Reviews

Community Care: Agenda for Action. A report to the Secretary of State for Social Services. By Sir Roy Griffiths. London: HMSO. 1988. Pp 28. £3.90.

The difficulties experienced by people who are unable to compete on the open housing and employment markets because of a mental or physical disability have been well-publicised. Charitable organisations were first to point them out. The Commons Social Services Committee and the Audit Commission added their public and impartial voices. Most recently, the Commons Committee of Public Accounts has rubbed home the lesson yet again. Sir Roy Griffiths therefore had little devilling to do when asked to make his own personal appraisal for the Secretary of State for Social Services. His report is brief, well-written and blessedly free from waffle. It deserves, and will receive, line by line consideration. The conclusions can be considered under three main headings: structure, finance and philosophy of care.

The approach on structure is logical. A Minister of State in DHSS should be made responsible for defining and presenting Government objectives and priorities, laying down standards, reviewing local authority plans for services, approving funds for those that meet criteria, and following up to monitor the results when plans are put into action. All this will require a sizeable central office, an excellent information base, and strong motivation and expertise, none of which is in evidence at the moment.

Sir Roy assumes that local authorities already have the responsibility for community care. They should be required by the Minister to take this seriously – to identify individuals at risk, assess their requirements, design packages of care to meet the needs, plan services to deliver the care, put these plans out to tender, and fund and then monitor progress in order to achieve the most cost-effective system possible. The Social Services Departments would not necessarily manage the services. They could contract out to charities, housing associations or private companies; whoever provided the most competitive bid. Any expertise required to make the skilled assessment and evaluate the quality of care could be bought in. Sir Roy's examples are almost exclusively devoted to residential services; registering and monitoring such homes and hostels would be a prime duty.

The incentive necessary to work this structure effectively would be provided by an earmarked grant from central government, comprising the fraction of the rate support grant now devoted to community care, adjusted to local need. In addition, the community care element of the Social Fund (mostly for housing) would be under local control as would joint funding. In this way, central government could hold local authorities to account, while social services would have security of funding over time in order to develop their plans coherently. An extra contribution to local funds would come from those disabled people (and their families?) regarded, after a means test, as able to pay.

Sir Roy's analysis is ingenious and his proposals coherent and practical. Other suggestions – on the creation of a cadre of practical carers, the appointment of a care coordinator for each handicapped person, a broader training for care staff, the construction of better assessment and monitoring systems, and the importance of consulting and attempting to satisfy consumers, including family and informal carers – are less clearly spelled out though very important. They depend for detail, on the underlying philosophy of care.

The major weakness of the report is that no such philosophy is apparent. Sir Roy's four types of disability – mental illness, handicap and infirmity and physical handicap – are mentioned only once and no attention is paid to the immense and fluctuating variety of needs – biological, psychological and social – to which each gives rise. Though health and social needs are indivisible, community care is defined narrowly and operationally, so as to exclude health care. "Action will be needed to deal with the situation" when health authorities provide good community services that "more appropriately will fall to be discharged by social service authorities".

So two major problems remain that the report does not address. The first is that it will cost more to create, organise and maintain a good community service than anything being provided at the moment. Sir Roy was not asked to consider the level of funding but justly points out that "poorly implemented programmes for change are very often worse than the status quo". The second is how to find a structure and financial incentives that will require health and social services to work closely together rather than forcing them apart.

Sir Roy remarks that "there is nothing so outdated as to provide today's solution to today's problem". What would be the fallback position if Sir Roy's solution for today did not work? Perhaps Griffiths managers could be given a salary bonus for recognising, as many do already, that inadequacies in community provision can be effectively remedied by action initiated by the health service. Such action falls squarely within the remit of the NHS, which is also a social service. It would, however, require 'ring-fencing' the whole of the NHS psychiatry and physical disability budget, not only the small community care fraction that Sir Roy recommends otherwise it will risk further depletion as savings from ward closures, etc., are diverted to reducing District overdrafts. Another solution would be to give responsibility for the community care budget to a joint board drawn from both health and local authorities, as the Audit Commission suggested.

The Commons Social Services Committee said it would be a generation before the health and social services could be brought together again. Surely that is an unduly pessimistic judgment. Tomorrow's solution might be worth trying earlier than that.

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The College's comments on Sir Roy Griffiths' report will appear in the September issue of the *Bulletin*.

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In youth as medical student, as resident and even as psychiatric trainee one is sharp-witted, retentive of memory, and one has time. Then for the next 30 years in the rush of practice and responsibilities there is no time, memory weakens, new perceptions come rarely, one uses the knowledge of youth and relies on reiterated experiences to solve ones daily problems. Up till about 1938 that was good enough, but not since.

Year by year now we are exposed to a flood of new drugs with new risks, new diagnostic aids, even new diseases, and on top of all that new concepts which propose new aims or reorganise our knowledge with new implications. We are compelled to try to keep up with it, some of it will become essential in daily practice. Some of it, but which bits? A river of weekly, monthly and quarterly specialist journals pours down on us, drug company promotions shower over us, all pushing more and more information at us. Some of it is mistaken from the word go, more of it is dubious because the studies on which it is based are seriously flawed, and some of the rest seems right today but will be withdrawn next year after further enquiry.

And then there is relevance. Some news is only for the research specialist other news can affect the doctor in the clinic. A few things may change everybody's outlook, but there is a mass of material of uncertain relevance which will soon get lost, or occasionally later blaze out with influence. You and I with our limited time and mental energy will never read and absorb all the papers in each month's *Journal*, let alone half a dozen other important journals in the field. We will probably not even read all the summaries. We rely on pilots to guide us through the muddy torrents: occasionally the odd textbook or major review article, more often advertisements or abstracts. We want pilots who are clear-sighted and sail straight for the point, or advise us not to start the voyage. They must select and explain to us the significance of the news, and be brief about it; so they must be wise and expert judges, and we shall sometimes like second and third opinions if views differ.

'Current Opinion in Psychiatry' is such a bimonthly pilot, on very promising new lines. Each issue covers two topics – No. 4 will be 'child and adolescent psychiatry' and 'psychogeriatrics', while this first one is 'psychoses' and 'neurosciences'. Each topic has a couple of pages as overview and then several short reviews of three or four pages each, followed by an annotated reference list of useful further reading. Each review has a standard format, with good short introduction and informative summary. The brevity and the organisation make for easy assimilation. Each overview allows the topic editor to state his opinion on the situation today and where it is heading, to give us the right mental set for the reviews following. These in turn are carefully chosen for subject importance and relevance and author reliability. We readers are going to swallow whole what they say, so it had better be good.

Not a bad start, this first issue. Deakin gives a good overview of 'neuroscience', but Hanson and Kroll waste their space detailing editorial plans and good wishes instead of filling us out on the position of the 'psychoses' in psychiatry today. Some of the reviews could do with sharper editing. We do not want to waste time on poor stuff. What is the use of telling us about supposed differences in symptoms between schizophrenic in-patients in Malta and in Libya when differences in admission policies, chronicity, drug treatments, etc., between the two hospitals might account for the difference?

If we want to form our own judgement we can read the original paper. Otherwise '*Current Opinion in*