An Open Letter to Sir Roy Griffiths

An open letter to Sir Roy Griffiths as he studies the practicalities of 'community care' from a practising psychogeriatrician who is not persuaded that the report of the Audit Commission on the same subject provides a sound primer.

DEAR SIR ROY

As you trawl the literature on community care and travel the country to glean opinions and examples of practice, you may well have felt comforted to have available the recently published *Making a Reality of Community Care* which purports to be an independent and well balanced review of the subject. It seems to me that there are flaws in the understanding and thinking behind this document and these have led the Audit Commission to confident conclusions and advice that are not of uniformly high quality and some of the advice makes alarming reading to a practising psychogeriatrician:

Required under section 27 of the Local Government Finance Act 1982 "to undertake or promote studies designed to enable it to prepare reports as to the impact of any particular statutory provision or provisions or of any direction or guidance given by a Minister of the Crown ... on economy, efficiency and effectiveness in the provision of local authority services or on their financial management..." the Commission addresses itself to three questions:

(i) To what extent are community care policies being adopted in practice?
(ii) To what extent are funding policies helping or hindering local authorities' economy, effectiveness and efficiency?
(iii) To what extent are organisational arrangements helping or hindering local authorities' economy, effectiveness and efficiency?

Its answers, published a little over a year after the formation of a small study group, are presented in a style reminiscent of a sales brochure or prospectus. The speed with which the material was collected betrays a shallow depth of understanding and the 'hard sell' style of presentation makes one uneasy and suspicious.

The opening 'summary' suggests that care at home is much less costly than care in hospital or residential care for similarly disabled or ill people—a case by no means proven but repeatedly assumed and asserted in the body of the report. Three quarters of the summary is devoted to conclusions and recommendations which are reaffirmed in the 'Introduction'. Before immersion in the data and discussion one is left with little room to doubt:

(i) There are serious grounds for concern about the lack of progress.
(ii) Fundamental underlying problems need to be tackled.
(iii) Radical steps will be necessary if the underlying problems are to be solved. Fine tuning the existing arrangements or treating the symptoms will not meet the needs of the situation.

How far the evidence goes to support these conclusions requires careful and determined thought.

Three chapters and four appendices bring together a wealth of interesting and relevant information and data, some of which has not been easily available previously. Services for the three 'priority groups': the mentally handicapped, the mentally ill and elderly are considered both individually and as a group of three with similar characteristics, aims and aspirations. This latter device is problematic: for whilst care for the mentally handicapped may (arguably) be modelled without reference to periods of illness this is clearly not reasonable when considering the mentally ill nor the elderly/'geriatric' populations.

One might go further to point out that the elderly with psychiatric disorders which include dementia are not identified as a separate group, being largely subsumed under 'mental illness' and to a lesser degree 'elderly'. Yet they do represent a group of particular vulnerability whose problems are different in nature, duration and/or progression from those of younger people with psychiatric disorder and elderly people who are not suffering from mental illness.

In addition, whilst 'community care' is agreed to be appropriate for many of the disabled in all these groups, the reduction of institutional/residential places that may be appropriate for the younger mentally ill has not been agreed to be desirable for the elderly, most certainly when they are both physically and mentally impaired. In failing to recognise these very important differences and confusing itself by attributing trends in services of one priority group to all of them, the report does the reader a disservice and leads the Commission to make false conclusions.

To what extent are community care policies being adopted in practice?

Mental handicap

Progress in mental handicap (Table 5 of the report) is said to be slow. A 39% move towards the target in hospital bed reductions in the first 15 years of a 22 year transition, together with 56% increase toward local authority residential place target and 52% advance toward training centre place target, does not seem too bad to me.

Mental illness

The run down of mental illness hospital beds by 25,500 or 45% of target over 10 years has been 'matched' by 41% of target increase (3,300 beds) between the local authority, private and voluntary sectors in residential care. There has been a net loss of 22,000 beds or 20% of the total 1974 capacity despite meagre advances in the provision of day care: 17% of target. 'Progress' in terms of reducing facilities has been more impressive than progress in building up alternatives.

The elderly

The total capacity of residential and in-patient beds for the elderly (not including those in psychiatric care) has increased from 207,700 to 269,300 but this represents little more than maintenance of previous levels: 85.1 places per 1,000 aged 75 years and above in 1984 compared with 84.2 in 1984 because of increases in the number of elderly. When the shift towards very elderly, 85 years and over, is taken into account maintenance of previous provision is probably best seen as a modest and desirable achievement rather than an excessive development of the residential sector. Indeed it is salutary to remember that fewer elderly people per head of population were in institutional care in the 1970s than in the 1900s when people over 75 years and 85 years were rarities.

Within this 'residential' sector there have been significant redistributions: geriatric beds have been reduced by 20% and local authority beds by 12% whilst the private sector, rest homes rather than nursing homes, has expanded. It is this expansion that has allowed maintenance of previous levels of provision. Thus there has been a shift away from the facilities with the greatest therapeutic potential and toward the private sector.

Enabling facilities within the community have been increased: (day hospitals marginally, day centres doubled) or just failed to hold their own: (home helps and meals on wheels).

Variations in provision

There is considerable variation in the rate at which changes are occurring in mental handicap and mental illness services. This is to be expected in a rapidly changing situation where there remains uncertainty about the best pattern of service.

The uneven distribution of residential and domiciliary provision for the elderly is fascinating. Exhibit 7 of the report demonstrates dramatically the 'two nations' syndrome with the affluent south and coastal areas well endowed with private and voluntary homes. The rest of the country is bereft. The reasons for this variation one assumes to be historical and related to characteristics of the housing stock, the financial status of the local elderly population and their preferred practices when responding to the difficulties of old age. Such an assumption is supported: areas with the most private care not only spend less on the elderly but are rated low by indicator E14 of the Rate Support Grant (which is an "adjustment for debt charges, revenue contributions to capital outlay and income on residential care" rather than a measure of need as suggested in the report) and do not include much in the way of sheltered housing. This distribution was almost certainly the same or very similar before the creation of Board and Lodgings payments, yet provokes the Commission to its role of 'scold' of these payments and their "perverse effects of attracting support for people receiving residential rather than community care who live in areas of the country where the need for care ... is below average". It may be that local elderly people without means now have easier access to private homes in these areas but others move into homes from areas that are less well endowed and 70% of beds are still occupied by paying customers.

Residential care for the elderly might be reduced

The suggestion that some people currently in residential care could be managed elsewhere is not new but may not be correct. Indeed the report mentions in another context anxieties that arise because homes are now catering for people who would previously have been in hospital. It is a common experience that at allocation meetings throughout the country the criteria for admission to local authority homes remain distressingly harsh, with deserving cases frequently having to wait for a place. Surveys that identify some in care who appear capable of living more independent lives probably underestimate their vulnerability which may be based in factors not within the scope of the survey instrument. There are real grounds to doubt the commission's view that the impact of the Board and Lodgings payments has been 'perverse'. Without them the provision of residential care for the elderly would have fallen below levels that had been felt by many to be inadequate in 1974 and many people would have been placed at unacceptable risk and to unreasonable discomfort without them.

To what extent are funding policies helping or hindering local authorities' economy, effectiveness and efficiency?

Referring to the House of Commons Select Committee's statement that "... the proposition that community care could be cost-neutral is untenable ... genuine community care policies are achievable only in the context of some real increase ... in expenditure on services ..." the report observes perplexingly. "However Table 12 shows expenditure exceeded targets", and goes on to declare with repeated exhibition of the costs of caring for example A (a frail elderly person) and example B (a mentally handicapped adult) that care at home is cheaper and more cost effective than care in residential homes or hospital.

It is fascinating to see, in fact, how little difference there is in the cost of maintaining a frail elderly person at home: £97.35 per week or in local authority care: £133.25 per week—a difference that disappears when 'some day care' is introduced, upgrading the cost of care at home to £135.35 per week.

No account is taken of the different range of disability and illness requiring treatment in the modes of care considered. The average resident of a Part III home is more dependent and has more 'illness' than the average elderly person at home supported by a home help and a weekly visit from a district nurse. Very few elderly people in geriatric hospital beds are not either severely disabled or seriously ill and receiving active treatment. More disabled and ill people are more expensive to care for properly. Equivalent care and treatment at home would be more expensive if it were possible. *Cash limited care at home, i.e. limited to the costs mentioned here, would be cheap, inadequate and equivalent to neglect.*

This is an important basic flaw in one theme of the arguments that recur throughout this report and undermine one's confidence in its honesty and competence. This is a pity for other points are clearly correct:

The way that NHS resources are determined and allocated to Regions does not at present make provision for the shift of funding to social services. It should and must do in the future.

The present systems of distributing the Rate Support Grant act as a deterrent to the expansion of community based services. This is a major problem and is carefully and clearly demonstrated by examples. Correction should be achieved by a modification of the present systems.

Bridging funds to cover new capital developments and revenue costs of running down existing services at the same time as preparing for and building up new services are required, need to be substantial and cannot be produced from existing budgets despite the range of ideas and creative accounting that have been explored. This is a matter that demands more money for a short period. There is no way round it. It does not require a major reorganisation.

There is a need to increase and realign recruitment and training programmes for staff to work in new style services. The model wherein all the caring professions (including medicine?) might require completion of a 200 hour 'helpers' training course before accepting candidates into the more specialised modules of training sounds attractive and workable without major dislocations.

These are all sound points and could be acted upon without radical changes in existing systems, representing practicable modifications to existing structure.

To what extent are organisational arrangements helping or hindering local authorities' economy, effectiveness and efficiency?

The paragraphs that explain existing patterns of responsibility, interaction and planning are helpful but emphasise the difficulties that can and do occur rather more than is appropriate. Many of the apparent difficulties would be eased by adoption of the modifications to funding and training outlined above.

Board and lodging payments

What can only be described as a preoccupation with the perverse effects of social security policies is very distracting. The false trail laid with the unreasonable and inaccurate comparison of costs of caring for Examples A and B in different situations is pursued with bitter and self-righteous determination to claim that care at home is cheaper, more appropriate and more cost effective and that the nation is being exploited by the claimants of the Board and Lodgings Allowance.

At present 543,000 individuals receive £567 million p.a. (rising) in Attendance Allowance; only 42,000 individuals receive Supplementary Benefits Payments for Board and Lodgings in independent rest homes or nursing homes amounting to £200 million p.a. (rising); 84% of these payments are to elderly people. As outlined above, this has allowed maintenance of residential care provision for the elderly at previous levels with a shift away from the more therapeutic sectors and toward the private sector. Changes that have occurred in mental handicap and mental illness services have not for the most part included use of these payments.

From the point of view of an individual in need of care or treatment there is little to commend residential care if one is looking to achieve more disposable income, more freedom to control or determine the daily routine, more time with valued possessions, memories or long-loved territory. All these are lost. Its only major claim is to provide safety and reassurance in the face of grave disability and to provide this reliably, round the clock and throughout the year. This is the balance of pros and cons to be taken into account when an individual supported by relatives, friends, and professional advisers decides to enter residential care. There seems no justification to sully them for yielding to "the temptation . . . to make use of the more generous and far less stringent payments for board and lodgings". Individuals are not made rich by these payments. The provision of some day care makes care at home more expensive than care in Part III and people opting for residential care are on average considerably more vulnerable and disabled or ill than those who remain at home.

There may be some misuse of payments. There are arguments, and they may be sustained, for modifying the system and introducing assessment of need before placement. Yet the characteristic of these payments that appears to disturb the authors of this report is that they are not subject to cash limits, rate capping or other devices that ensure rationing determined by central government's political decision about how much is to be spent. They are responsive to need as perceived by the disabled and their close friends and advisers. It is far from clear that they have been used perversely and there is nothing to commend their cash limiting from the point of view of the elderly disabled, nor the other 'priority' groups, nor indeed the other sectors of care that provide services to them.

In conclusion: This report is helpful where it provides useful information and sensible suggestions.

Considerable progress has been made in reducing beds used by the mentally ill and in transferring (as planned) the mentally handicapped to local authority accommodation. Residential care for the elderly has been maintained through increased reliance on the private sector at the cost of losing beds with the greatest therapeutic potential.

There has been relatively little progress in providing more care for people living in private households and in particular no improvement in provision for the elderly in their own homes. This failure can be attributed to cash limits preventing developments in the NHS and the workings of the Rate Support Grant disincentives to punish local authorities for their developments.

There should be strong support for changes in those

funding systems and for changes in training programmes so that more people are equipped to perform well in the community. **But there are flaws and these must be recognised:**

Arguments for more radical changes such as the creation for the elderly of "a single budget in an area . . . by contributions from the NHS and local authorities . . . determined . . . by a formula agreed centrally . . . (and) under the control of a single manager" are not persuasive. They seem to be based in current fashions: to make radical changes every few years, an overenthusiastic belief that 'management' has magical powers beyond those of the caring and curing professions and the hardly concealed wish to include all provisions within cash limited budgets.

Let's try some fine tuning based on the sound observations and more sensible suggestions in this report and leave radical change for further consideration if these aren't helping, given a realistic time trial—of the order of a further ten years.

Let's leave Supplementary Benefits Board and Lodgings payments free from cash limits as a safety valve in a system where the pressure falls heaviest on those least able to stand up for themselves.

D. J. JOLLEY
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Audio-Visual Aids to Teaching

Videotape Reviews

Back to the Community (UK, 1986, 29 mins)
A mixed audience of health professionals at a recent Mental Health Film Council screening welcomed this video which shows a variety of community-based initiatives. Most participants thought it would be useful in several contexts, for fellow professionals and for the general public. Those working with individuals who are ill, have a handicap or are old could be helped by the video, it was believed, to clarify their own attitudes to institutions: local residents might be introduced to the idea of care in their own community.

The video has a direct, optimistic approach: it looks at several projects where ex-inhabitants of large institutions appear to be living richer, more positive lives because of the move in to the community. There is recognition of the problems. The video acknowledges that the concerns of those who will become neighbours of such schemes have to be considered along with those of the individuals in need of care. It even admits that, although such care may be cheaper in some instances, it is likely "that the whole exercise is going to be more expensive".

The production of the video is competent, business-like and unpretentious. It uses the technique of intercutting shots which show the different projects with statements by some of the professionals responsible for developing the facilities and by some of those who work in the community. The commentary is authoritative and clear. It might be argued, indeed, that the general effect of the video is to err on the side of confidence and clarity. The problems are honestly raised but the difficult ones are not explored through all their pain and much of the contentious discussion will inevitably come after the television set is switched off.

The format is a familiar conventional one of mixed film and interview but it may give an unintentional balance of importance and value to professionals. We *see* the radically changed circumstances of several people, old, ill and handicapped but we *hear* too little, directly, of what they feel about the changes. They are not substantially allowed to speak for themselves. More significance is given by the style of presentation to those who are involved in the projects because of their work. As is usual in this kind of video, each professional is signalled by a caption with name and job description; individuals whose lives are being described are named in the commentary only. This is one of several techniques which recreate the 'them' and 'us' divide which may not be helpful.

Many groups and individuals will find this video a useful starting point. It may be that some who are firmly committed to the concepts would have preferred a more forceful presentation to stir the emotions and evoke the doubts. Without question, though, anyone who cares about the issues and wants more knowledge and understanding, will find the video a helpful tool.

Production: Holmes Associates for the Department of Health and Social Security.
Distribution: CFL Vision, Chalfont Grove, Gerrards Cross, Bucks SL9 8TN. (Telephone 02407 4433). Available on free loan or for sale on VHS.

ELIZABETH GARRETT
Director
Mental Health Film Council

Seeing Eye to Eye (UK, 1985, 24 mins)
This tape deals with the transition from pre-clinical to clinical medicine as seen through the eyes of two medical students. They embark on their clinical training at Sutton Hospital where an apparently inhumane and thoughtless surgeon talks literally over the head of a recently admitted