Thursday 16 May

About 0200 two men were brought to me complaining of symptoms due to exposure to gas. Their symptoms were identical: a tight feeling round the chest, worse on breathing, and a dry mouth. The evidence that there had been gas was that there had been a smell like phosgene, which the company commander had said was gas. I came to the conclusion that the attack was a false alarm and sent them back to the trenches, firstly, having been along and discussed the position with the intelligence officer. Later it was agreed that the rumour had been caused by the unaccustomed smell of the exploding shells.

I got back to bed again about 0300, but an hour later a man was brought in who had been shot by a sentry on failing to answer a challenge. He had been shot through the chest and was in a very bad way. I sent off an urgent message to the advanced dressing station at Huldenberg, which the assistant director of medical services had told me the previous day would evacuate my patients, but the station replied that they were not evacuating us and that we should go to another advanced dressing station. I sent off a message to them, but by this time the man had died. It would have been impossible to do anything for him anyhow. I spent the whole day in a steadily increasing fury as I was unable to find anyone who would accept the responsibility of evacuating us. I had two sick to get rid of, but what mainly worried me was that we were being pretty continuously shelled and that we were expecting to be heavily attacked that night, and I had nowhere to send my casualties. Eventually, at about 1600 I went off in

the brigade major's car to the station at Huldenberg to discuss what to do with Harvey, a friend of mine, who was in charge of it. He agreed to take my casualties, and I returned much relieved but still in a very nervous state. I stopped to report and have a whisky at brigade and was impressed by the calmness of the brigadier—and he, moreover, must have known that by then the Germans were right through some 10 miles further to our right.

In the evening both sides began an intense artillery duel, the noise of the guns and shells becoming a continuous roar. A man was brought to me with a severe compound fracture of his right leg; this had occurred when he was moving his own Bren gun. He had probably done it on purpose and had certainly succeeded in getting himself out of the war for many months. This made the third casualty, all caused by our own men—or rather the fourth if you count a fractured clavicle—the result of stumbling over a rock. Harvey came and took him away and left a party of eight Royal Army Medical Corps stretcher bearers to carry the wounded down to a car port established in the village half a mile away; the carry was entirely under cover, being mostly down our beautiful cutting. I settled down to sleep early as I was expecting a lot of work during the night. The guns continued the whole time, accompanied after dusk by the sharper note of continuous small arms fire. Presently I was woken to be told to prepare to move in either direction at a moment's notice; then Harvey came to withdraw his stretcher bearers and I returned to sleep.

Part II will appear next week

After the Asylums

Can the community care?

Trish Groves

The government was criticised for taking so long to respond to Sir Roy Griffiths's well received report,¹ and yet, now that it is implementing most of his recommendations, it is being criticised again. The government, it seems, cannot win. After all, the Department of Health has funded and evaluated a range of community care projects and has shown that the linchpin of the new proposals—case management—is a sensible way to work.² The department has clarified the responsibility of social services for people with overwhelming needs for social care and suggested that professionals trained for welfare work might be suitable brokers of welfare services. It has halted its programme of hospital closures, listened to psychiatrists' views on aftercare, and has agreed that asylum care is still needed. Ministers have rightly acknowledged the contributions of informal carers and voluntary organisations and recognised the new consumer movement in mental health³ with its concepts of advocacy and user participation. So why has the white paper *Caring for People*⁴ been ill received?

Underfunding and overloading

Cynics might suggest that it is fashionable to knock the government, but party politics do not explain all of the criticisms now voiced about the community care proposals. In the last article of this series I look at those criticisms that fall into three main categories: underfunding, bureaucratic overload, and poor information.

Perhaps the biggest problem with *Caring for People* is that it failed to endorse Sir Roy Griffiths's emphatic proposal to earmark or "ring fence" community care funds. Under the new system the government will transfer to local authorities funds that it would otherwise provide through the Department of Social Security as income support and housing benefit for people using community care facilities. Under the existing system it is much cheaper for social services to place an elderly or disabled person in a residential home (the fees for which will be paid mostly by social security benefits) than to provide them with care in their own homes (funded by local social services budgets). The new system avoids what ministers have called this "perverse incentive" to place people in residential care when they may not really need it. So far, so good.

But Sir Roy Griffiths, while recommending such a change, also noted that residential homes could at least provide a safety valve until better domiciliary services were organised. He emphasised that any money saved should be earmarked to improve community care, and when the government decided against this Sir Roy's disappointment was only thinly disguised by humour (box). Failure to earmark the money means that local authorities are under no obligation to spend it on community care. Other priorities and pressures may mean that they spend it elsewhere. Thus the government's budget juggling could mean less money for community care.

Some idea of those other pressures was provided by

The original Bethlem Royal Hospital in 1720, its heyday. It now faces cuts of up to £600 000

a recent survey conducted by the Association of Directors of Social Services and commissioned by BBC Radio 4. Speaking on the programme *Special Assignment* on 23 March, the association's secretary, Bob Lewis, described how only a fifth of the social services departments surveyed were managing to work within their set budgets, despite recent increases in funding. More than a third had cut services or abandoned new plans because the community charge will not bring in sufficient money. Three quarters thought they would not be able to afford to implement the new community care proposals in 1991. Even if sufficient funds come from the Department of Social Security to run services they will not cover the costs of data collection, administration, and training that underlie the proposals: one county council has estimated its transitional costs at nearly £1m. Although these results must be interpreted with caution because only 61% (71 out of 116) of the social services departments in England and Wales responded to the survey, their gloomy message of underfunding is hard to ignore.

Underfunding also threatens the NHS's chances of providing adequate community care. Despite the implication in *Caring for People* that health authorities will be providing less social care many fear that this is a red herring: the most difficult (but not necessarily the most ill) patients may remain in hospital if case

managers cannot find alternative accommodation. Yet regional health authorities will soon have to provide specific grants to fund mental health projects in the community, leaving less money for district hospitals. District health authorities have already cut existing services to meet their budgets. For example, the Bethlem Royal and Maudsley Hospitals, which provide community care to a disadvantaged inner London area, had to save £1.4m between 1987 and 1989 and a further £600 000 this year.⁵ For many health authorities the problems of underfunding are compounded by reductions in capital. Land and property values in London and the home counties have fallen by nearly a fifth over the past year, making it increasingly difficult for authorities to finance new facilities by selling old hospital sites. Those who want to make the NHS a party political issue can have a field day linking these problems directly to the government's economic policies.

Bureaucratic overload

Another criticism of *Caring for People* was its bad timing: it came when the health service was struggling with its sister document, *Working for Patients*, and the new contract for general practitioners. It is hard to understand how these proposals relate to each other, how they should be implemented, and what it will all mean for patients.

For social services departments both the bureaucratic and financial implications of the Children Act 1989 may far outstrip those of the forthcoming legislation on community care. The act replaces some 20 different laws relating to children and heralds a complete reorganisation of the way social services and others deal with problems of child care. But in an excellent and practical guide to the changes comes the familiar warning that the act is "ominously silent" on resources.⁶ One director of social services told me that he foresees some departments spending the specific grant for mental illness on child care and justifying this action by calling it preventive psychiatry. When social workers are faced with a rising tide of child abuse and with the threat of suspension and trial by the media if they fail to combat it should we blame their managers for ignoring adults with chronic schizophrenia?

"I had provided a purposeful, effective, and economic four wheel vehicle but the white paper has redesigned it as a three wheeler, leaving out the fourth wheel of ring fenced funding. I am happy that such a vehicle is capable of moving in the right direction, although occasionally I pray that I shall not be left singing 'Three wheels on my wagon' with the ultimate undesirable fate which befell the driver at the hand of the Cherokees."

Sir Roy Griffiths, speaking at a conference of the National Association of Health Authorities, London, December 1989

Accurate information wanted

Much of the literature about community care describes specific projects. But isolated success stories do not provide sufficient evidence about community care throughout Britain and neither do the Department of Health's data on health, social, and independent sector services. Planners in all sectors need up to date, accurate information about what is available now before they can make sense of the proposals for change. For example, it is impossible to decide how many more hostels are needed for new long stay patients under 65 if the current total includes many part III homes for elderly people: the two age groups have different needs.

We also need better information about the failures of community care throughout Britain and neither do direct relation between closures of mental hospitals and the increase in homelessness in Britain. This assumption conjures images of elderly long stay patients being turfed out of the hospitals that have been their homes for 20 or 30 years into the cold, dirty streets. Sadly, for some homeless people this may be true,⁷ but for most it is much more likely that the association with hospital closures is indirect. "Old long stay" patients are usually well known to psychiatric services, whereas homeless mentally ill people probably comprise a potential "new long stay" group, having had numerous relatively short brushes with hospitals and clinics but never having received regular care.⁸

This point may seem academic, but it must be confirmed by further research because the needs of the new long stay group will differ from those of more institutionalised former patients. Even if there were more long stay beds it would not be possible or reasonable to round people up from the streets and take them to hospital: we have gone too far down the line of liberal thinking (and rightly so in most cases) for that. But we do need a bigger and better range of drop in centres and night shelters as well as more formalised community care. There is some room for optimism: Roger Freeman, parliamentary secretary for health, recently announced that he was working on a package of such initiatives for up to 500 homeless people in London.⁹

Patients and relatives need more information too. Last month the National Schizophrenia Fellowship announced that schizophrenic patients and their carers rate the help provided by police more highly than that provided by health or social services.¹⁰ Although the study was hurried (the Department of Health gave a month's notice that it wanted such data) and had only a 10% response rate from the fellowship's 6200 members, such results as there are show that more work should be done. One reason for finding the police more helpful than other professionals may concern accessibility. Patients and relatives do not always know what kind of help is available or how to obtain it, a problem that the charity Schizophrenia: A National Emergency (SANE) is trying to rectify by setting up a national telephone helpline for practical advice in emergencies.

Conclusion

I have looked at the way government policy may affect community care. The other major influence is the attitude of the community itself: unlimited funding

of luxurious facilities cannot provide full care if society still fears and stigmatises people with mental illness. Neighbours objecting to plans for hostels can be educated at open days, public meetings, and even barbecues with considerable success,² but hard work by local people will be wasted if prejudice persists on a wide scale. Last month a high court ruled that former psychiatric patients could not live together in two new houses bought by Bath District Health Authority because the residents would not constitute "an ordinary family unit."¹¹ Thus the houses would count as business premises rather than private dwellings, in breach of the property developers' covenant, and this would lower the value of neighbouring houses. This case might be unusual because it concerns new "executive" homes on an estate rather than rambling Victorian villas, but it gives a depressive insight into the "not in my backyard" (or NIMBY) mentality. The health authority is appealing against the decision.

At the start of this series I said that community care is not working. Certainly it is not working well enough if care is an unknown quantity with an unknown distribution round the country. Depending on his address, a young man with severely disabling chronic schizophrenia might block an acute psychiatric bed for a year, enter a slow stream rehabilitation ward, move to a hostel in the centre of town, return to his parents' home, stay in bed and breakfast accommodation, or sleep in a cardboard box. Admittedly, in a district with exemplary community services he could still fall through the net of care by choosing not to take what was offered, but in a district with less on offer his choice would be narrowed. Diversity within districts seems to be healthy, but considerable variation among them (excepting that dictated by different demographics such as the age structure of the local population) inevitably means that some patients lack adequate care.

Many of the proposals for reorganising community care are commendable, but it is impossible to judge whether they will work. Even though *Caring for People* is subtitled *Community Care in the Next Decade and Beyond* reassurance is needed now.

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- 1 Griffiths R. *Community care: agenda for action*. London: HMSO, 1988.
- 2 Cambridge P, Knapp M, eds. *Demonstrating successful care in the community*. Canterbury: Personal Social Services Research Unit, University of Kent, 1988.
- 3 Anderson J. Patient power in mental health. *Br Med J* 1989;299:1477-8.
- 4 Secretaries of State for Health, Social Security, Wales and Scotland. *Caring for people: community care in the next decade and beyond*. London: HMSO, 1989.
- 5 Bebbington P, Checkley S, Lishman A, et al. Effects of cutbacks on psychiatric services. *Independent* 1990 March 5:18.
- 6 Allen N. *Making sense of the Children Act 1989*. Harlow, Essex: Longman, 1990.
- 7 Marshall M. Collected and neglected: Are Oxford hostels for the homeless filling up with disabled psychiatric patients? *Br Med J* 1989;299:706-9.
- 8 Hamid WA, McCarthy M. Community psychiatric care for homeless people in inner London. *Health Trends* 1989;21:67-9.
- 9 Durham M. Help is on the way for homeless mentally ill. *Sunday Times* 1990 Jan 21:7.
- 10 Took M, Evans T. *Provision of community services for mentally ill people and their carers*. Surbiton, Surrey: National Schizophrenic Fellowship, 1990.
- 11 Sherman J. Decision to bar ex-patients from house "could wreck care plans." *The Times* 1990 April 13:4.