Community care: developing services for people with a mental handicap

Summary

Around £1 billion a year is spent in England and Wales on help for people with a mental handicap. The Commission's report last year, entitled Making a Reality of Community Care (ref 1), showed that in this and other areas organisational problems were preventing the most effective use of these large resources.

Since then, Commission staff have examined in more detail services for people with a mental handicap. This paper reviews that work and describes the challenges faced by local authorities. The population of mentally handicapped people is changing fast; perceptions of their needs are altering, and financial mechanisms are inadequate.

Unless local authorities work with health authorities quickly to ensure a needs-based allocation of available resources, the totality of services may contract unacceptably. The paper points the way both to better organisational and financial solutions, and to a more effective service. Auditors will be taking this work forward in a structured way at local level over the next year.

Introduction

1. Services for people with a mental handicap are undergoing a revolution. A major restructuring is underway in favour of care in the community. The range and type of services considered appropriate are changing fundamentally. This in turn is shifting the balance of responsibility between different public bodies — notably, the National Health Service (NHS) and local authorities, increasing the local both on personal social services, who must provide additional care, and on housing authorities, who face increasing requests for accommodation. In addition, the private and voluntary sectors are growing as a result of social security support. Accommodation is also being provided by housing associations and the number of places in private residential homes is increasing steadily by about 20 per cent each year. The task of combining these various contributions to the care of individuals is therefore becoming more and more complex.

2. But the organisational and financial framework within which these changes are taking place is seriously flawed, as described in the Commission's report. As a result, local authorities face a herculean task to make community care a reality for people with a mental handicap and to manage the changes currently sweeping through the service.

"Around £1 billion a year is spent . . . ."
Changes affecting local authority responsibilities

9. Local authority responsibilities are affected both by the total numbers of people within the client group and by the proportion of them cared for by other bodies - particularly the NHS. The average age of the client group is increasing and the proportion cared for by the NHS is decreasing. Both of these trends are placing an increasing burden on local authorities.

The changing population

10. The statistics available at the national level on the prevalence of mental handicap are extremely poor. Further work to improve these statistics would be very valuable - particularly considering the resource implications that may result. However, in spite of the limited information, it is possible to identify some clear trends with major implications for local authorities (see Fryers, ref 2). There are estimated to be some 160,000 people of all ages with either a severe or profound mental handicap in England and Wales. This total is unlikely to change significantly until well into the next century but the age structure of the population is changing. This in turn is changing the pattern of dependency on the statutory services.

11. Over the last 30 years, improvements in medicine have made significant changes to the incidence of handicap. During the 1960s, these improvements resulted in the survival of more children born with a mental handicap. As a result, there is a high incidence of mental handicap among those born during the 1960s. Subsequently, further improvements in obstetric and paediatric care, combined with more extensive screening programmes, have led to a reduction in the numbers of children born with a handicap. The drop in the general birth rate has also reduced numbers, while the life expectancy of people with a mental handicap has increased in line with general population trends.

12. These trends are likely to have combined to change the client population as follows:

- There appear to be smaller numbers of children with a mental handicap currently in schools (although the number

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Exhibit 1

NUMBERS AND TOTAL PUBLIC EXPENDITURE
(Adults with a mental handicap in England and Wales)

<table>
<thead>
<tr>
<th>Numbers</th>
<th>Expenditure</th>
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</tr>
</thead>
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<tr>
<td>130,000</td>
<td>£100m</td>
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</tr>
<tr>
<td>Community</td>
<td>77,000</td>
<td>£70m</td>
</tr>
<tr>
<td>P/V</td>
<td>7,000</td>
<td>£20m</td>
</tr>
<tr>
<td>LA</td>
<td>11,500</td>
<td>£120m</td>
</tr>
<tr>
<td>Hospital</td>
<td>34,500</td>
<td>£140m</td>
</tr>
</tbody>
</table>

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7. Furthermore, there are many steps that local authorities can take to improve their own services. During 1983, the Commission's auditors intend to undertake local audits of personal social services for people with a mental handicap to help review management, organisation and service delivery. Under the Local Government Finance Act 1982, auditors are required to satisfy themselves that "the body whose accounts are being audited has made proper arrangements for securing economy, efficiency and effectiveness". In the case of services for people with a mental handicap, the effectiveness of the service - the extent to which it achieves the objectives for a good service - is likely to be the most significant of the three. It is also the most difficult to determine. But auditors will also be reviewing the range of services available in each authority and the way these services are financed. They will be commenting on the efficiency with which the limited resources available are used. The aim is to work with each authority to help identify the main opportunities for progress.

8. This Occasional Paper outlines the basis for the forthcoming audit of local authority services for people with a mental handicap. It details the challenges facing local authorities and aims to:

- outline changes affecting local authority responsibilities;
- show how an effective service can be established.
Changing NHS services

16. Although at any one time the NHS only provides residential care for about a quarter of the client group, it spends about 50 per cent of the money (see Exhibit 1). As Exhibit 2 shows, it has been spending more on fewer patients. These trends (over the period 1975 to 1985) are explained by the following:

- The most profoundly handicapped have usually been cared for in hospital and their care requirements have been higher.
- Deaths and long stay discharges have exceeded admissions by just over 2,000 a year.
- However, the number of hospital patients in England is only declining annually by 1,300. The difference comes from an increase in the admission of short stay patients from about 11,000 to 36,000 a year. Such short stay patients may be expected to cost more per day than long stay residents.
- There have been increases in the standard of care from the very inadequate levels of the 1960s.
- There have not yet been decreases in the fixed cost element of hospital care. As a result, the average cost has increased as in-patient numbers decline but this decline is not yet sufficient to allow significant numbers of hospitals to close.
- The "hospital" costs also include the costs of a variety of new out-patient services, and the rising cost may be in part a reflection of the inadequacy of the accounting system.

17. Given that the total population is broadly constant, the burden on local authorities is increasing as the NHS reduces its provision of long stay places in hospital.

This process of change appears set to accelerate. Many health authorities now have plans to close long stay hospitals within the next ten years, and at least two regions are hoping to close all of their provision in that time period. If these targets are to be realised, there will need to be a considerable increase in the rate of resettlement, and the people actually being resettled will inevitably be older and more dependent. Health authorities face major problems as a result and bridging finance is needed if satisfactory alternatives are to be developed.

18. The implications of these developments need to be addressed urgently and require a coordinated approach with health authorities.

Resettlement arrangements

19. The resettlement programme has been gathering pace for some time now, and most local authorities will have some experience of how to accommodate people coming from hospital. Each authority ought by now to have negotiated some sort of strategy with health authorities and set up a rolling programme for people coming out of hospital.

20. The balance of initiative and responsibility between the health service and local authorities will vary from place to place with health authorities setting the pace in some areas, and retaining some responsibility for part of the service in other areas — for example, provision for people with more profound handicaps. Elsewhere, local government has taken the lead. The most important consideration is that the balance should be set by agreement, that plans should be internally consistent and that the resulting service should be appropriate.

"... the burden on local authorities is increasing ..."
scheme and from region to region. Also, criticisms are made that the same amount of money tends to be made available for each person irrespective of dependency. But at least there is a mechanism for financing resettlement in most regions, although even now not every region has such a system. In contrast, financial mechanisms are inadequate for people who would in the past have been admitted to hospital and whose cost would have been borne by the NHS.

22. Some residents are resettled directly into the private sector. Research by the School for Advanced Urban Studies (Ref. 7) has shown that:
- 90 per cent of them are financed wholly by social security;
- private homes usually take residents of relatively lower dependency;
- only a quarter of metropolitan districts and London boroughs have such homes within their boundaries compared to half the counties;
- provision is increasing by 20 per cent each year.

Such factors can bias resource allocations between areas and can mean that the money "saved" by the NHS is not necessarily available for the care of people with a mental handicap.

Exhibit 3

CHANGING POLICY
Flows into and out of Long Term Care

Table 1: COSTS OF CARE FOR DIFFERENT DEGREES OF DEPENDENCY
Local authority costs: £ per year, 1987 prices

<table>
<thead>
<tr>
<th>Form of care</th>
<th>High support</th>
<th>Medium support</th>
<th>Low support</th>
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<tbody>
<tr>
<td>Residential care</td>
<td>£23,000</td>
<td>£15,500</td>
<td>£2,500</td>
</tr>
<tr>
<td>Day care</td>
<td>£5,000</td>
<td>£2,000</td>
<td>£2,000</td>
</tr>
<tr>
<td>Total cost of care</td>
<td>£28,000</td>
<td>£17,500</td>
<td>£4,500</td>
</tr>
</tbody>
</table>

Social Workers recommended joint training for mental handicap nurses and social workers. Both agencies have now approved this recommendation, paving the way for joint training.

24. Inner cities face other complicating factors. Most large hospitals were located in the country by the Victorians, and an inner city authority’s residents can be dispersed far and wide. For example, Islington has clients in 12 hospitals in four different regions. Establishing a resettlement programme and securing an adequate share of the NHS finance is, to say the least, extremely difficult under these circumstances.

Reducing admissions

25. Exhibit 3 shows, in diagrammatic form, the flows of people to health and local authorities in the past (top diagram) and in the future (bottom diagram). As described previously, flow c (resettlement) is continuing and is set to increase, with a mechanism in place to finance it.

26. However, the flow of long stay patients to the hospital (flow b) is slowing very considerably, and in some areas has almost stopped. The same people are now finding their way to local authorities. This is in accordance with the Government’s community care policies and many authorities are duly making provision for these extra people. Nevertheless, local authorities are being required to meet the needs of their traditional client group (flow a) plus the additional needs of flow b, often without any extra finance to meet their increased workload. This is particularly serious, as traditionally the health service has met the needs of the most severely handicapped who have resource requirements out of all proportion to their numbers.

27. Table 1 shows the costs of supporting three people with a mental handicap in different settings. These costs are illustrative only and will vary from place to place according to local conditions. But they show the very high costs of residential and day care for people with a profound handicap or challenging behaviour who require high levels of support, compared with the cost of providing medium support in a day centre and a staffed group home, and low levels of support in a day centre and an unstaffed group home for people with a lesser handicap.

... transferring money is not enough on its own.
Most local authorities are currently neither financed nor equipped with the staff or the facilities to meet the needs of people with a profound handicap. Indeed, the Government expressed some concern about this group in Care in Action (ref 10) and some other solution may be required for a few individuals – particularly those with challenging behaviour.

28. In practice, the situation is considerably more complex than is shown in the simplified Exhibit 3, since hospitals are increasing short stay provision and the nature of the underlying population is changing. But, if the hospital closure programme proceeds as planned, the temporary relief provided by short stay admissions may disappear and the full burden of the responsibility for care will fall on families and on local authorities. Health authorities are continuing to provide professional support to joint local and health authority community mental handicap teams but day to day care and accommodation will also be needed.

The population changes will also have a marked effect. Although the numbers of young people requiring care from social services departments should gradually reduce, the resource requirements may rise since more of them will be profoundly handicapped. At the same time, as people with a mental handicap live longer, the proportion outliving their parents will grow, further increasing the burden on local authorities. Expectations are also rising. Parents and relatives are demanding better services such as despite care and the option of independent accommodation when their children grow up.

"Expectations are ... rising. Parents and relatives are demanding better services ...!"

30. Already there is a "two tier" service emerging in many areas, with parents seeing high quality services and facilities provided for people coming out of hospitals, financed by the health authorities, while their own sons and daughters get very little in comparison, simply because they opted from the start to look after their children at home. This situation is clearly unfair. But many health authorities understandably do not want their "money" (the resettlement grant) used to finance people in the community while they have people still in hospital, and deadline dates for closure.

31. If the present arrangements continue, there is the very real danger that the financial burdens on local authorities will increase because of population changes and NHS policy. The present system of cooperation between the NHS and local authorities is largely limited to joint finance and duties. But the finance that supports those who die in hospital is not always available for the care of younger people coming through the system. The possibility of joint finance and responsibility in a single body should be considered as a way of easing this difficulty. This would ensure that money currently spent on mental handicap services continues to be available and is not lost upon the death of particular patients.

An integrated service

32. An integrated service is already possible under existing arrangements following the issuing of the circular, Health Service Development: Care in the Community and Joint Finance (ref 6). Several authorities are making use of these powers to develop an overall service. Local authorities appear to be the more natural lead agencies for a community-based service for this client group and funds and services are being transferred to them in many cases. The process is easier where the health authority is not responsible for a large institution and its associated fixed costs. The problems of staff transfers are also thereby reduced. Conversely, additional complications result where responsibility for personal social services and housing is split between county and district councils; and where health and local authorities do not share common boundaries. Thus significant structural problems are avoided in single tier local authorities (London boroughs and metropolitan districts) – especially where a single local authority relates to a single health authority.

33. For example, Hillingdon has launched its mentally handicapped scheme (MESH), outlined in Exhibit 4. A single organisation now serves Hillingdon, facilitated in part by the absence of any long stay hospitals in Hillingdon for people with a mental handicap.

34. But it is also possible to reach agreement where there is a hospital and where authorities do not share common boundaries. Somerset County Council is pressing ahead with a programme to take
over all services. Three hospitals scheduled for closure fall within the county boundary. There have been difficulties over transferring staff from the health authority to the local authority, with problems relating to different conditions of service, but a jointly-agreed plan is now in place. West Sussex County Council has recently signed a formal memorandum of agreement with the three district health authorities and the South West Thames Regional Health Authority which serve the county, confirming the transfer of revenue and arrangements for capital provision.

35. Examples such as these are becoming more common but they are still the exception rather than the rule. They are characterized by trust and mutual respect between the authorities concerned, both from members who must share a clear vision and provide support; and from officers who must develop good working relationships. But some way of integrating services and, in particular, finance must be found if the problems created by the changing population and NHS policy are to be tackled effectively.

In Making a Reality of Community Care, the Commission suggested that the option of making local authorities responsible for the long term care in the community for people with a mental handicap should be seriously examined. Exception may be made for the most severely disabled who require regular medical supervision. Health services available to the general public, such as primary health care, psychiatric care and paramedical support, would of course continue to be provided by the NHS in the normal way. The resources necessary to allow local authorities to adopt this responsibility would then need to be identified and transferred from the NHS. The initiative for such a change would need to come from the centre to ensure that all authorities follow best practice. Appropriate devices such as formal transfer orders for staff would be needed.
Establishing an effective service

36. Finance and an integrated organisation are necessary, but not sufficient, conditions for success, as Exhibit 5 shows. An effective service still needs to be put into place at the local level whatever the organisational arrangements. The main features should be:

- Clear vision of the service required, with aims and objectives clearly stated and jointly agreed.
- Effective management – particularly case management which involves thorough assessment, individual programme planning and frequent review.
- A flexible range of services to provide suitable choice and an efficient use of resources.

These three items are considered in turn.

Developing concepts and vision

37. The concept of an effective service has been evolving rapidly over the last 30 years. For a century or more, the main service for people with a mental handicap was one of asylum and protection in a long stay institution. The Victorians undertook a prodigious building programme of such institutions throughout the latter half of the nineteenth century. It is this heritage which still dominates, even today. At the time, this development produced a considerable improvement in care, and the investment and energy put into the programme demonstrated a high degree of commitment. The philosophy adopted was one of segregation and separate development. The numbers of people accommodated in these institutions grew steadily to a peak of just under 60,000 in the late 1960s before starting to decline.

"... segregation was not the right policy ..."

38. The idea that segregation was not the right policy had been gaining support for a long time. General dissatisfaction with the arrangements was further fuelled by a number of scandals concerning the treatment of in-patients in some hospitals. However, in practice, most people with a mental handicap have always lived in the community with their families. Until 30 years ago, hospital or family home (without external support) were practically the only options available. A major turning point occurred

"An effective service still needs to be put into place at the local level ..."

with the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-7 (ref 11) which emphasised community care and an end to segregation. This led in turn to the 1969 Mental Health Act which required local authorities to provide a mental health service for persons of all ages living in their areas, including residential accommodation and the provision of training facilities and supporting services.

39. A further impetus to the change from institutional to community care occurred with the publication in 1971 of a white paper Better Services for the Mentally Handicapped (ref 12). This paper came down firmly in favour of community care, setting out a framework of general principles and providing guidance to local authorities and health authorities on the lines on which the Government wished services to develop.

40. During the 1970s the role of the hospital was increasingly challenged and questioned, with proposals put forward for smaller hospital units. Units of 70-80 beds were planned and locally-based hospital units and community units of 24 beds were proposed, providing long stay, short stay and emergency places and a base for community staff, all supported by regional hospitals of 200 beds. Increasingly there was a realisation that the 1971 White Paper had overestimated the need for hospital places.

41. A major move forward in the development of concepts of services for people with a mental handicap came with the publication in 1978 of the Jay Report (ref 8). While its main recommendations concerned staffing and training arrangements, the report also included radical and far-reaching proposals for a new model of care. This model is summarised in Exhibit 6. It is comprehensive and uses only small units of accommodation – preferably ordinary domestic housing. There is no role for the hospital. It also espouses a major change in attitude towards people with a mental handicap, who should be treated as individuals with dignity and respect, and who should appear and be treated in the most normal way possible with attractive age-appropriate dress, hairstyles, activities, etc.
42. The lay Committee model was relatively controversial when it was first produced, but, in subsequent developments, many of the principles have been adopted and extended and have led to a number of community-based models of care. A key feature of such developments is the encouragement of greater independence and self-reliance of people with a mental handicap. Quite apart from the improved quality of life for handicapped people and their relatives, such a process reduces the amount of care required in the long term, although more intensive support and training is required initially. In 1981, in a hand book of policies and priorities for the health and personal social services in England entitled Care in Action (ref 10), the Government endorsed the lay approach, although with reservations:

"The Government has accepted in principle the model of care set out in the Report of the Committee of Enquiry on Mental Handicap Nursing and Care (lay Committee) but has indicated the need for further consideration of the best way of providing for the special needs of the relatively small number of the most severely multiply handicapped people."

43. Subsequently the Welsh Office has put forward its own bold and imaginative proposals for a radical new service in Wales in the All Wales Strategy for the Development of Services for Mentally Handicapped People (ref 13).

44. In parallel with Government initiatives, professional groups have also been pushing ahead with major policy initiatives. In 1980, the King’s Fund Centre published a report entitled An Ordinary Life (ref 14) which set out guidelines for a comprehensive locally-based residential service, based on ordinary housing supported by an integrated service. In 1981, the Independent Development Council (IDC) was formed bringing together leading professionals and senior representatives of the main voluntary organisations in the field of mental handicaps. In 1982, it published a report entitled Elements of a Comprehensive Local Service for People with Mental Handicap (ref 15). Thus there is a very considerable consensus about the "vision" for a new service.

"... the vision for a new service."

45. This vision has at its core a different attitude towards people with a mental handicap, recognising them as full and valued citizens who have as much right as anyone to an ordinary life in the community.

"... a different attitude towards people with a mental handicap, recognising them as full and valued citizens who have as much right as anyone to an ordinary life in the community"

46. The consensus of what services should be like contrasts sharply with practice on the ground with a succession of reports recording slow progress. Thus, in 1980, the Government published Mental Handicap: Progress, Problems and Priorities (ref 17). In 1985, the House of Commons Select Committee on Social Services published a report entitled Community Care with Special Reference to Adult Mentally III and Mentally Handicapped People (ref 18). In 1986, the Commission’s own report, Making a Reality of Community Care, drew attention to slow and uneven progress.

47. The Government has not been deterred by these difficulties and has reaffirmed its commitment to the promotion of community care with a policy statement (ref 19; Annex II), appended to its response to the Select Committee report. But there is a need to close the gap between policy and practice, and the aim of the forthcoming audit is to help with this process. Auditors will need to establish that each local authority has a clear statement setting out the philosophy behind its services for people with a mental handicap, which should be recognisable in accordance with the principles endorsed by both the Government and professional organisations, while taking into account any special local circumstances. These objectives should be capable of translation into realistic service patterns.

Management

48. The new approach has at its core the needs of the individual. If this approach is to be translated into reality, operational arrangements must focus on the individual. Core plans need to be tailor-made. This requires an individual case-management approach, based on thorough comprehensive assessment taking into account not only each person’s abilities, but also their circumstances in the community, the needs of their family and friends, and their own aspirations. At the same time, it requires a thorough understanding of and coordination with the provider of services—health, housing, the independent sector and personal social services—so that needs and services can be matched within overall strategies and resource constraints. Case management and the development of individual plans are thus at the very centre of effective and efficient care. In addition, each person’s plan must be constantly reviewed and adjusted to match changing requirements.

"... field staff must have sufficient autonomy. . . ."
50. Particular attention will be needed to ensure that cost-effective solutions are adopted, making efficient use of scarce resources. For example, authorities should cooperate to the full with the voluntary sector. Staff will be used in a flexible and adaptive fashion, with emphasis on "flexicare" systems, and less use of rigid rosters. Full use will be made of other sources of funds.

51. Of particular significance are the needs of the most profoundly handicapped who can use vast quantities of resources - especially staff time - although careful case management can focus the resources in the most effective and efficient way.

52. Greater autonomy, more flexible use of services and full use of other sources of funds all require skills of a high order. A considerable investment in training will be required if an effective and efficient service is to be delivered, but this investment should be more than offset by savings from the more effective and efficient use of expensive and scarce resources.

"Efficiency ... requires a comprehensive range of services."

53. Improving staff skills is not enough on its own. Efficiency also requires a comprehensive range of services. Inefficiencies may not lie in the individual service itself, but in the lack of a wider range of options forcing an inappropriate use of an otherwise efficiently-run service. To be efficient, an authority should have a balanced range of services tailored to match the spectrum of needs emerging in the community. A gap in the range either means that people are receiving an unnecessarily intensive and expensive service (the next service up the range), or a service insufficient for their needs (the next service down the range).

54. The framework for a comprehensive range of services includes three main components:

- A residential service to provide suitable accommodation for those that need it, including short stay accommodation.
- A day service which should include education, leisure and employment opportunities as well as more specialist facilities for training and occupation.
- Support services, including coordination and case management, as well as domiciliary support and respite care.

55. For reasons of both effectiveness and efficiency, authorities should be able to offer a range of choice in all services so that individual packages can be assembled. In practice, the quantity and quality of services will depend, as in all things, on the amount that authorities are prepared to pay.

56. Thus, residential options will probably include a range of units (often houses in the community) with different staffing structures - from very high support for the most profoundly handicapped and for those with challenging behaviour, to minimal staff cover for people with higher abilities. Adult placement schemes ("adult fostering") and boarding-out schemes can be particularly cost-effective, although care is required in selecting and supporting such facilities. Indeed, the careful monitoring of standards is more important and more difficult in a highly decentralised service - especially where services are provided by the independent sector. Authorities will need to ensure that adequate monitoring arrangements are in place.

57. Given the growing importance of the private sector, local authorities will need to improve their arrangements for training private sector staff and to make more resources available for liaison and control. Day facilities should also be open to the private sector. More generally, local authorities will need to involve the private sector in their plans and to attempt to redress the mutual distrust that has arisen in some areas (ref 7).

58. In day care, the backbone of the service in the past has been the day, training or social education centre and, increasingly, authorities are promoting alternatives which are often more cost-effective and more closely integrated into the community. These include work and leisure opportunities for the more able in horticultural units or sheltered workshops, or in open employment with support. The Department of Employment and the Manpower Services Commission provide various opportunities in support of such initiatives. Also, further education centres are being used increasingly. Some authorities provide "satellite" day centres linked to the main centres but sited in a neighbourhood to serve the local population. "Special care" facilities for the more severely handicapped are increasingly being required as hospitals reduce support for these people, although where possible they are best integrated with others rather than segregated.

59. Support services have also been diversified although they will normally be based around core teams, such as community mental handicap teams, who will oversee assessments, individual programme plans and placements. Support services also include such services as respite care, "flexicare" domiciliary support services, care attendants and family link schemes, as well as providing information and advice for carers. Of particular importance is the provision of "care for the carers" since such support can help to keep families together and make life tolerable for people who might otherwise no longer be able to cope.

"Of particular importance is the provision of care for the carers since such support can help keep families together and make life tolerable for people who might otherwise no longer be able to cope."
"Local authorities should . . . evaluate . . . the quality of life of the consumers."

60. During the audit, auditors will be bringing good practice examples to the attention of social services department staff to promote further developments. Local authorities should also be taking steps to evaluate the effects of their mental handicap services on the quality of life of the consumers. A number of systems for such evaluation are available although some of the methods are detailed and time-consuming to use. Programme Analysis of Service Systems (PASS) (ref 20), for instance, should only be attempted by someone trained to operate it. But, although the importance of evaluation is well recognised, there is less consensus on the appropriate methodology. Considerable research is underway, for example, at the Mental Handicap in Wales Applied Research Unit, at Cardiff University. Local authorities will wish to be aware of the techniques available for seeking the views of consumers.

Finance

61. These care programmes do not necessarily require more money, but they certainly require more flexible use of the money available. As Table 1 showed, costs of services for different individuals with different degrees of disability will vary widely with some costing a great deal and others being relatively cheap. Furthermore, the appropriate balance of the service mix is constantly changing as the needs of the individuals change. The cost-effective management of such arrangements is a complex challenge and one which requires imaginative solutions — especially if the limited budgets available are to balance. Part of this management process involves ensuring that the opportunities presented by the following options are used to the full:

- Cooperation with voluntary organisations on many services, such as respite care, help with travelling and befriending and family-link schemes.
- Grants and initiatives from government departments and the European Community (for example, urban programme, community programme, Manpower Services Commission sheltered employment schemes, Youth Training Schemes).
- Health authority finance in the form of joint finance, dolevies, and per capita payments for places in local authority facilities.
- Use of DHSS benefits such as attendance and mobility allowances.
- Use of DHSS supplementary benefits for board and lodging to finance family placements and other residential settings.

62. In this last case, if residential care in the independent sector (housing associations, voluntary organisations, private homes) is used, benefits of up to £150 per week are available to individuals and considerable savings can be realised by the authority. Table 2 illustrates how the costs to the local authority in Table 1 might be reduced where this course of action is followed.

63. However, if health service property is employed or health service staff are used to provide support for residents, these benefits may not be forthcoming, even where a voluntary organisation or housing association manages the property. There appears to be confusion over this point, which can work against cooperation between the health service and other agencies. Such schemes can be particularly appropriate for people who have severe difficulties including profound handicap and challenging behaviour, where costs are high and the use of small scale accommodation in the community may depend on health service expertise and support.

Table 2: COST OF CARE IN INDEPENDENT HOMES FOR DIFFERENT DEGREES OF DEPENDENCY.

<table>
<thead>
<tr>
<th>Source of finance</th>
<th>High support</th>
<th>Medium support</th>
<th>Low support</th>
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<tr>
<td>Total cost of care (from Table 1)</td>
<td>£28,000</td>
<td>12,500</td>
<td>4,500</td>
</tr>
<tr>
<td>Less supplementary benefits payments to individuals for board and lodging</td>
<td>7,500</td>
<td>7,500</td>
<td>2,500</td>
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<tr>
<td>Net cost to local authority</td>
<td>20,500</td>
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The next steps

64. The delivery of an effective and efficient service for people with a mental handicap is a complex business. It is made more complex than necessary by the current division between agencies based on outdated historical models of care. The first step should be the integration of the service.

65. But the resulting £1 billion business requires more than just integration. It also requires:

- Vision
- Effective management
- The right mix of services

Each of these items is necessary for a cost-effective service. During 1980, the Commission's auditors intend to undertake local audits of personal social services for people with a mental handicap and will be looking to see how authorities are meeting these requirements.

66. Authorities are being asked to nominate a liaison officer who can coordinate the review internally and work with the auditors in producing: first, a position statement of the services available using a questionnaire; second, an evaluation of the strengths and weaknesses of the current service; and third, a programme for future initiatives. The aim is for auditors to work with each authority to help identify the main opportunities for progress in each of the three areas above.

"The first step should be the integration of the service."
References


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