

Reviews

Implementing Community Care: Population Needs Assessment. Good Practice Guidance. London: Department of Health. 1993

Implementing Community Care: Community Care Plans. A Preliminary Analysis of a Sample of English Community Care Plans. Social Services Inspectorate, London: Department of Health. 1993

One of the more positive aspects of the community care reforms set in motion by the White Paper *Caring for People* in 1989 was the requirement on the local authority to produce a community care plan. The 1990 Policy Guidance set out in broad terms how these plans should be produced (emphasising a collaborative approach with statutory and voluntary agencies) and their expected scope and content. One important plank of the planning process was to be an analysis by local agencies of the needs of their local population, a task for which most social services departments were utterly unprepared.

The Department of Health, rather late in the day for the first two rounds of community care planning, commissioned Price Waterhouse “to provide good practice starting points and examples . . . to assist authorities in implementing the needs-led principles underlying the NHS and Community Care Act”. The resulting document was pulled together over a two month period during late 1992. Simplification is the order of the day. A bald and possibly tautological definition of need as “the ability of an individual or collection of individuals to benefit from care” is offered (surely concepts of impairment and disability would have been helpful here?). An idealised planning cycle (assess population needs; develop and implement strategic plans; undertake individual assessment and case management; review strategic plans) is then presented. Imaginary “worked examples” involving elderly care in “Greenshire” illustrate the argument.

The overlap between the responsibilities of health and social services authorities in the planning and provision of community care is obvious. This is confirmed by the very useful analysis of a sample of community care plans carried out by Gerald Wistow and colleagues on behalf of the Social Services Inspectorate. A key finding was that the majority of the plans could be defined as “jointly owned” by the local health and social services authorities. The lack of uniformity in approach to the planning process was striking, as was the relative weakness of the local assessment of need in most plans. Perhaps more surprisingly there was a general lack of financial

sophistication within the plans, which may in part have been due to the appalling uncertainty facing local government finances. Although the processes of individual and population needs assessment were scrutinised the proforma used in the comparison between plans did not seek to identify eligibility criteria for the receipt of services. This will be of crucial practical importance.

Neither document discusses in any detail the implications of the purchaser/provider distinction for the planning process, although Wistow does review the extent to which authorities have addressed the requirement to develop a “mixed economy of care”.

The distinction between community care planning and health care planning is obscure. There is clearly a potential role for Public Health Medicine specialists both in providing basic epidemiological advice and in supervising local surveys of need on behalf of local authorities. Joint planning will become the norm. The next step, joint commissioning, has already received official encouragement. The final link in the chain, combined local health and personal social services agencies, cannot now be far away.

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Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction. The Law Commission Consultation Paper No. 128, London: HMSO. 1993. Pp 118. £8.50

This paper follows from the Law Commission’s earlier “overview” of the law in this area. The introduction identifies the most obvious deficiencies in current law. These are the lack of effective provision to protect incapacitated people from abuse and neglect, to resolve disputes between individuals about their care and to legitimise and regulate substitute decision-making. The proposals in the present document expressly exclude consent to medical interventions (to be considered separately) and concentrate on “private law” relating to finances and personal care.

The proposals would authorise anyone who has care of an incapacitated person to do what is reasonable in caring for that person and promoting his or her welfare. Carers would be expected to act in the best interests of the incapacitated persons,

taking into account their past and present wishes and feelings, the need to encourage their participation in decision-making and the general principle of the "least restrictive option". Carers would not be authorised, except in emergency, to confine an incapacitated person or enforce a decision to which the incapacitated person objected. Carers would be liable in law only if they acted in bad faith or without reasonable care and the offence in S127(2) of the Mental Health Act would be extended to protect all incapacitated people from ill-treatment or wilful neglect by their carers.

A new jurisdiction would extend to people aged 16 years and over with established mental disorder or disability as defined by the Mental Health Act and people unable to communicate who failed a legal test of capacity. This would depend on the person's ability to understand and retain relevant information for long enough to take an effective decision. Mental disorder preventing a person who otherwise understood relevant information from making a "true" choice would also count.

Provisions are also suggested for administrative decision-making and for establishing a judicial authority with extended powers similar to those of the present Court of Protection but covering personal care and welfare as well as financial matters and for modifying some of the "mechanics" of the enduring power of attorney. The Court would have powers to resolve specific issues and to appoint proxies to manage the incapacitated person's personal care and financial affairs.

The main concern for psychiatrists is the need to establish the presence of mental disorder and whether this should be done by a "registered medical practitioner" as the document suggests or whether it should be done by a doctor approved under the Mental Health Act. The whole tenor of the document is to deal with matters at the simplest level possible and to avoid judicial procedures whenever possible. Nevertheless, we might expect some increase in demands upon psychiatrists' time if this worthy document's provisions are eventually enacted.

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Let There be Light Again: A history of Gartnavel Royal Hospital from its beginnings to the present day. Pp. 130. 1993. £5 plus postage and packing. Available from: Eileen Ross, Voluntary Services Organiser, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH

Hospital histories usually appear at some significant anniversary. For Gartnavel Royal, 1993 marks 150 years of its existence on the present site, although

its first building, elsewhere in Glasgow, dated back to 1814, and its Royal Charter was granted only ten years thereafter. The original foundation was established by public subscription, whereas some other Royal asylums owed much, or all, to individual philanthropists like the pioneering Susan Carnegie in Montrose in 1781. However, the citizens of Glasgow responded with generosity, and adequate funds were raised. With expansion and relocation, however, the hospital finances were later much burdened by debt.

There are different approaches to this kind of history. On the one hand there is the meticulous annual account as in the magisterial *Easterbrook* and, later, *Turner Chronicle of Crichton Royal*. On the other, extracts from hospital records can be used to enhance a wider essay on psychiatric and cultural history, a plan used by Whittet and MacLeod for the centenary volume of *Craig Dunain in Inverness*.

A "thematic survey" has been adopted here, with multiple authorship of three psychiatrists, and one psychologist, chaplain, nurse and medical historian. The essays cover Administration and Finance, Religion and the Chaplaincy, Environment of Architecture – "environment" being liberally interpreted, Medical Officers and Therapeutics, in two sections for before and after the arrival of (Sir) David Henderson in 1921, Keepers to Carers, referring to nursing; and the patient population. There is some overlap, but this helps to keep these rather arbitrary divisions interesting, and each essay stands easily on its own.

Naturally, there is comment on some periods when management and treatment were strange to modern eyes. Like other Royal asylums, Gartnavel catered for both paupers and minimally paying patients. Architecturally, West House was for the latter, and the less attractive and worse furnished East House for the paupers. By the end of last century, these patients had been relocated in the newer District Asylums, and the paupers' house accommodated other categories, including, in this reviewer's time, junior doctors.

For medical treatment, it is wise to remember that many psychiatrists of today may have limited experience of psychotic end states, and thus may be less able to appreciate the major problems their predecessors faced. Treatment policies were understandably dictated by the Physician Superintendents with individual attitudes. Much is made of David Yellowlees' strong views of physical control and organic causation, but the balance is maintained by some references – for example his advocacy of female nurses in male wards – to the intimate domestic atmosphere of hospitals then. (One of Yellowlees' distinguished sons insisted he began his psychiatric career at the age of six months, being placed by his mother in the arms of a melancholic patient).