The College

The Royal College of Psychiatrists' comments on the Griffiths Report: *'Community Care: Agenda for Action'*

I *Summary*

The Royal College of Psychiatrists welcomes the Griffiths Report as an important contribution to the debate on the future organisation and funding of community care. We welcome the suggestion that a Minister of State be appointed with special responsibility for community care and recognise that this will promote development and ease the transfer of funds. The College has strong reservations about other proposals. In particular we believe that:

i. the needs for the mentally ill and the mentally handicapped should be considered separately. [see para II (i) for text]
ii. the NHS should have overall responsibility for the care of the mentally ill. Local authorities should have responsibility for the mentally handicapped, but the NHS must continue to provide for their psychiatric needs. [see para II (i) and (ii) for text]
iii. there is no real division between 'acute' and 'chronic' health care. Both must be available from the NHS and not be 'bought in' by local authorities whose funds may not match the local needs for health care. [see para II (iii) for text]
iv. there is an over-emphasis of provision by private facilities at the expense of statutorily funded facilities. [see para II (iv) and 3 (viii) for text]
v. we are not convinced that the tight centralised controls proposed will encourage local initiatives [see para II (v) for text]
vi. we strongly support the recommendation on training. We are concerned that the 'best possible price' of private care may not include the considerable costs which will be required to provide training. [see para III 4 (ii) for text]

We have made detailed comments on various of the Report's recommendations and we would gladly contribute to planning on the further implementation of community care.

II *Introduction*

The College welcomes the Report as an important contribution to the debate on the future organisation and funding of community care. On the other hand, we do not agree with many of its overall recommendations or the underlying assumptions on which the Report is based.

i. The various care groups are all treated alike. We believe they need to be treated separately. In particular, there is a majority of mentally handicapped people whose needs will largely be met by residential and social care. (A substantial minority will still require a considerable amount of health care.) The great majority of the mentally ill, of all ages, on the other hand, require a sustained input of health care.
ii. Griffiths' analysis of the situation is based largely on the reports of the National Audit Office and the Audit Commission. Their main findings were the very patchy and inadequate provision of care, both by local authorities and DHSS. The provision of private care using social security monies could be seen as a compensation for this. Although described as a 'perverse incentive', there is little evidence for *over-provision* or for inappropriate provision, which could anyway be avoided to a large extent by appropriate screening of individuals, together with appropriate provision of a *range* of facilities, without recourse to alternative funding systems. Screening, in many cases, would need to be multidisciplinary, relying not only on a social worker and a general practitioner. There are clear resource implications in providing such screening.
iii. There is a serious over-simplification of the division between 'acute' and 'chronic' health care. This is deleterious both to the care of patients and to the education and practice of doctors. There is increasing evidence that, in the more stimulating but also more demanding surroundings of ordinary life and domestic

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responsibilities and opportunities, both the mentally ill and the handicapped are at times more psychologically unstable. Thus they require sophisticated supervision in order to avoid the 'revolving door' type of treatment. In the case of the elderly, the careful supervision of physical health is also essential.

No clear division can or should be made between 'acute treatment' and 'chronic care'. The great majority of such long-term care goes on, and will continue to do so, in the patient's ordinary home rather than in special residential facilities. When these facilities are required, nursing and care by psychiatrically trained staff will be necessary for many groups.

The Griffiths proposals may be seen by some Health Managers as an excuse to desert the chronically sick and concentrate their thoughts and their budgets on the acute sector.

iv. There is an assumption that the expansion of care will occur only in private care or in the voluntary sector. We believe that this will depend very much on local circumstances. There should probably be a balance between all three. We are concerned that the private sector will not fund any training of staff.

v. There is an assumption that this tightly controlled system will encourage more activity and innovation than the present rather pluralistic and uncontrolled one. This is at least questionable. The main obstacles to development in recent years have been the lack of funds in the system – 'making bricks without straw' – as Griffiths remarks – rather than the system itself.

The system proposed may in fact discourage development and innovation. It also removes the individual's current rights to a grant of money from the social security system.

vi. The proposals suggest a system to control expenditure of community care by delegating authority to one body under very strict conditions – an analogy can be made with the Local Authority Education Grant. Funding however in this case is derived from several sources:

a. transferred from Department of Health and Social Security and Department of Environment
b. from social security funds (the community care element of the Social Fund)
c. from the rates support grant
d. means tested residential allowances allowed to individuals
e. from local authority funds (approximately 50%).

The government grant will only be given if a local authority's plans and management systems are regarded as satisfactory. In particular, a very considerable use of the private sector is demanded (6.49). Some authorities may be unwilling to co-operate with such a system. The main allocation will be calculated on the basis of local need. It is not at all clear how this will be assessed, but it seems only too likely that those local authorities with the greatest need will be those who are least able to provide their 50% contribution to the total fund.

III *Specific comments*

1. Appointment of Minister of State in DHSS with responsibility for community care (para 1.2)

The report is a welcome attempt to define the responsibilities for community care more clearly. We welcome the suggestion of the appointment of a single responsible Minister. However, that person will have more of a supervisory role than an executive one because at least 50% of the money required will need to be raised from local authority sources.

2. Chapter 4: Responsibilities

i. *Mental illness*

In the past years, local authority provision of care for the mentally ill has been uneven and inadequate. Their contributions in terms of services and expertise have been eroded, by funding and organisational difficulties, and the increasing demands of child care and homelessness. Compared with the Health Service, there have been fewer efforts to establish national standards of care or routine statistics. We recognise and appreciate the valuable contributions of social workers to psychiatric care. They are essential members of our psychiatric multidisciplinary teams. But the other demands on their time have left Social Service Departments very short of the resources and skills demanded of them by the Griffiths proposals. We have been particularly concerned by the Government's recent refusal to fund the extra year which has been proposed for social work training – a proposal which our College strongly supports.

Furthermore, the mentally ill of all ages require a great deal of continued input from the psychiatric services whether at home or in some sort of sheltered accommodation. The Health Service contains by far the largest fund of expertise in the assessment and care of the mentally ill and an evaluation of services.

In our view, Social Services Departments are not the appropriate organisations to provide or to bear the responsibility of developing

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community care for the mentally ill. This responsibility must be vested mandatorily in the Health Authorities.

ii. *Mental handicap*

We believe that Social Services should be responsible for the care needs of the majority of mentally handicapped people – this is wholly consistent with the underlying philosophy of new approaches to care. It would remain essential for there to be adequate NHS services, including specialised residential and hospital units, to provide psychiatric assessment and treatment for the substantial number of mentally handicapped people with psychiatric illness and behaviour disorders and offender patients. These services should be properly structured, comprehensively and systematically provided in all Districts, should remain an NHS responsibility and be available according to need. A certain flexibility in approach will be needed in respect of certain groups, e.g. the profoundly and multiply handicapped, where the boundary between NHS and Social Services responsibility is still uncertain. We have serious reservations about the notion of Social Services 'buying in' NHS services as required. This may well result in neglect of medical needs, since systems which depend on paying for services, usually act as a disincentive to use them. The most impoverished local authorities may have the greatest need for medical care.

3. **Chapter 6: Recommendations**

i. *Local Authority/Social Services Authorities* (para 6.4)

In the case of the mentally ill and elderly mentally ill, much of the assessment and care plans could be the responsibility of the family practitioner and the local psychiatric services, together with CPNs. Assistance from local social workers and local authority facilities e.g. home helps, meals on wheels, would also be required in many cases. It should be remembered that a considerable number of mentally ill people, especially in cities, are not registered with a GP.

ii. *Local Authority Housing Authorities, Housing Corporations* (para 6.10)

We are concerned that the 'bricks and mortar only' suggestion would reduce the contribution of the Housing Associations and their special projects grants, which are playing an increasingly important part in providing residential facilities. In addition, housing welfare workers and housing managers have been extremely helpful in the care of vulnerable people. The 'bricks and mortar only' rule seems an attempt to 'ring-fence' possible sources of money to an unnecessarily restrictive degree.

iii. *Regional and District Health Authorities* (paras 6.12 and 6.13)

The definition of what health authorities provide is potentially very broad. But as there is a caveat that 'Health authorities should not provide services which fall outside this definition', it may not be so broad as it looks. In particular, we are concerned that 'treatment and rehabilitation' may be seen as a comparatively short-term process and that 'long-term care' is somehow excluded. We have already argued that there should be no division between acute treatment and long-term care in terms of responsibility. Many GPs are now trained to provide long-term psychiatric care, but decisions about the transfer of care have to be made on an individual basis.

iv. *Joint planning and action* (paras 6.15–6.18)

We support the statements that joint planning and action will still be essential at a local level regardless of whether responsibility is invested in the NHS or in Social Services.

v. *Central Government* (paras 6.22–6.33)

The specific grant could be made out to the locally responsible body. The statistical information required would be provided by both NHS and local authorities.

vi. *Funding: Regional and District Health Authorities* (para 6.34)

We support the recommendation that the budget for these authorities for the delivery of community care objectives should be separately identified in their plans, and budgets 'ring-fenced'.

vii. *Supporting people in the community instead of in long-stay hospitals* (para 6.37)

We believe that funds released from the run-down of long-stay hospitals for the mentally ill and mentally handicapped should remain within the health service. Health service funding, particularly for patients in the community, is inadequate. All the funds from long-stay hospitals — both capital and

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revenue – will be required for future health services.

viii. *The private contribution to care*

a. *Para 6.49:* Griffiths makes strong recommendations for the expansion of private care and the voluntary sectors. 'Central government should not fund a general expansion of local authority run homes'. In addition, local authorities 'should negotiate the best possible prices in the private sector'.

We are concerned both with the quality of private care at 'the best possible price' and of its geographical distribution, which is very unevenly spread at present and makes for particular difficulties in liaison with health authorities. In some particularly deprived boroughs, there are very few private facilities and these seem unlikely to develop in the future. It is possible that voluntary sector care may be arranged, but we feel that the contribution of statutorily funded facilities are underemphasised. Some of the most innovative developments are to be found within the statutory sector.

b. *Para 6.51:* We support the statement providing a significant input to domiciliary care, and that assessments should not be considered between residential care and very little else. These decisions should, however, be made on the basis of need and not of expense.

ix. *Registration and inspection* (paras 6.52–6.58)

The recommendations on 'Setting and Maintaining Standards', contained in *Residential Care – A Positive Choice: a Report of the Independent Review of Residential Care* ('Wagner Committee'), seem rather more stringent, and we would support them.

4. **Chapter 8: Other issues**

i. *Professional roles* (para 8.4)

There may well be a case for a new occupation of 'community carers' to undertake the front-line personal and social support of dependent people and for the development of multi-purpose domiciliary services. We would envisage these as being recruited from the local neighbourhood and given a little basic training.

They should not be confused with 'case managers' who would take a co-ordinating role and would require to be trained staff, as would those involved in training mentally ill or handicapped people, to cope with everyday demands and to make use of the local facilities.

ii. *Training* (paras 8.5–8.8)

We are pleased that the Griffiths Report makes a particular point of mentioning training which is extremely important in the implementation of community care. We have already noted our regret that social workers are not going to receive a third year of training. We are particularly concerned about the organisation of training in private care. The 'best possible price' of private care may be obtained by not allowing residential staff and other workers time off to complete their training and studies and by not providing any teaching staff. At present, practically all the training for the NHS and in local authorities is provided at public expense; there is very little training in private facilities. If private and voluntary facilities are to take an increased role in the provision of community care, the cost of training their personnel must be included in their costs.

Approved by Council – June 1988

Centenary of the Gaskell Medal

To mark the centenary of the inauguration of the Gaskell Medal, the members of the Gaskell Club have very kindly presented a silver candelabrum to the College. The candelabrum bears the following inscription:

"1887–1987. Presented by the Gaskell Club to The Royal College of Psychiatrists to Mark the Centenary of the Gaskell Medal".

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