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'Community Care: Agenda for Action'

A response from the National Demonstration Services in Psychiatric Rehabilitation

The Department of Health and Social Security has designated eight services as 'National Demonstration Services in Psychiatric Rehabilitation'. The aim of this was to identify services which would exemplify good practice in psychiatric rehabilitation and long-term care. In preparing his report Sir Roy Griffiths met with representatives from these services. It was felt appropriate that the National Demonstration Services should comment on the recommendations in so far as they are likely to affect those with long-term psychiatric problems.

There are many recommendations in the report which ought to be acted on.

(i) There must be a clear policy on community care, with adequate resources made available (p. iv, para 9). The appointment of a responsible Minister of State (6.19–6.21, 7.2) is an appropriate step in realising this aim.

(ii) If services are to be effective and comprehensive they must be developed in an integrated manner rather than piecemeal (4.20).

(iii) Any adequate system of care must be based on "packages of care tailored to meet... the needs of individuals" (6.5). The nature of the disabilities from which many people suffer makes it difficult for them to seek out and utilise services. Services have to be delivered (3.9).

(iv) Community care programmes must be designed to meet the needs of a wide range of individuals including those who have never been in hospital (4.14).

(v) The consumer's voice must be given prominence especially in the planning of individual programmes (1.3.2, 3.8.iii, 6.4). It is unfortunate that the report gives less prominence to the consumer in the planning of services.

(vi) All services should have to conform to the same established minimum standards both in terms of the physical environment and of care (4.6).

Definition of community care

(i) Until we have an agreed definition of community care, no clear policies will be developed and services will continue to be provided in a patchy and poorly integrated manner (p. iv, para 9).

The report offered no definition of community care, instead the recommendations as to responsibility are a rather conservative shift from the traditional: "community care" is what is done in the community to: "community care" is what is done by Social Services.

(ii) The aims identified for community care (3.6, 3.8) are not exclusive to any organisation and the responsibility placed on Social Services to assess the individual's needs (6.4) is not explicit enough to provide a demarcation of areas of responsibility.

The report identifies Health Service responsibilities with hospital care (2.6, 4.12) and the hospital is conceived of as providing acute interventions (e.g. 4.11, 4.12, 6.12). Despite identifying the "continuing need for some long-term hospital care" (4.13) the idea of continuing care is omitted from the definition of the Health Service's responsibilities.

This conceptualisation is unnecessarily restrictive and simplistic. It assumes that there is a self-evident distinction between what is and what is not "health". The report prescribes a philosophy which not only enshrines the narrowest and most arid of disease models but is out of tune with most thinking and achievements in the area.

A more fruitful approach would have been to view "community care" as a co-operative venture not just between Health and Social Services, but including housing and education authorities, those responsible for leisure and recreational resources and all the other agencies, statutary, voluntary and private which go to make up the community (society).

The differing needs of the reference groups

The report, despite its emphasis on individually tailored packages of care, makes universal recommendations, without reference to the varying needs, the genesis of these needs or their consequences in three very different groups: the mentally ill, the mentally handicapped and the elderly. In fact it reads most coherently if one regards it as addressing primarily residential services for the elderly.

In the field of chronic mental illness the Health Services will always retain an interest in the range of provisions available, in part because of the nature of the disabilities of the chronically mentally ill but also because poor provision of services will result in "deterioration" and the inability to function adequately "in the community" and at this point

"the community" (society) will expect the Health Services to provide "appropriate" care, treatment or support. This assumption of continued responsibility is clear in the report. However, the difficulties experienced by these individuals will not be narrowly "medical".

There must be a mechanism for long-term support and review of needs for as long as necessary – in some cases in to advanced age.

The over identification of community care with accommodation

The report focuses too much on accommodation. Little attention is given to the other elements of an adequate community care service. The report contains only a general endorsement of some recommendations in the Firth report (6.48), and a vague statement about day care and leisure activities (6.52). Rehabilitation receives only a passing mention (6.12). If community care is to be successful it must fulfill all the beneficial roles of the hospital services it is replacing in a co-ordinated manner.

There is a danger that the continuing emphasis on a reduction in hospital beds will lead to a situation where the number of beds remaining and their designation may make it difficult for Health Services to provide appropriate care by re-admitting those psychologically fragile individuals when it becomes necessary.

The report encourages Social Services departments to use the services of private and voluntary agencies and points to the inspectorial powers of the Social Services departments in ensuring quality of service in these sectors. There is concern, however, as to the effectiveness of these inspectorial powers in enforcing satisfactory standards of service.

Co-ordination of the NHS and Social Services

Despite stating that it does "not favour . . . major transfers of responsibilities between existing authorities" (5.3) the report recommends that all non in-patient services become the responsibility of local Social Services departments, that Social Services departments assume the responsibility for identifying people with community care needs (6.2), assessing those needs (6.4) and also assume an overseer function with respect to "other authorities" (6.3). These recommendations represent a major shift of responsibilities.

The ideal that Health and Social Service departments should develop "a clear framework . . . of co-ordination" (page vi, para 23) is worthy but vague. Specific recommendations on planning are limited to the run down of hospital beds. It is recommended that "targeted specific grants should be made available to Social Services authorities to enable them to build up services **so that people can be discharged from long stay hospitals**" (emphasis added) (6.37). And that "specific plans should be made . . . for the reduction of long stay hospital beds and any necessary increase in the contribution of community Health Services to community care. Plans from the two agencies should be closely integrated and preferably in a single document." (6.37). It is difficult to see how these recommendations would lead to an improvement on the present "patchiness of provision" (4.20) by providing an "incentive to plan, prioritise or organise" (4.20). Most worrying is the lack of any consideration of continuity of care which should be an essential feature of services for people with long term disorders. The danger is that we will move from the era of the "revolving door" patient into that of the "shuttlecock patient", batted back and forth with nobody having overall or continuing responsibility.

Delivery of services

We support the recommendation that there should be a care plan for each individual, designed to meet his/her needs, and that these needs should be identified on the basis of a thorough assessment involving consultation with both the client and the informal carers.

A distinction needs to be drawn between the co-ordination of a care plan for an individual on one hand, and assessment and intervention on the other. Good practice indicates that optimum care is delivered when both these functions remain the responsibility of a single multi-disciplinary team. Where the delivery of care is fragmented, however, it is important that some identified individual assumes the administrative role of co-ordinating the care plan.

The tasks of assessment, identifying needs and meeting them can only be satisfactorily performed by a properly constituted multi-disciplinary team. No one discipline is equipped to carry out the task of identifying all an individual's needs and deciding how these might best be met.

The report recommends the establishment of a new position: "Care Managers" (6.6). The Care, or Case Manager will have to perform a number of tasks of questionable compatibility:

(i) oversee the assessment and identification of individual needs and design packages of care (1.3.2)
(ii) arrange for the delivery of packages of care (1.3.3)
(iii) act as Gatekeeper (and by implication, agent of those who hold the purse strings) (1.4.1)
(iv) act as advocate for the individual.

Given the tension between these roles it is unreasonable to expect that they can be exercised by

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one individual to the benefit of the patient/client. One cannot strive after excellence and be responsible for rationing resources at the same time.

The report fails to address the issue of what training, other than in management skills (8.6), or support and back-up the case manager will need.

The report also proposes that a new position of "community carer" (1.6.6) be created. There are some attractions in this but the report is unclear as to the exact role, training, relationship to the multidisciplinary team, and responsibilities, especially as informants and sources of immediate support (6.7) of the "carer". These are not tasks to be taken lightly.

Quality of life is referred to only in the context of providing discharge plans for long stay patients (page v, para 18). This is an important omission.

Lack of evaluation of implications of recommendations

The brevity of the report has resulted in the implications of some recommendations not being fully examined.

It is recommended that the role of the CPN, for example, should not be diminished (6.13), but that they might be subcontracted to Social Service departments. A large part of the skill of the CPN is not narrowly medical. If these skills are only to be exercised when they are subcontracted (e.g. 6.13, 6.17) then this aspect of their role is beyond the jurisdiction of the NHS and it is inappropriate that it should train people with such skills. Social Service departments are not in a position to train CPNs. So when the present post holders are no longer available this valuable asset is condemned to extinction – a substantial diminution of their role.

Relocation of staff

The report does not adequately address the issue of the relocation of staff. It recommends that staff are seconded to Social Services, or transferred or made redundant and re-engaged by Social Services (7.14). It does not consider the possibility that Social Services may be unable to take on all NHS staff "made available" by the proposed shift in responsibilities.

Little attention is paid to the loyalty staff feel towards the institutions in which they work. One cannot demand of these individuals that they transfer this loyalty to new services, especially when little thought appears to have been given to either their security or career structure.

Similarly despite claiming that "It is important that the skills of staff formerly employed in long stay hospitals are not lost" (7.13) the report ignores the fact that most long stay hospitals serve several health districts, whose boundaries are hardly ever coterminus with local authority boundaries, and that the hospital is normally some distance from the "receiving district". Relocating large numbers of staff in these situations will cause substantial problems, especially if the employing authority has to be changed at the same time. No doubt these problems are not insoluble but exhortations to find local solutions (7.15) are of very limited usefulness.

Finance and planning

We are concerned about the financial implications of some recommendations. The idea that monies should be related to targets and "ring-fenced" should be pursued. The report recommends that "community care needs . . . should be considered separately in the public expenditure planning process." (6.22). It goes on to suggest that central government provides a specific grant to Social Services departments to cover about 50% of the estimated costs of the "national objectives" (6.23). The main component of this grant would be contained in the rate support grant and so subject to the vagaries and uncertainties of that system with the consequent problems for long term planning and commitment which are essential in this area. Social Services authorities would have the "discretion to 'top up' from their other sources of funds." (6.26). However, in the straightened financial circumstances in which many Local Authorities find themselves, they will still be able to ignore their responsibilities to the long-term mentally ill. Decisions will be made on the basis of cost, and where there is a shortfall of revenue no services will be bought in. Unlike the present situation, however, the NHS will not be able to provide a safety net, partly because of the demarcation of responsibilities and partly because the monies now used to finance such projects will go directly to Social Services and not be available to the Health Services (6.32). The fear is that, as at present, Social Service departments will concentrate on those areas for which they have statutory responsibility, while the Health Services will devote ever increasing attention to acute care leaving the long-term mentally ill a priority group in name only. Nor has any attempt been made to address the difficult issue of the temporary increases in expenditure while moving from one type of service provision to another. Bridging finance is mentioned only in the introduction to the report (page v, para 14).

We are unclear about the implications of recommendation 6.43. Does it mean that some people, even though they are identified as needing residential care, will be deprived of it because it is decided that they (or their family) could afford to pay for this service themselves? If this is the case it would be a most unwelcome development. What effects is such a provision expected to have on the family of the

person needing care? It hardly seems likely to act as an incentive to remain in close contact.

The report's failure to look in some detail at personal finance is a serious omission. This issue is one of the most critical factors in determining the success of community care. This area must be given further close scrutiny.

Recommendations

(1) An adequate definition of "community care" must be developed. This should reflect the need for comprehensive services, providing continuity of care and enabling a wide range of individuals to survive optimally in as normal a situation as possible.
(2) The Government must articulate an explicit policy on "community care", and a Minister should be appointed to oversee its execution.
(3) Adequate and guaranteed funds must be made available to enable policies to be realised.
(4) All services should meet the same established minimum standards.
(5) The services, both offered and planned, by the Health Service and by Social Services departments must be integrated. Central Government must provide appropriate structures to ensure this. The emphasis must be on continuity of responsibility and care, not on discontinuities of location and the run down of hospital beds.
(6) The continuing responsibility of the Health Services for those with long term psychiatric disabilities and in consequence their interest in the range of provisions for these individuals must be acknowledged.
(7) There must be an adequate range of resources, including day care and in-patient facilities as well as residential accommodation in any adequate community service.
(8) Adequate resources must be retained to enable individuals to be re-admitted to hospital to receive high levels of care and supervision when necessary.
(9) The delivery of services must be based on individualised packages of care, not block treatment. The patients/clients and other relevant individuals should be involved in the design of these packages of care.
(10) The consumer should also be involved in the planning of services.
(11) The needs of the individual can only be adequately assessed and appropriate care plans devised and delivered by a properly constituted multi-disciplinary team.
(12) Where new positions such as that of care manager or care worker are proposed their relationship to those with existing responsibilities, the responsibilities of the new position and the training necessary should be made explicit. No position should be created which enshrines a conflict of interests.
(13) The skills and knowledge of existing staff must not be lost in the development of new community services. Mechanisms must be developed to ensure that these are safeguarded.
(14) Any policy of "community care" must pay close attention to the personal finances of the consumers of these services.

Dr Len Rowland
District Services Centre
The Maudsley Hospital
London SE5

Dr Linda Hall
St Crispin Hospital
Northampton

Ms Caroline Sincock
Prestwich Hospital
Manchester

Dr Brenda Morris
Royal South Hants
Hospital
Southampton

Mr Mark O'Callaghan
District Psychologist
Basildon, Essex

Dr John Howatt
St Anne's Hospital
Nottingham

Ms Jackie Ferris
St George's Hospital
Morpeth
Northumberland

Ms Pam Hewitson
Hollymoor Hospital
Birmingham

Dr Mounir Ekdawi
Netherne Hospital
Coulsdon, Surrey

Dr Hugh Griffiths
St George's Hospital
Morpeth
Northumberland

A copy of the full report is available on request from Dr Rowland or Dr Morris.

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