the council."

Problems in meeting needs

The practical problems of meeting needs have proved to be considerable. Some of the problems are organisational; some stem directly from the separation of accommodation and support; some reflect lack of resources; others the physical problems of providing appropriate housing in the right place and at the right time.

Organisational problems.

A theme which recurs, time and again, is the difficulty of working with other agencies. If the aim was to encourage agencies to work together, community care has not proved an outstanding success. In some cases, the problem seems to be the attitude or approach of a particular agency:

> "[The Health Board] appear to prefer to work in isolation to other agencies, which obviously impedes coherent joint planning."

But this is only a limited part of the issue; the test of an organisational structure is not that everyone works with good will, but that people can work together even when there is not good will. Sadly, community care policy seems designed to generate poor relationships. Some part of this can be attributed to teething problems: a number of complaints about regional councils seemed to refer to lack of information, when the regions themselves hadn't worked the information out. There was one case referred to in the replies where a housing association had funding withdrawn from a pipeline project. From the region's point of view, the proposed development was in an area which their figures showed to be well served by comparison with others, and they had marked out other areas for priority support. But since none of the criteria for the decision had been made public, or even explained to the housing association, the decision looked and felt thoroughly arbitrary. Once people know the ground rules, this kind of problem should not occur.

At the same time, many of the problems cannot be expected to get better as time goes on. The first problem is that agencies are working to different priorities. Tayside RC refers to the `balance' of health and social care. Motherwell DC points to conflicting requirements:

> "Currently requests for assistance are multi-various from a range of different agencies. The main problem with this approach is lack of co-ordination from Health Board/Social Work to prioritise projects."

Bield HA, similarly, points to the conflicts between priorities of Scottish Homes, Social Work and Health Boards. From the perspective of a Health Board, Greater Glasgow comments that other pressures on housing are an important restriction:

> "the main problem in implementing community care has been our dependence on other Agencies for property acquisition. These Agencies have their own problems and objectives which are not always coterminous with our objectives. In particular, over the last decade, the virtual halt of local authority programmes and the compulsory selling of houses has led to an increasing demand on a vastly reduced council housing stock. A corollary to this is that the council's ability to meet the needs of supported accommodation is limited."

Second, agencies are working to different planning cycles and time scales, which is crucially
important from the point of view of development.

'the target timescales the Health Boards operate under cannot be accommodated within the Scottish Homes timescales for agreeing Housing Association Grant funding.' (Tollcross HA)

This is a fairly basic problem: it means that housing associations cannot meet Health Board requirements and get Scottish Homes funding at the same time. Greater Glasgow Health Board comments that offers from HAs have tended to be for new building which won't be made rapidly enough to meet the Health Board's aims. Tayside RC has encountered similar problems, with the additional problem that the restrictions in the public sector which accompany the standard 12 month financial year are inappropriate for some of the projects.

Third, there is the problem of trying to serve several different masters at once, a problem which the Griffiths reforms were surely supposed to avoid.

"The main difficulty, is in securing revenue funding for the scheme. This has been a time consuming exercise involving lengthy and close consultation ... The Association has had to devote considerable resources to co-ordinating this aspect of the project, as well as the capital funding application with Scottish Homes." (Cube HA)

"We are keen to forge close links with Social Work but find it difficult to plan ahead because of uncertainty over what funding will be available from Scottish Homes." (Partick HA)

This leads to the unhappy situation in which the efforts of some agencies are frustrated through

failures of co-ordination with others.

"The Association has developed three projects for use by agencies and has found at the date of commissioning that the agencies have had to withdraw from using the accommodation." (Langstane HA).

"The Association has been dismayed at the lack of commitment from the Health Board ... The association's position is difficult. We cannot be seen to have properties lying empty for an inordinate length of time ..." (Southside HA)

The separation of `accommodation' from `support'.

The separation of accommodation and support places important limitations on housing agencies, not least because it limits what can be funded from different sources. Grampian, for example, complains that respite care is not treated as `housing' by Scottish Homes. Nor is residential care, which greatly restricts

certain kind of provision. Viewpoint, a group of five housing associations, reports:

> "It is the policy of Viewpoint to provide the level of care that its residents require until they die. This policy of providing continuous care has encountered problems as it crosses traditional boundaries. For example we regard the accommodation that we provide in our nursing homes as a form of housing but that is not a view shared by bodies such as Scottish Homes. The result is that we have not been able to provide sufficient final stage accommodation."

One might have thought that this was just the sort of flexible approach which the community care reforms were supposed to favour.

Besides the explicit restrictions, there are continuing problems which come from the lack of a clear allocation of finance for projects which bridge housing and community care. Part of the problem, identified by a number of HAs (Old Town, St Margaret's Home, Kirk Care and Kingdom) is that where care elements are being provided, the source and level of funding is unclear, which makes financial planning for future provision - a requisite for housing association activity - virtually impossible. Part of the problem, too, is that the source of revenue funding has to be clarified before services can be provided. Fife SWD and Health Board are in dispute about who is responsible for which bills: the Health Board says that "great difficulty in accepting the line being pursued by the Regional Council on the subject of funding of new developments in community care." The backwash is experienced elsewhere:

> "Fife Health Board and the Regional Council agreed a joint discharge programme for people with learning difficulties. We agreed to incorporate within our planned building programme a number of cluster flats which we intended to lease to Social Work Department. They have failed to reach an agreement for a further period in respect of funding and are unable to commit themselves to properties which are now complete. The restructuring within the Social Work Department has not helped in that the representative who negotiated with us has now left the authority." (Kingdom HA).

One of the questions that Scottish Homes asked in last year's consultation paper was, `What are the likely consequences of encouraging mixed funding for Care in the Community Projects?'[18] The answer now seems plain: it increases the number of hurdles which providers have to clear, and it makes planning substantially more difficult.

Funding

A chorus of agencies complained about lack of funds for community care, which no-one will find surprising. Fife RC's plan details a long list of objectives, including support in extra care housing, transport for rural areas, more flexible support for elderly people in sheltered housing, all subject to a common condition: "assuming co-operation and/or sufficient resources are forthcoming". This is unusual in the Regional Council plans, because most of the others adopt the more `sensible' approach of confining their projects to what they can afford - which is not very much. The Health Board in the same region is unusually bleak:

> "the current situation is not encouraging as regards the money which is available to provide supported accommodation. ... Projects other than those listed above will not be supported in the foreseeable future. Whilst this is not a very encouraging position it is hoped it is a clear message to allow for future planning.

Dunfermline DC comments that

> "There is no fundamental objection to housing investment being used to provide suitable housing for those in need of support from Community Care systems. The crucial point is that no additional investment capacity is being made available to meet this demand and consequently the general housing needs of the wider community are being forsaken".

The problem is not just that people with other kinds of housing need are ignored; support is actually being withdrawn in some cases from existing services to people with special needs.

The role of local authorities as providers is currently being played down by the government, and there are important disincentives to the involvement of local authorities in new building. Lochaber DC writes:

> "This Council in its Housing Plan has indicated that the additional housing required for community care should be provided by Housing Associations. It is not possible for the Housing Authority, due to financial constraints, to provide the necessary additional housing stock and with Local Authority tenants having the right to buy there is no incentive to spend a lot of money, particularly in remote rural areas, on new housing which after a period of 5 years could be transferred to the private sector at a cost significantly less than the outstanding debt."

These restrictions mean that new housing is largely in the province of housing associations. But housing associations are also suffering from serious financial constraints, partly because they are effectively competing for limited funding, partly because the sources of funding are unpredictable - which makes planning very difficult - and partly because they have to pull several sources of funding together to make community care projects possible. Complaints about lack of funds came from, among District Councils, Clackmannan, Kilmarnock and Loudon, Perth, West Lothian, Tweedale, Falkirk, Roxburgh, North-East Fife and Western Isles, and among Housing Associations Linthouse, Albyn, and Bield.

Providing housing

Money is not the only limit to what is possible. Houses are not simple items to produce; sites have to be found, permissions sought, funding obtained, agreements negotiated. The planning process obstructs development: Cloch HA comment that

> "Without any clear guidance or information on future requirements, and given the normal three year lead in time for any new projects, it will be a long time before the Associations can make a serious contribution to new Care in the Community initiatives."

Where housing is being developed, it is usually done only on a slow, incremental basis. One housing authority commented that the Social Work and Health Board had had a certain naivety about their ability to provide accommodation as and when required: this had given way to "a new realism which acknowledges the difficulty in actually being able to provide accommodation at the point of need".

If new building cannot be relied on, the housing elements in community care have to be met by existing buildings. This is the largest resource most housing organisations have, and requests for help are commonly met by trying to use the stock in different ways: Lothian RC have negotiated an agreement with various housing agencies in principle for flexible arrangements including special lets and management agreements. The first problem is the numbers of houses likely to be available. Clearly, with a reducing stock and limited resources, local authorities in particular are greatly restricted in what they can provide. Many authorities are losing stock through the Right to Buy, which Argyll and Bute comment is "detrimental to our attempts to make rapid provision for Community Care needs". Dunfermline DC wrote:

> "Unless there is a change in the housing policies of Central government the District Council will not be in a position to provide directly for additional new housing to meet the needs generated by Care in the Community. The

> use of existing Council housing stock will contribute to the meeting of Community Care needs but the extent to which this is possible is limited because of Right to Buy sales and the necessity of the Council to meet the general housing needs of other groups such as the homeless and overcrowded and those unsuitably housed. ... The need for suitable accommodation within the community to ensure the delivery of effective care will increasingly determine housing investment priorities and unless there is additional funding the social housing needs of the wider community will suffer."

The second main problem in using the existing stock is that the accommodation is often of the wrong type. Lanarkshire Health Board comments that "the major difficulty ... seems to be the acquisition of suitable accommodation from Local Authorities who are in many cases unable to identify suitable accommodation or give priority allocation of suitable accommodation." Greater Glasgow refers to "offers of accommodation which have been rejected as totally unsuitable." The position is unsurprising, because bad housing becomes available disproportionately, and because large units, which many community care agencies are trying to use, are very infrequently available. Hamilton DC points out that "people want big houses we don't have. Adjoining properties in reasonable areas are rarely available." As a result, Hamilton continues, they are finding they don't have much of a role in provision.

There are some ways round these problems, though the options are limited. What do people need? It is fairly unusual for people to need purpose-built housing. Angus DC argues that specialised new building has disadvantages in comparison to using existing stock; it is not always needed by the time that it becomes available, and it is often less able to build on existing community relationships than adaptation would be. One option, then, is to adapt wherever possible. But large units are difficult to find, and there are problems which come from adaptation: in particular, large units have to meet standards for fire and facilities, which means that purpose-building sometimes works out cheaper.

The real question is whether large units are really necessary. They offer economies in relation to staffing, but add to costs in other ways (particularly the cost of conversion). From the point of view of residents, smaller units are often desirable, and the general trend has been to develop small units where possible. One way of achieving this is to use cluster housing. Supported housing does not have to be large, and it does not have to be adjacent to other supported housing; the principle of cluster housing is only that people are near enough to the support. There are many people who could be housed sharing ordinary homes, with support staff being situated in a house nearby. (In some cases, it is possible as greater independence is achieved to move the support away rather than forcing the people to move, which is the approach advocated by Scottish Homes[19].)

Eight plus one ordinary three bedroom houses or flats could house and support 24 people; that sort of arrangement can go a long way towards meeting target figures for mental illness, learning disabilities or some of the other specialised client groups, and the capital cost is minimal. (It also has the advantage of providing non-institutional accommodation, with some prospects of normal social contact in the community.) The main limitation is that it is not appropriate for high levels of dependency.

A further problem, and one for which it is more difficult to offer any way out, is the level of public resistance which is sometimes encountered to developments for community care needs. The problem is mentioned both by Aberdeen DC, and by West Lothian, which has also had councillors objecting to certain projects being situated in their wards. There are no simple answers to the problems; it probably helps for developments to be small and non-institutional, but there have been cases of vehement protest even where this is true.

Managing community care

The Scottish Office circular outlines a number of issues to be taken into account during management. They include

- the revision of allocations policy
- making allocations policies available to people with handicaps
- consultation with local residents
- avoiding clustering people with special needs together so that they form a `ghetto'
- provision of backup services
- making stock more accessible
- co-operation between housing and social work staff.

There was little reference, in the replies, to this kind of work. I reviewed allocations policies in Scotland in 1990, before current reforms[20]; at the time, I asked local authorities about allocations in relation to community care, but received so few answers that I did not include the material in the published results. There is little from this survey to add to that material (though Kyle and Carrick mentioned it had introduced a new scheme), and Tayside RC comments that existing policies do cause difficulties. On the problems facing housing managers, only a couple of agencies considered the issues - which suggests either that they have not yet engaged with the problems, or (more likely) that the responses represented more about the frustrations of planners and managers than they did about problems experienced in the field. Moray DC commented that the management of younger tenants and people with mental health problems was proving very labour intensive - an issue which probably reflects a general trend, because the input of social work services in many cases is limited. Dunfermline

DC reported that there had been important problems in co-operation with social workers.

> "At a frontline operational level a seemingly intractable difficulty for housing staff has been in gaining a meaningful access to the social work care system. There is nothing in the Community Care Plan or restructuring of services which specifically attempts to tackle this problem. At best, this seems to be left to individual workers to establish their own networks or as at present to rely on blind contact with Social Work services. It is intolerably frustrating for housing workers to be in this position."

Moray DC was particularly concerned about the lack of funding for management support, which is a crucial element in the provision of community care.

> "Care in the Community will only be achieved satisfactorily provided it is adequately funded to ensure proper support-staffing levels. Otherwise it will be an unmitigated disaster for both `customer' and `provider'."

Is community care meeting needs?

It is often difficult to identify needs for accommodation precisely, particularly when there has been little service in the past. The Scottish Office circular, which is fairly specific in its expectations, outlines target figures for particular types of housing according to the size of the population. This is by no means enough by which to judge community care provision; it says nothing, for example, about responsiveness to needs or consumer satisfaction; but it offers, at least, a point to start from.

Elderly people. For elderly people, there should be for each 1000 elderly people over 65:

- 20 units of extra care accommodation
- 46 units of sheltered housing
- 80 units of `medium dependency' housing, including amenity housing, housing with a community alarm service and some adapted properties.

This is less generous than a previously circulated standard which set 23 per 1000 for extra care, and 132 per 1000 of medium dependency[21].

The Social Work Services Group reports that current levels of provision stand at 38 units per 1000 for sheltered and extra care housing - 57% of what is nominally required. This disguises very considerable variation, not only between regions, but within them; in Tayside, for example, provision in Dundee is substantially over the targets, while that for Perth is very substantially below.

Physically disabled people. The needs of physically disabled people are estimated by the Scottish Office at 1% of the housing stock suitable for wheelchair users, and 10% for ambulant disability. (There is some confusion here, because the Scottish Housing handbook recommends a different level, of 3.6 houses per 1000 population.) Monklands DC, which has conducted detailed research in its area, suggests that of the numbers of disabled people (normally 6% of the population, though there are more in Monklands), 30% will use ordinary housing, 61% require adaptations for ambulant disabled people; and 9% will use wheelchairs. The standard applied by Fife, which requires that 3.66% of housing should be suitable for ambulant disabled people, seems to be based on the same calculation as Monklands rather than Scottish Office guidelines.

Margaret Blackwood HA, a specialised association dealing with housing for physically disabled people, have surveyed the demand for wheelchair housing in most Scottish districts (the main exceptions are in the Highlands and Islands).[22] Some of the local authorities consulted said that there was no need; for many others, the levels of need outlined varied considerably, largely because the estimates seemed to be based on current demands rather than the potential need which the Scottish Office has been concerned with. Overall, statements of need tend to reflect the priority given to the problems in the community care strategy for an area; so, Fife's painfully honest confession of past inadequacies seems far more likely to mobilise resources than the confident reassurances of others who seem, on paper, to be little better provided for.

There are no general figures, but those which are available give cause for concern. Renfrew DC, using the Scottish Office targets, has 138 houses for disabled people, a shortfall of 8,190 units for ambulant disabled and 736 units for people with wheelchairs. Monklands DC, relying on a survey of disability in its area rather than a generalised figure, calculates on this more moderate basis that 379 wheelchair houses, and 3859 houses for ambulant disabled people, are needed; the total provision is 164, leaving a discrepancy of 4,234 houses. If this is right, the scale of the shortage is overwhelming.

People with learning disabilities. There is no specific guideline, but the Social Work Services Group has recommended 1.8 units per 1000 population (or 180 for each 100,000). This is a manageable target figure, though it is probably rather lower than an estimate of needs; when the Scottish Office introduced the figure in 1979, they commented that "existing residential provision is so inadequate quantitatively and qualitatively that arguments for increased provision are academic."[23] In most authorities there is little indication about whether or not it is being met. The position is complicated by the existence of unstaffed accommodation which does not have to be registered; its use is growing, not least because it is a cheap alternative, and Philip Seed's local studies suggest that although this is well planned and supported in some areas (he mentions Borders and Central), in others there is little support. The fullest information is provided

by Strathclyde Regional Council, which reports figures ranging from just over 10 per 100,000 in Hamilton to 124 in Argyll and Bute - a huge disparity, but one in which all the Districts seem to fall substantially short of the Scottish Office target. Their figures are qualified and provisional because of the problems of collating information and the exclusion of certain types of accommodation, but they do seem to indicate a significant general shortfall.

Psychiatric patients. The standards for people recovering from mental illness are unclear, but a number of authorities have applied a range of standards: Monklands DC refers to 1 unit per 3000 population, Renfrew to 0.51 per 1000, and Roxburgh to 0.6 per 1000. The DHSS recommended 0.19 per 1000 in 1975; the Scottish Office upped this to 0.34 per 1000[24], which is more or less the Monklands figure. Strathclyde's figures show that provision is extremely patchy; a number of districts have nothing, and others have only a handful of dwellings. Research has been done recently on problems associated with the process of discharge[25], but there is no assessment of the scale of the problem.

The criteria which are being applied are not uniform. Some authorities are using the criteria of the Scottish Office; others apply further notional criteria, e.g. Fife for physically disabled people, and Aberdeen, e.g., is trying to provide 125 places per 1000 elderly people, substantially in excess of the Scottish Office target. Others seem to rely on an assessment of currently existing need, which is (I think) the basis for Falkirk's estimate of shortfall in provision for former psychiatric patients; the figures seem to be intended to reflect actual rather than notional need.

Having established some basic criteria, it should in principle be possible to work out to what extent the criteria are being met. Unfortunately, the material in the plans is not, in most cases, presented in a way which makes the comparison possible. The most common pattern is that a few specific schemes are mentioned, but the numbers provided are not related to an assessment of need. The reason is simple enough; the gap in many districts between needs and proposals is so large that the numbers being provided are fairly meaningless in their own right. The figures for elderly people and disabled people give some idea of the scale of the problem; in relation to other groups, there is not much indication, but it seems likely that shortages are at least as serious, and probably worse.

The history of achievement for this kind of `target' in the past has not always been a happy one[26], and attempts to follow a similar régime in the 1970s were given up[27]. Past failures have prompted some cynicism; one contribution to the consultation exercise in the Borders region took a very dim view of the process, complaining that targets set in 1972 have not been met. "When such targets are not achieved the goal posts are moved to cover up." [28] The problem

is not that people do not see the issue as a priority, or are not willing to provide services; targets for provision cannot be reached by good will and hard work alone. They cost money, and the money is often not available. What is likely to happen, instead, is a slow, gradual development of provision, piece by piece, and sometimes the shortfall is so great that there seems to be little prospect of making it up.

Overall, the picture seems fairly bleak. The target figures which are proposed by the Scottish Office point to needs for housing units that often number in the hundreds, and sometimes thousands. Where the local authorities think their provision can sensibly be compared with the target figures, those are the terms the plans use. But where they cannot, developments are listed individually, and this is the main way that most provisions are described within the documentation.

The problem is not really a reflection of the new administrative arrangements; the shortages of provision relative to needs is long-standing. What is not clear is what the new arrangements can do to make things better. There is not enough money, and without the basic resources some of the grander ideals associated with community care seem hopelessly unrealistic. The planning authorities know it, and their documents tend, as a result, to plump for what is sensible and feasible rather than what is needed. Being sensible has its limitations, and it seems important to say something relatively irresponsible: *unless much more money is put into housing for community care, community care in Scotland is not going to work.*

3. The future of community care in Scotland

The effect of the Griffiths reforms in Scotland was never likely to be the same as in England. The first, and most obvious, problem is that Scotland is suffering from a huge `care gap' - what Fife RC describes, with good reason, as `a fairly massive shortfall for most client groups'. The Griffiths report argues for greater flexibility and consumer choice, by giving people a range of options from which a `package' of provision can be selected. I think there are reasons to doubt whether this ever works in practice quite as well as it is supposed to in theory[29]; but in a situation where there is hardly any basic provision, the idea that people are being offered a `choice' is nonsensical. Second, in the absence of adequate care provision outside institutional settings, Scotland has relied to a much greater extent than England or Wales on the health service[30]. Community care planning which did not directly involve the Health Boards in Scotland would be an absurdity. There was never any prospect, then, of centring control on Social Work alone, and agencies who want to make a contribution to community care often have two bodies to negotiate with (if not more). Third, Scotland has long had a much higher proportion of social housing than England and Wales, which limits the options for developments in ordinary housing in the private sector, and increases reliance on social housing providers. There has been an exponential increase in private and voluntary provision in Scotland over the last five years[31], but the process has a long way still to go.

The system which has emerged under these constraints is very different from that which Griffiths envisaged, and it seems unfair to attribute all the problems in the Scottish system to the reforms; the evidence suggests that, in many important ways, what is happening is not what Griffiths wanted at all. There is not a single authority in charge; there is no real division between purchaser and provider; there are few simple `contracts', in which people are given money to do a job and told to get on with it. Many of the problems come from trying to persuade public agencies with overlapping functions to work together, rather than establishing a clear division of labour.

At the same time, it is not obvious that reforms along the lines Griffiths suggested would help very much. The main positive fault of the reforms is the separation of accommodation and support. It is not only wrong in principle, but also impractical, because it requires at least two bodies (and often more) to be involved in commissioning work. But most of what is wrong with the reforms is negative - concerned with what they do not do, rather that what they do. The reforms have nothing useful to say about the level of funding which is needed, or on the crucial issues of priorities between groups and for different types of provision. There is no mechanism for making plans stick. The financial arrangements mean that community care provision is made at the expense of

other social priorities, including provision for people who are badly housed or homeless. And there is no real incentive for the main current providers of social housing - the local authority housing departments - to provide for community care at all.

Overview

The report describes the results of a survey of agencies involved in the planning and delivery of housing for community care. The role of housing has been underplayed in the process, but it is crucial for the development of appropriate care.

The role which housing is expected to play within the plans is often unclear. Formal arrangements for consultation with housing organisations have in many cases failed adequately to draw them into the planning process; many housing organisations feel undervalued or marginalised. Their role, in fact, is already extensive, including planning, enabling, providing `bricks and mortar' and offering accommodation with support; it is important to incorporate these efforts appropriately into the process of providing care.

The current reforms in community care planning seem to have led to deteriorating relationships, and in the first instance to have increased administrative obstacles rather than reducing them. The arrangements suffer from a range of problems, including many problems of co-ordination and liaison. This is aggravated by the attempt to separate `accommodation' from `support', which has meant that initiatives require funding from different sources. There is not a single authority in charge, and the division of labour between authorities is unclear.

The most serious problem at this stage seems to be the shortage of housing available for community care. There are serious deficiencies in information about needs and the state of current provision which have to be remedied in the near future. The indications there are, however, point to a massive shortfall in provision relative to need. Although there are options which might be used more widely, like cluster housing, the limitations of the stock, and conflicting pressures, reduce the ability to respond. There seems to be little practical hope of remedying the situation without a very substantial injection of funds.

This can only be an interim report. The survey was undertaken at a time when, although the new procedures were supposed to be implemented, many of the structures for community care planning were not really in place. Some of the problems described here will prove to be short-term, some will not; it is difficult to tell at this stage. Further research will help to clarify what is happening, as

well as giving more information about specific groups of people or problems in certain areas.

References

1. R Griffiths, 1988. Community care: agenda for action, HMSO.
2. The best known critiques were E Goffman, 1961, Asylums, Penguin; R Barton 1976, Institutional neurosis, Wright (3rd ed). For a description of institutional scandals, see Martin J P, 1984. Hospitals in Trouble, Oxford: Blackwell.
3. A Scull, 1977. Decarceration, Prentice-Hall.
4. D Hunter, G Wistow, 1987. Community care in Britain, London: King's Fund.
5. N Baker, J Urquhart, 1987. The balance of care for adults with a mental handicap in Scotland, Edinburgh: Scottish Health Service Information Services Division..
6. M Bayley, 1973. Mental Handicap and Community Care, RKP.
7. I argue the case in P Spicker, 1992. Packages of care, University of Dundee Working Papers in Political Science and Social Policy.
8. Wagner G, 1988. Residential care: a positive choice, HMSO, p.166.
9. Wagner, op cit, p.24.
10. *Inside Housing*, 18th November 1988, p.3.
11. Cm 849, 1989. Caring for people: community care in the next decade and beyond, HMSO.
12. Scottish Office, 1991. Community care in Scotland: Housing and community care, Circular ENV 8/1991.
13. A McCollam, 1992. Community care planning for mental health in Scotland, Edinburgh: Scottish Association for Mental Health.
14. Scottish Office Social Work Services Group Statistical Bulletin, CMC1/1991: Community Care Bulletin 1989-90, Edinburgh: Scottish Office December 1991.
15. Scottish Office, op cit, p.10.
16. Highland Regional Council/Health Board, 1992. Community Care Plan 1992-95 Bulletin no.21, p.17.
17. I Taylor, 1992. Discharged with Care, Edinburgh: Lothian Health Board/Scottish Council for the Single Homeless, ch 4.
18. Scottish Homes, 1991. Scottish Homes and care in the community: Consultation Paper, Edinburgh: Scottish Homes, p.23.
19. Scottish Homes, op cit, section 2.23.
20. P Spicker, 1991. Access to social housing in Scotland, Edinburgh: Shelter.
21. Central Research Unit, 1990. The Housing Needs of Elderly People in Scotland, Scottish Office.
22. Margaret Blackwood Housing Association, 1992. Business Plan 1992-96, part 1.
23. Scottish Home and Health Department, Scottish Education Department, 1979. A Better Life: report on services for the mentally handicapped in Scotland, Edinburgh: HMSO, pp. 79-80.
24. Scottish Home and Health Department, 1985. Mental health in focus, Edinburgh: HMSO, p.100.
25. I Taylor, op cit.
26. A C Bebbington, 1979. "Changes in the provision of social services to the elderly in the community over 14 years", Social Policy and Administration, 13(2).
27. T Booth, 1983. "Whatever happened to LAPs?", Policy and Politics, 11(2).
28. Borders Social Work Department and Health Board, 1992. Community care plans: Consultation report, p.76.
29. P Spicker, op cit, 1992.
30. D Hunter, G Wistow, op cit.
31. Social Work Services Group 1991, op.cit.