

Care in the Community

Authored by
mohammad looti

November 19, 2022

RECOMMENDED CITATION

mohammad looti (2022). *Care in the Community*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=39272>

Care in the Community (also called Community Care" or "Domiciled Care") is the British policy of deinstitutionalization, treating and caring for physically and mentally disabled people in their homes rather than in an institution. Institutional care was the target of widespread criticism during the 1960s and 1970s, but it was not until the 1980s that the government of Margaret Thatcher adopted a new policy of care after the Audit Commission published a report called 'Making a Reality of Community Care' which outlined the advantages of domiciled care.

Aims of community care policy

The main aim of community care policy has always been to maintain individuals in their own homes wherever possible, rather than provide care in a long -stay institution or residential establishment. It was almost taken for granted that this policy was the best option from a humanitarian and moral perspective. It was also thought to be cheaper.

The Guillebaud Committee reporting in 1956 summed up the assumption underlying policy. It suggested that:

Policy should aim at making adequate provision wherever possible for the care and treatment of old people in their own homes. The development of domiciliary services will be a genuine economy measure and also a humanitarian measure enabling people to lead the life they much prefer

Three key objectives of Community Care policy:

The overriding objective was to cap public expenditure on independent sector residential and nursing home care. This was achieved in that local authorities became responsible for operating a needs-based yet cash-limited system.

There was a clear agenda about developing a mixed economy of care, i.e. a variety of providers. The mixed economy provision in residential and nursing home care has been maintained despite the social security budget being capped. And there are now many independent organisations providing domiciliary care services.

To redefine the boundaries between health and social care. Much of the continuing care of elderly and disabled people was provided by the NHS. Now much of that has been re-defined as social care and is the responsibility of local authorities.

An important point to note though is: that NHS services are free, whereas social services have to be paid for. So how the care you require is defined, that is health or social care, determines whether or not it will be free.

The Griffiths Report: 'Community Care: Agenda for Action'

Sir Roy Griffiths had already been invited by Margaret Thatcher to produce a report on the

problems of the NHS. This report was influenced by the ideology of managerialism. That is it was influenced by the idea that problems could be solved by 'management'. Griffiths firmly believed that many of the problems facing the Welfare State were caused by the lack of strong effective leadership and management. Because of this previous work, which was greatly admired by the Prime Minister, Griffiths was asked to examine the whole system of community care. In 1988 he produced a report or a Green Paper called 'Community Care: Agenda for Action', also known as The Griffiths Report.

Griffiths intended this plan to sort out the mess in 'no-man's land'. That is the grey area between health and social services. This area included the long term or continuing care of dependent groups such as older people, disabled and the mentally ill. In 1988 Griffiths said of community care that it was everybody's distant cousin but nobody's baby.

Basically he was saying that community care was not working because no one wanted to accept the responsibility for community care.

Community Care: Agenda for Action made six key recommendations for action:

Minister of State for Community Care to ensure implementation of the policy - it required ministerial authority.

Local Authorities should have key role in community care. i.e. Social Work / Services departments rather than Health have responsibility for long term and continuing care. Health Boards to have responsibility for primary and acute care.

Specific grant from central government to fund development of community care.

Specified what Social Service Departments should do: assess care needs of locality, set up mechanisms to assess care needs of individuals, on basis of needs - design 'flexible packages of care' to meet these needs

Promote the use of the Independent sector: this was to be achieved by social work departments collaborating with and making maximum use of the voluntary and private sector of welfare.

Social Services should be responsible for registration and inspection of all residential homes whether run by private organisations or the local authority.

The majority of long term care was already being provided by Social Services, but Griffiths' idea was to put community nursing staff under the control of local authority rather than Health Boards. This never actually happened. The Griffiths Report on Community Care seemed to back local government whereas, the health board reforms in the same period, actually strengthened central government control.

1989 white paper 'Caring for People'

In 1989 the government published its response to the Griffiths Report in the White Paper Caring for

People: Community Care in the next Decade and Beyond. This was a companion paper to Working for Patients and shared the same general principles:

A belief that State provision was bureaucratic and inefficient. That the State should be an 'enabler' rather than a provider of care. The UK state at this time was actually funding, providing and purchasing care for the population

Separation of the purchaser / provider roles

Devolution of budgets and budgetary control

Caring for People key objectives

The White Paper followed the main recommendations of the Griffiths Report but with two notable exceptions.

The White Paper did not propose a Minister of community care and

It did not offer a new system of earmarked funds for social care along the lines advised by Griffiths.

It did however; identify six key objectives which differed slightly from Griffiths Report.

New funding structure

Promotion of the independent sector

Agency responsibilities clearly defined

Development of needs assessment and care management

Promotion of domiciliary, day and respite care

Development of practical support for carers

These objectives required new legislation which was enacted in the National Health Service and Community Care Act 1990.

The impact of the community care reforms

The community care reforms outlined in the 1990 Act have been in operation since April 1993. They have been evaluated but no clear conclusions have been reached. A number of authors have been highly critical of the reforms. Hadley and Clough (1996) claim the reforms 'have created care in chaos' (Hadley and Clough 1996) They claim the reforms have been inefficient, unresponsive, offering no choice or equity. Other authors however, are not quite so pessimistic.

Means and Smith (1998) claim that the reforms:

introduced a system that is no better than the previous more bureaucratic systems of resource allocation

were an excellent idea, but received little understanding or commitment from social services as the

lead agency in community care

the enthusiasm of local authorities was undermined by vested professional interests, or the service legacy of the last forty years

health services and social services workers have not worked well together and there have been few 'multidisciplinary' assessments carried out

in reality little collaboration took place except at senior management level

the reforms have been undermined by chronic underfunding by central government

the voluntary sector was the main beneficiary of this attempt to develop a "mixed economy of care"

Mental health and community care

Under the National Health Service and Community Care Act 1990, people with mental health problems were able to remain in their own homes whilst undergoing treatment. This situation raised some concerns when acts of violence were perpetrated against members of the public by a small minority of people who had previously been in psychiatric hospitals.

The National Health Service and Community Care Act 1990 was passed so that patients could be individually assessed, and assigned a specific care worker; in the unlikely event that they presented a risk they were to be placed on a Supervision Register. But there have been some problems with patients "slipping through the net" and ending up homeless on the street. There have also been arguments between Health and Social Services departments on who should pay.

In January 1998, the Labour Health Secretary, Frank Dobson, said the care in the community programme launched by the Conservatives had failed.