The future of community care

Trish Groves

Community care is not working. The government has decided to stall its programme of hospital closures (box), and the virtues of asylum care are being extolled once more.¹ In the jargon of planners, reprovizion is not keeping pace with deinstitutionalisation. Former patients have ended up on the streets² and in prisons,³ prompting great public and political concern.

But the biggest scandal of community care is that it has not been monitored adequately. Nearly 100 000 long stay patients have been discharged from Britain's mental hospitals in the past 35 years and fewer than 4000 places have been provided in local authority hostels. These statistics, which are much quoted, do not necessarily mean that community care has failed the remaining patients. The numbers simply tell us that the Department of Health does not know what has happened to that invisible cohort. Probably some of these people live with their families, some in hostels run by voluntary or private organisations, and some in independent accommodation. And some must be dead, because they were elderly when discharged. But no one knows for sure.

Community care is not needed only for former residents of large mental institutions. Young people with relapsing psychotic illnesses and related long term disabilities—the “new long stay” population⁴—still need shelter and rehabilitation. Champions of community care have been too optimistic, hoping that neuroleptic drugs and new psychological treatments might provide permanent cures for all.

“Our unease that some districts may have moved the balance to community care too far, and left themselves short of beds for long term care, is why we gave authorities what I have called ‘the amber light.’ Not to discourage increased provision of community services, and certainly not to put the policy since 1975 into reverse but to try to ensure that authorities proceed with proper caution in a very difficult area with very little established knowledge.”

Roger Freeman, parliamentary secretary for health, speaking at the annual conference of the National Schizophrenia Fellowship, London, December 1989

Changes in government policy

The government has known for some time that something had to be done, and three years ago it asked Sir Roy Griffiths to rescue community care.^{5,6} Most, but not all, of his proposals were incorporated in last year's white paper entitled *Caring for People*. This document is misnamed because it heralds legislation that allows statutory services to stop caring for people. Local authorities will act as brokers of social care and leave families and independent organisations as main providers. Sir Roy likens this system to business in “my own company in determining whether distribution is to be done by our own depots and workforce or by outside contractors.” He says that he decided against the option of radical structural change but admits that “nothing could be more radical in the public sector than to spell out responsibilities, insist on performance and accountability and to [seek] evidence that action is being taken.”⁷

To those who work in social services and the independent sector the white paper is certainly radical. Newspaper headlines proclaim a new breed of “chequebook social workers” who will work in a consumers' market as case managers. Their tasks will include arranging multidisciplinary assessments of clients' needs and handling budgets to arrange delivery of care. They will be expected to make maximum use of services in the independent sector, something that many social workers may not consider ideologically sound. If, after full assessment of a client, residential care is thought to be the best option there will be financial disincentives to discourage placement in a local authority home.

The independent sector will be expected to provide services for case managers to buy. Most independent organisations for chronically mentally ill people are voluntary groups that do not make profits. They have developed locally and haphazardly, complementing but never intending to usurp the roles of doctors, nurses, and social workers. They usually specialise in one aspect of mental health care, plugging holes unfilled by statutory services and not wishing or trying to provide a comprehensive service. The relation between the two sectors is set to be reversed.

Health authorities are less affected by this review and in several ways they have benefited. They will no

PHOTO CO-OP

What will the future hold for discharged long stay patients?

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A CARING COMMUNITY?

The plight of Britain's mentally ill

It was a startling idea: to release the mentally ill from asylums and put them back into the mainstream of life, into a caring community. It was a plan born out of compassion, optimism and the discovery of new drugs which controlled some of the most crippling mental disorders. It started 25 years ago and it has been pursued, as a policy, by every government since. At first it worked. But now, 25 years later, the optimism has run dry, the compassion looks threadbare and in too many instances the forces of commercialism are all that is being brought to bear upon the problems of progressively sicker people as they are uprooted. So far, 60,000 patients have been returned to the community and more continue to be as the old asylums like Liverpool's Rainhill Hospital (right) are demolished. For many people, as our investigation shows, the concept of a caring community amounts to little more than a sick joke

A special investigation by Marjorie Wallace. Photographs by Snowden

One of many campaigning articles by journalist Marjorie Wallace, "Sunday Times Magazine" 3 May 1987

longer have to provide social care: long stay units will cater only for patients who need the attentions of doctors, nurses, and paramedical staff. In psychiatry, that relieves health authorities of any obligation to provide hospital hostels and rehabilitation units for patients who have greater social than mental disabilities, although it will not be easy to separate a person's needs in that way. One problem for mental hospitals particularly is the need for double funding. It is not always possible to close a whole ward and transfer the money to a hostel or day facility in one neat movement, and plans to sell sites to developers have been thwarted by the collapse of the property market. Health authorities must have been pleasantly surprised by the recent announcement of a £50 million bridging fund for new facilities because it will help them to maintain the fabric of old hospitals during gradual closures. But some have argued that this fund is too little, too late.

The Griffiths report made it clear that local authorities would be in charge of community care, both financially and administratively. Ministers' slowness in responding to its recommendations may have reflected their reluctance to give so much power to local authorities,⁷ and in the white paper they have diluted that power. Rather than give direct funds to local authorities for all community care they have agreed to provide a specific grant only for mental health, and this will come from (and will be controlled by) health authorities. The implication is that the money could be withheld if a proposed community project does

not suit a medical model. And, despite Griffiths's recommendation that they be abolished, dowries—payments which represent the savings made in health budgets when patients leave hospital—will still be paid. Local authorities do not consider this to be a reliable source of funding,⁸ and they will not be pleased.

New training requirements

For all those who provide community care services there will be problems of staff training. The white paper announces management courses for qualified social workers that will cost the government £2 million, but there will also have to be changes in core training. Some voluntary organisations such as the Richmond Fellowship train their own staff, others recruit nurses and social workers, and some rely heavily on untrained volunteers. Griffiths recommended a generic breed of community care workers, but the government has decided to continue with the existing workforce, perhaps helping some to gain recently proposed national vocational qualifications. Families and friends of chronically ill and disabled people, who have been much praised but little reassured by the white paper, will have to muddle through, although there are vague suggestions that both statutory and independent organisations should provide better information about the task of caring. These informal carers may not see much advance on Kenneth Clarke's acknowledgement that "for rather too long community care policy has rested on empty exhortations to do better."

Although changes in community care will also affect elderly and physically handicapped people, the government has focused particularly on the plight of people with severe chronic mental illnesses. In this series of articles I will concentrate on the future of psychiatric community care and will try to answer the following questions:

- What kind of care do severely mentally ill people need?
- Who provides that care now, and in which settings?
- Will informal carers and the voluntary sector be able to rise to this challenge?
- What will these changes mean for patients?

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- 3 Coid J. How many psychiatric patients in prison? *Br J Psychiatry* 1984;145:78-86.
- 4 Mann S, Cree W. "New" long stay psychiatric patients: a national sample survey of fifteen mental hospitals in England and Wales 1972-3. *Psychol Med* 1976;6:603-16.
- 5 Griffiths R. *Community care: agenda for action*. London: HMSO, 1988.
- 6 Anonymous. Local authorities should coordinate community care, says Griffiths. *Br Med J* 1988;296:945.
- 7 Murphy E. Government must act on community care. *Br Med J* 1988;297:1558-9.
- 8 Audit Commission. *Developing community care for adults with a mental handicap*. London: HMSO, 1989:9-10.

ANY QUESTIONS

According to recent research findings the cholesterol in crustaceans such as prawns, shrimps, crabs, and lobsters is of the HDL type. Should they still be excluded from a cholesterol lowering diet and should molluscs such as oysters and mussels also be excluded?

There is virtually no evidence showing that the form in which cholesterol is present in foods has any biological significance for the person eating the food. Moreover, the mechanisms involved in cholesterol absorption suggest that the form ingested would have no effect on the proportions of high density lipoprotein cholesterol in the blood.¹ The lipoprotein

complexes would be denatured during digestion. Esterified cholesterol is hydrolysed by pancreatic cholesterol esterase and together with the free cholesterol is absorbed in mixed micelles in the jejunum. Some of the cholesterol is re-esterified in the epithelial cells and these esters together with the free cholesterol leave the intestinal cells in chylomicrons. The subsequent metabolism of the chylomicrons then contributes cholesterol to the various lipoprotein carriers. Until there is experimental evidence that the consumption of high cholesterol foods such as crustacea and molluscs do not affect cholesterol levels it is prudent to continue to exclude them.—D A T SOUTHGATE, head, *Agricultural and Food Research Council Institute of Food Research, Norwich*

- 1 Newsholme EA, Leach AR. *Biochemistry for the medical sciences*. Chichester: John Wiley, 1986:252-9.