CHC NEWS

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EDITORIAL

The Secretary of State has replied to the Steering Committee, accepting its recommendations (see CHC NEWS 4, page 19). The Department of Health and Social Security has had discussions with the King's Fund and the Chairman of the Steering Committee on the detailed arrangements for the coming months, and it has agreed to provide the finance for the Steering Committee, CHC NEWS and information services, and a national conference of CHCs to be held in Autumn 1976. The King's Fund has agreed to continue to provide the premises and other generous help. The Steering Committee's next meeting is on Thursday 5th February when it will start to work on the detailed proposals for a national body which can be put to CHCs at the autumn conference.

CHC NEWS will therefore continue to be published, and this is the last issue to appear in the present format. We want to produce sufficient copies for each CHC secretary and member to receive their own, and we want to produce issues every month instead of every two months. This can be most easily achieved by having the paper printed commercially, and the next issue will be the first in the new format, starting the monthly sequence. Anyone apart from CHCs who wants to obtain copies will be welcome to do so, and there will be a modest annual subscription or a charge for individual copies. (Details of the charges will be sent out later).

As a result of requests we have been receiving so far, we intend to continue to provide information about the health service that is of relevance to CHCs from a range of both statutory and other sources. We will also assemble information on practical procedures, reading lists, research findings, meetings and seminars, and information from 'experts' and other organisations. We hope you will feel free to telephone or write in if you think we could be of help in providing information of this type, or in putting you in touch with someone who could help you in other ways. The idea is that CHC NEWS will contain selections of information that are likely to be of wide interest, and we hope you will contact us with your own particular enquiries so that we can try to help you more directly. Any suggestions, comments, criticisms or points of view which would be suitable for publication in CHC NEWS are very welcome, since it is through contributions from people closely involved with community health councils that CHC NEWS can develop in line with their needs and interests.

A Directory of Community Health Councils is being prepared now and will be available soon. It will contain the names, addresses and telephone numbers of all CHCs in England and Wales as well as the names of their Chairmen and Secretaries. Details of regional groupings of members and secretaries will also be included. Because so many CHCs have been in the process of transferring from temporary to permanent accommodation, there would have been no point in issuing the Directory earlier, since it would have rapidly become out of date. We will make the Directory as accurate as possible, and any amendments that arise subsequently can be published in CHC NEWS.

RUTH LEVITT

YOUR LETTERS

WILL HASTY CUTS BE MADE ? from Pat Gordon, Secretary, City & Hackney CHC, Charlotte Rawcliffe, Secretary, West Roding CHC, Julian Knox, Secretary, Islington CHC and Sue Thorne, Secretary, St. Thomas's CHC

Your summary of the Report of the Resource Allocation Working Party (CHC NEWS 2) was excellent and exactly the kind of information we need from CHC NEWS. The Working Party has devised a "fairer" system of allocating NHS money to the Regions. This means that some Regions will have their budgets cut and the money will be redistributed to those who are relatively under-provided. We would draw your attention to the last paragraph of the report where it is made quite clear that budget cuts will mean hospital closures and hasty decision-making.

> "A change of this order is dependent absolutely on the ability, particularly in those regions suffering a reduction in their allocations, to carry into effect a rationalisation programme involving substantial closures of uneconomic units, reductions in excess beds, changes of use etc. In encouraging this approach, we cannot emphasise enough that rationalisation of the order envisaged will be illusory unless Ministers are prepared to take a resolute stand when politically sensitive cases or those which are otherwise contested, for example, by CHCs, are presented for decision. The need for prompt and decisive action will also be critical. Allocations are made in advance of the financial year and cannot subsequently be materially changed. Unless therefore, early and speedy decisions are reached to eliminate wasteful services, cuts would inescapably have to be made in services which ought to be maintained at present levels, with possibly even greater repercussions. We hope that in considering our recommendations these important points will be kept in mind."

Some hospital closures may be entirely appropriate but at present decisions are being made piecemeal with no overall plan. The new NHS planning cycle is about to come into effect but what is happening at present in certain areas has little to do with comprehensive planning. Few Districts or Areas have any experience of this kind of planning; nor do they have the staff to provide the necessary statistical back-up. Naive and expedient measures to save money are not the answer. Other alternatives must be explored so that hasty decisions now do not turn out to be costly errors in the future. There is a danger of rationalisation becoming a euphemism for closure and we urge all CHCs to be alive to the implications of the Working Party's report.

CHC PUBLICITY from A.R. Wright, Secretary, Doncaster CHC

In view of the fact that there are still many people in this area unaware of the existence of the CHC, I recently wrote to the editor of four local newspapers asking if they would be prepared to write a feature concerning the work of the Council. I stated that it was possibly only through the press that the public would become familiar with the role of the CHC, as there had been a noticeable increase in the number of enquiries following a previous advertising campaign we had undertaken. I set out the ways in which the Council would advise the public in matters relating to the NHS and added that many people, who had approached us for help concerning health problems had expressed satisfaction that such a Council had been established. The results of the exercise have been very worthwhile. In the Doncaster Evening Post we had a

special feature on the role of the Doncaster CHC under the caption "The Patient's Friend" (half-page display including photograph of the Secretary). Brief mention was also made in two other papers about the activities of the Council. Have you taken full advantage of the local press ?

WHO ARE YOUR FRIENDS ? from Joan Gornall, Secretary, Havering CHC

"It is said that CHCs are ganging up with DMTs against the AHAs." At a one-day symposium on 14 November 1975 organised by the Centre for Extension Training in Community Medicine, this was an idea thrown at us for discussion by the Chairman, Dr. Donaldson. Possibly it was only to get us talking, and possibly it was said with tongue in cheek, but judging by the stunned silence which greeted it, I am confident it was a complete surprise to the secretaries present. Surely it is acknowledged that a good working relationship with the DMT is essential if progress is to be made without anguish. Must it be inferred that such a relationship leads to "ganging up" against the AHAs ? In any case, is there any evidence to support the implication that DMTs and AHAs are at variance beyond the normal divergence of views which must arise from time to time in any management situation ? Is there anything to support the suggestion that a good relationship with the one body necessarily means a bad one with the other ? In the discussion which followed it was clear that to some people, the whole CHC concept was not popular. However, whatever personal views may be held about the wisdom of public participation, the CHCs must be granted the benefit of the assumption that they act with integrity. I consider the hypothesis is a dangerous one to present to any gathering, even for discussion, and I should be glad of the views of other people.

RECRUITING NURSES IN RURAL AREAS from J.A. Dunning, Secretary, Norwich CHC

Rural hospitals in North Norfolk are staffed largely by local people on an assorted arrangement of working periods, but the ingenuity of some hospitals is being put to the test because the adequacy of the local reserve of suitable staff is running down. At times they are in difficulties because vacancies for trained nurses and auxiliaries cannot be filled. Advertisements for staff recruitment could be extended over a wider area to take in the next distant adjoining town, but with the almost complete lack of public transport between towns in some parts, the car is the only means of transport. The health service appears to have no system whereby some financial contribution may be made to staff towards the cost of transport from home to work. This would only be necessary for nursing staff and could be strictly controlled. The Norwich CHC is carrying out a study of the problems of staffing in this very rural area, and it would be helpful to hear from CHCs who may have discovered a legitimate way in which a contribution towards specialist nursing staff travelling costs between home and work where a car had to be used may be paid by the National Health Service.

SERVICES FOR DRUG DEPENDANTS

by Bob Searchfield, Coordinator SCODA (Standing Conference on Drug Abuse)

To the late-night shoppers hurrying home John could be just another vagrant alcoholic, like the many others that frequent London's West End. As he staggers along the busy pavement people step quickly aside. When he eventually collapses in some shop doorway a small crowd will gather to watch with morbid curiosity as he is carried to the waiting ambulance.

At the age of 21 John already has much in common with the older derelicts drifting in city centres. Homeless and rootless, on the roundabout of insecure squats, night shelters and sleeping rough. Intoxication at least brings temporary relief from his harsh surroundings and personal problems. However, if John drinks alcohol it is usually when he cannot get enough barbiturate sleeping tablets or other drugs that he is now heavily dependent upon. Such indiscriminate drug taking is highly dangerous and frequently results in overdose. Unless he is helped soon he is likely to die. In the past week John has been admitted three times to hospital casualty units - only to be back on the streets a few hours later ready to start again.

John is one of a number of young multiple drugs misusers in the London area and in other cities across the country. Some are known to attend drug treatment clinics, but others find it easier to obtain their drugs from gullible general practitioners or "black market" sources. As a group they are a growing cause of concern to police, hospitals and street agencies who inevitably end up trying to help them, and they reflect a significant change in the patterns of youthful drugs misuse over the past few years - one that calls for the urgent re-appraisal of existing drug treatment services.

The existence of a small, yet possibly growing drug problem in this country first became apparent in the mid-sixties. Newspapers carried often sensational reports of young heroin addicts and a number of voluntary organisations operating in the West End began to press for action. New laws were introduced in 1967 and the prescribing of narcotic drugs was restricted to licensed doctors working in newly established National Health Service Drug Dependency Clinics. Fifteen such outpatient clinics were set up in the London area where most of the addicts were believed to have gravitated and a similar number in other major cities in the country. Alongside these essentially medical and psychiatric services, voluntary organisations provided community based day centres, hostels and residential programmes to assist in the process of social rehabilitation.

Each drug treatment clinic was to a large extent free to develop its own approach, under the direction of its consultant. Most adopted a broad policy of meeting their patients' immediate needs for drugs while attempting to eventually persuade them to withdraw. In this way those addicted to narcotic drugs were encouraged to 'register' with a clinic and could be 'notified' to the authorities for the purpose of collecting information on the size of the problem. Treatment clinics also effectively prevented an organised 'black market' being established, for who would go to all the bother of illegally importing heroin when addicts could obtain pure NHS supplies.

In 1969, the first full year after the treatment clinics were established 2,881 heroin addicts were notified to the authorities and by 1971 this had fallen to 2,501, indicating that some addicts had been helped to come off drugs and that the problem was under control. While there has been no dramatic increase in the numbers, and although these problems can be seen to only affect a relatively small proportion of young people, the trend from 1973 has been towards a continuing and slightly larger number of young people becoming involved. The 1974 figures, when published are expected to confirm this picture and fears about groups of multiple drugs misusers like John who do not attend treatment clinics cast doubts as to the reliabilty of official figures.

Explanations for this development are many and varied, but it would seem that the initial success of treatment clinics was mainly with those addicts who were more amenable to help and less heavily involved in the drug subculture. Around 1970 it was already apparent that many of those continuing to attend treatment clinics were supplementing their prescribed drugs with others from legal and quasi-legal sources. Chinese heroin, a crude smoking opium, became popular on the London scene and those who could not afford this turned to barbiturates and other more easily obtainable drugs prescribed by some family doctors. It is thought that addicts began to seek other drugs when efforts to persuade them to reduce and withdraw completely were made by the clinics. Amounts of heroin prescribed were restricted and a synthetic opiate called methadone was substituted instead. The latter was and still is considered by some doctors to be an easier drug to manage, a view not entirely shared by addicts many of whom resented the switch.

Whether the intervention of the drug treatment clinics led directly to the multiple-drugs misuse problems of today is debatable, for it can be argued that few heroin addicts ever kept solely to narcotics and most would experiment with other drugs. What is obvious is the limitations of prescribing clinics and other sources in dealing with the current situation. There is now a hard core of 'geriatric' addicts attending most clinics, many of whom first registered when they opened and appear resistant to efforts to encourage them to withdraw or engage in less damaging drug misuse. The care of this group is demoralising for the staff who are anyway under increasing pressure to take on new patients, particularly from other parts of the country where no special services exist. Multiple drugs misusers like John are reluctant to approach official centres for help and if they do the clinic staff can find little justification for extending their prescribing powers to include drugs like barbiturates that are highly dangerous and easily obtainable elsewhere.

While John needs medical attention and help with his drug problems he is also desperately in need of somewhere settled to live and much social support. Many of the voluntary organisations that can provide this kind of help are currently starved of funds and in the past few months a number have had to cut back on their operations and some have been forced to close. If the drug problems of young people in urban areas are to be effectively tackled then not only must treatment clinics adapt their work to meet the new situation, but also greater priority must be given to supporting the work of community based voluntary services.

John's problems did not begin in London. Difficulties with his family, personal problems and limited opportunities for work in his home town may have led him to experiment with drugs. Arriving in London he quickly found that getting somewhere to live without much money was impossible and without an address it is difficult to claim social security. Job prospects were not as good as he was led to believe and very soon he began to drift into a rootless lifestyle that merely added to his problems. If John can get help he may survive, but how much better if that help had been readily available earlier and within his home area.

Combating the drug problem in our society is not just a matter of providing better specialist services for the young drug addict. These may well help some of the casualties, but so often at a stage where the individual requires intensive long term help and when it must be admitted the prognosis is often poor. Nor is it just a matter for the 'drug experts', but must begin with promoting healthier attitudes within the community towards the use of all drugs, challenging the popular notion among the public and professionals that there exists a chemical solution to all human problems. In some situations drugs may well help cure the sick, in others simply mask the symptons and compound the underlying problems.

CHC ANNUAL REPORTS - A Brief Summary

CHCs are obliged to produce an Annual Report and in response to a note in CHC NEWS 2 requesting CHCs to send us copies, Annual Reports from 94 CHCs (45% of those in England) have so far been received. The following analysis therefore highlights some features of CHC activities since their formation, although the Annual Reports may not tell us the whole story !

To familiarise themselves with the field in which they are expected to work, CHC members have undertaken a programme of visits to hospitals, clinics, health centres and ambulance stations, and formed sub-committees and working parties or project groups to study health care issues of particular concern. Topics which have been covered include Maternity and Child Welfare, Geriatric Services, Mental Illness and Handicap, Disabled, Young and Chronic Sick, Chiropody, Waiting Lists, Outpatients, Transport, Ambulance Services, Accident and Emergency, Dental Services, Primary Care, Catering and decisions on hospital closures and changes. However, it is interesting to note that Geriatric Services, Mental Illness and Handicap, and Maternity top the list of these topics. They have been dealt with by approximately 39%, 38% and 24% of the 94 CHCs respectively. The other major task of CHCs has been to publicise their own existence as widely as possible. Though a few CHCs have expressed disappointment at the lack of public response, others feel they have made some impact.

Another striking feature that the Annual Reports show is the problems peculiar to different districts. One CHC, for example, has been concerned with the question of minority diets in hospitals, and recommendations for religious and ethnic dietary requirements have been made to its DMT. This came about after that Council discovered the problems of Asian patients in a hospital. The availability of NHS facilities to the non-resident population is the concern of another CHC, which has a large influx of tourists, commuters and itinerants. Some CHCs have a large rural population and therefore have to deal with special features of rural health care. For instance, one CHC which has a high geriatric population, has made a comprehensive study of domiciliary nursing services within its district.

Apart from tackling health care issues, CHCs have also been acting as the "patient's friend" and given advice on how and where to lodge complaints. One CHC has divided complaints into three major categories: (1) "grumbles, comments and suggestions", with no specific action required; (2) "expressions of distress and dissatisfaction", with a plea for help, generally dealt with informally; and (3) "protests, grievances or accusations", which are more formal complaints and therefore referred to the District Administrator, Family Practitioner Committee or another agency. This particular CHC received 47 complaints during the year and to date 30 appear to have been satisfactorily resolved. However, the volume of complaints handled varies from one CHC to another. One CHC reported receiving 22 complaints in three months, while another stressed that the number of complaints it has received has been minimal. Figures given by 18 CHCs (about 19% of the sample) show that 565 complaints have together been received by them during the past year. It is also interesting to see that one CHC has devised a thorough procedure for reviewing complaints. At quarterly intervals, and at the invitation of the District Administrator, a small panel of CHC members examines the list of complaints received by the management and is allowed to see correspondence and ask questions relating to the complaints.

Differences in the relationships between CHCs and the health authorities is another outstanding feature of the Annual Reports. Comments on their relations with RHAs and AHAs range from "good", "helpful", "courteous", to "tenuous", "limited and formal", "impartial and detached", "remote". All 94 CHCs expressed the hope for continuing or more co-operation from the RHAs and AHAs. Relations with DMTs appear to have evolved more smoothly and most CHCs seem to have established useful working arrangements with them.

Not all the 94 CHCs have mentioned their relations with the Health Care Planning Teams, Family Practitioner Committees, and Joint Consultative Committees. CHC contacts with FPCs and JCCs have tended to be limited and formal. In those districts where HCPTs have been formed, some CHCs have representatives on the Teams while others have been refused membership or even observer status. One CHC was told "Teams are purely officer teams looking in depth at the services and eventually reporting to the AHA". However, that CHC was told that the reports would subsequently be made available to it. Another CHC felt that HCPTs were "too hospital orientated, not enough community orientated", and "too large to operate effectively". Some CHCs have mirrored their working groups on the HCPTs working in their districts and hope that members of these groups would be asked to attend HCPT meetings as appropriate to express or research the community's views and opinions.

Several CHCs have made a plea for more information from the health authorities. In some cases, it has been difficult to obtain information and in others, the information received has been inadequate. One CHC described the lack of information as "one of the most disappointing features of the year". This Council had received no DMT or FPC minutes and its members have had only one meeting with the DMT during the year. They feel there has been virtually no consultation. Another CHC had difficulty obtaining information on services available in its district, particularly community services. Concern was also expressed on the length of time and number of letters it had taken to obtain some of the information. It seems that delays of several months occurred before this CHC was told that the information required was not readily available.

It is clear that CHCs feel incapable of performing their role satisfactorily without information on and involvement in forward planning and the method of consultation appears to have been one area of potential conflict. Several CHCs have requested a longer period of time so that proper consideration could be given to plans placed before them. The other cry of CHCs is the need to be brought into the planning process at as early a stage as possible. Most of the consultations have been at a late stage and often at a point where CHCs' comments could not be usefully incorporated into the plans. One CHC felt that it had been used merely as a rubber stamp.

Some CHCs have emphasised the vital need for collaboration between the health and social services, for example, in the provision of support services after elderly patients have been discharged from hospital. It was felt that liaison between the two services was essential to both and that the contacts already established by some CHCs should be developed.

In the face of many teething problems, it is encouraging to note that some CHCs have managed to carry out several surveys and projects during their inaugural year. These include patients' satisfaction surveys, surveys of consumer opinion with regard to priorities for health care services, and the availability and quality of health care services in specific areas in a CHC's district, a survey to discover the extent of breakdown of free chiropody services to the elderly, and another of the Accident and Emergency needs of industry in a particular locality. CHCs have also been asked to give their opinions on national issues including abortion, male midwives, fluoridation, and several CHCs have themselves conducted mini-surveys on these topics to find out the views of the community they represent. Some CHCs have undertaken their own projects as well. One CHC has done an in-depth study of how the former local authorities' offices could be purposefully used within the health service. The members of another CHC have participated in schemes intended to increase public participation in the running of local affairs which included a series of meetings between local councillors, party workers in their wards, voluntary organisations and the public.

Now that CHCs have got off the ground, they hope to develop the links already established with the health authorities and build up their expertise so that they can play a constructive and effective role as the public's watchdog on the health services.

PATIENTS' BENEFITS

by Margaret Newens, Secretary Ealing CHC

The poor uptake of welfare benefits is well documented and much debated. The recent introduction of two new social security benefits requires a particularly watchful eye from Community Health Councils as long stay hospital patients and the housebound are involved. The Non-Contributory Invalidity Pension (NCIP) was introduced with effect from 20th November 1975 and its payment to eligible hospital patients is described in DS 213/75. Mobility allowances will be phased in by stages, beginning in January 1976 (HSC (IS) 208). Other changes, such as the new scale of rates of supplementary benefit affecting the assessment of entitlement to hospital travelling expenses, and changes in the level of social security benefits payable to hospital patients, are also detailed in HSC (IS) 208.

The introduction of NCIP is potentially of great importance as, in time, it will remove the anomaly of some patients in mental illness and mental handicap hospitals receiving "pocket money" from hospital funds, whilst in other hospitals patients without resources of their own receive a personal allowance from the Department of Health and Social Security. The memorandum on the Mental Health Act (DHSS 1960) says that "there is a clear obligation to ensure that patients are not financially worse off merely because the Minister, rather than the National Assistance Board, is responsible for their pocket money". Sadly it seems that, in some hospitals, patients receiving pocket money from hospital funds have fallen behind. The standard rate for pocket money from hospital funds and for social security payments to long stay patients is adjusted from time to time and currently stands at £2.65 per week. However the amount awarded can, and often is, reduced under a number of circumstances including when "the doctor responsible for the patient's treatment considers that, because of the patient's medical condition the full standard weekly allowance cannot be used by or on behalf of the patient for his personal comfort or enjoyment". But the circular HM (71) 90 also acknowledges "the therapeutic value of saving for a purpose, particularly for purchasing clothes to be owned by the patient himself, or other large items, for holidays, or for use after discharge from hospital". Taking just clothing as an example, in 1974 there were more than 24,000 patients in mental illness hospitals alone without full personal clothing of their own. In the past "pocket moneys" have been one of many competing demands on the hospital funds of our under financed mental illness and mental handicap services. For the patients now transferred to NCIP, lack of available revenue cannot be used as a reason to justify a reduction in the standard allowance. It is not difficult to think of ways by which the quality of life of every patient could be improved by awarding the full allowance of £2.65 per week. We should ensure that the amount awarded to each patient transferred to NCIP has been thoroughly reviewed. Conditions of eligibility for the new pension are laid down in the circular. It is a non-means-tested, non-contributory benefit with eligibility based on incapacity, age and residence. Unfortunately some groups of patients will remain on pocket money from hospital funds at least for the time being. Two categories of patients excluded from the new pension are patients who are already of pensionable age and married women. The amount of money received by these patients also needs watching. Another recent change is that supplementary benefit is now payable to patients in hospitals for the mentally ill and the mentally handicapped who were admitted after 17th November 1975. As a result short-stay patients without other resources are removed from reliance on pocket money from hospital funds.

The new mobility allowance "is to provide a cash payment of £5 per week for severely disabled people of working age and for children from the age of 5 to assist with the mobility problems resulting from their disablement". The benefit is taxable (HSC (IS) 208, HSC (IS) 211 and

NI 211). "The conditions for eligibility for the allowance will be that the claimant is unable or virtually unable to walk because of severe physical disablement, that such inability is likely to persist for at least 12 months from the date of claim and that during most of that period his condition will be such as permits him from time to time to benefit from increased facilities for mobility." If patients already receiving help with personal transport under the existing National Health Service invalid road vehicle arrangements are found eligible for mobility allowance they have the choice of transferring to the new scheme. Similarly disabled people who qualify for the mobility allowance, but who would prefer instead to have a vehicle provided by the Department, can be supplied with one of the much criticized invalid tricycles. Mobility allowances will be introduced in stages from January 1976 and the first group to be included will be the 15-25 year age group. Applications from disabled people can be made direct to the Department without a medical recommendation. Community Health Councils will want to ensure that wide publicity is given locally to this new allowance, and also that health authorities act on the directive issued to them. The circular states that "health authorities should take action to identify any long stay hospital in-patients who they think may qualify, to bring details of the new allowance to their attention and encourage and assist them to make claims". Hospitals are further requested to "inform severely disabled people attending as outpatients of the existence of this allowance and how to apply for it". In the case of long stay patients, hospitals are also asked to "endeavour to ensure that patients have opportunities of taking full advantage of the allowance they receive".

Other alterations in benefits are outlined in HSC (IS) 208). The circular gives the increases in the rates of social security benefits and allowances, the rates of reductions for hospital in-patients and the amounts below which in-patients benefits may not normally be reduced. The new supplementary benefit scale rates are also given as they affect the assessment of entitlement to hospital travelling expenses. The action required to be taken by hospital staff in relation to benefits, from before admission of a patient until discharge, is laid down.

It is important that the availability of different benefits is widely publicised and that people are made aware of their eligibility. Some of the people eligible for the new benefits are patients in our most deprived hospitals; they, most of all, must be helped to take up their entitlement.

BETTER SERVICES FOR THE MENTALLY ILL
(Cmnd. 6233, HMSO, 1975, £1.35.)

This White Paper was published in October 1975 and issued to health and local authorities and to all CHCs. It sets out the government's intentions for integrating existing policies on the hospital and personal social services, the problems of children and adolescents, alcoholics and drug addicts, the elderly and homeless, and the education, housing and employment of the mentally ill.

The overall aim is to replace the services based on large mental hospitals with a more flexible system based on the health districts. In-patient treatment would be in psychiatric units at

general hospitals or day hospitals but would play a much smaller role. There would be greater emphasis on day hospital and outpatient treatment, on day and residential services provided by local authority social services departments, and on teamwork between all services.

The White Paper gives a detailed discussion of mental illness and the problems of care - this is well worth reading as basic background information for CHC members and others concerned with the mental health services. The full contents are summarised below:

CHAPTER 1 THE NATURE OF THE PROBLEM The considerable problems of defining mental illness and hence in estimating its prevalence. Clinical diagnosis provides one basis for classification. But from the point of view of planning services it may be more relevant to consider ways in which mental illness affects the individual and his family.

CHAPTER 2 DEVELOPMENTS IN SERVICES FOR THE MENTALLY ILL Far reaching changes in the pattern of psychiatric care in the 1950s. The underlying theme of these developments was integrating the care of the mentally ill with that of those suffering from other forms of illness. While acknowledging that not all the early expectations of "community care" have been fulfilled, the government believes that the aim for the future must still be to provide local, integrated services rather than care based on large specialist institutions. The problems still to be solved. The government's strategy intended to provide a framework for further experiment and refinement of current policies.

CHAPTER 3 TEAMWORK IN THE NEW PATTERN OF SERVICES An important aspect of the government's strategy is the development of the right organisational relationships between the various professional and lay groups concerned with care of the mentally ill at local level. Such teamwork is essential if the various facilities are to operate as a comprehensive service of treatment and care.

CHAPTER 4 THE DISTRICT SERVICES The future pattern of services for the mentally ill based on a comprehensive network of health and social services facilities in each district. The guidelines for the facilities are at present tentative and will need to be refined in the light of experience.

CHAPTER 5 SECURITY The district hospital facilities should be able to manage most of the smaller number of disturbed patients but where greater physical security is required, admission to a regional security unit or a special hospital may be necessary.

CHAPTER 6 HOUSING AND EMPLOYMENT In many instances people recovering from mental illness require ordinary housing rather than any specialised residential accommodation. Local housing authorities have an important contribution to make. The wide range of employment and training facilities provided under the aegis of the Department of Employment and the Manpower Services Commission can do much to help mentally ill people resettle into sheltered or open employment.

CHAPTER 7 CHILDREN AND ADOLESCENTS The continuing and wide-ranging discussion about the way in which child and adolescent psychiatric services should be developed. No definite policy statement in this White Paper. A consultation paper to be issued in the light, inter alia, of the recommendations of the Court Committee on child health services. In the meantime attention is drawn to the principal concepts which have emerged from the debate so far.

CHAPTER 8 ALCOHOL AND DRUG DEPENDENCE AND MISUSE Alcoholism and drug dependence present problems which differ in several respects from those presented by mental

illness. The current - and increasing - prevalence of alcoholism seems to justify the establishment of a network of services in most health districts with AHAs acting as a focal point for collecting information and planning. No major changes proposed in services for drug misusers. However, since trends in misuse change, a flexible approach is important.

CHAPTER 9 MANPOWER REQUIREMENTS A significant improvement in the levels of staffing in key disciplines is necessary for the successful operation of the new pattern of service. Provisional targets proposed for consultant medical staff and nurses. The further development of training is of particular importance for social services staff and others.

CHAPTER 10 RESEARCH AND EVALUATION Research is an essential element in the further development of the government's policies. A review of research priorities in the field of services for the mentally ill carried out by the DHSS.

CHAPTER 11 PROGRESS TOWARDS THE NEW SERVICE The considerable gap between existing services and the new pattern of services advocated in the White Paper. More emphasis on day hospital treatment, day care, and treatment and support in the home itself and less on inpatient treatment should mean, taking health and social services costs together, little increase in running costs. But substantial capital investment in new facilities is required (£38m annually over 20-30 years) and also a shift in the balance of services between health and local authority. In the present economic circumstances the next few years are seen as a time to make the best use of existing resources, but also for health and local authorities jointly to plan what should be done when additional resources do become available.

APPENDIX THE MENTAL HOSPITALS IN THE PERIOD OF TRANSITION TO THE NEW SERVICE Includes the suggestion that suitable arrangements be made between CHCs to enable one CHC to visit a hospital outside its own district and to comment to its own DMT on the services provided there for its own district. The DMT will need to ensure that these comments are made known to those responsible for the management of the hospital as a whole.

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SELECTED POINTS FROM MIND'S NATIONAL CONVENTION ON THE WHITE PAPER, 29th NOVEMBER 1975

Eric Moonman MP Too few MPs understand the practical problems of the mental health services, so you must put pressure on them through their advice centres, etc.

Dr Brian Ward (Royal College of Psychiatrists) Three priorities for the immediate future: (1) Standard prefabricated 60, 90 or 120 bedded psychiatric units designed on the Harness principle from existing Building Notes should be developed by the DHSS, of a 25-30 year building life and offered as a package deal to regions and districts to be placed in the grounds of existing DGHs. (2) Assign the development of all community mental health facilities to the health authorities and voluntary organisations. (3) Local authorities should be charged for the care of those hospital patients who are agreed to realistically be their responsibility.

Philip Hughes (Director of Social Services, Wakefield) Surprisingly, the White Paper does not mention the devastating effects of isolation and loneliness as predisposing social factors.

Dr Jack Norrell (General Practitioner, London) The medical model of illness and treatment is, in most cases, quite unsuitable for people with what are emotional and social problems. GPs

need to be trained to understand what they are hearing from their patients.

R. Grover (Peter Bedford Project) Housing associations could offer part of their stock to voluntary organisations for use by special groups such as ex-mental patients. The local authorities would then give up their rights of nomination to the housing association. The job creation and retraining services of the Department of Employment and the Manpower Services Commission could be used for those who are unemployed through mental illness.

Professor Peter Townsend, (The Disability Alliance) Why do successive governments put forward well-intentioned plans which show no signs of being put into effect ? It should be recognised that the shift of resources from health to personal social services has resisted happening for the last ten years - why is this ? The White Paper does not give guidance as to how ex-mental patients can exist outside hospital. The opportunities do not exist for them to subsist in the community - they need housing, employment and an income. The White Paper also asserts the professionals' superiority and claim to greater political power and higher income over those of the patients and denies the mentally ill the right to self-determination.

Ann Shearer (Campaign for the Mentally Handicapped) Wessex RHA runs a community-based residential scheme of mental health services. Other authorities should not spend money on doing up old psychiatric hospitals - they should spend the money on developing their own facilities in the community.

FAMILY PLANNING SERVICES : DOCTORS' FEES

A number of CHCs have expressed concern about the arrangements for paying doctors who provide certain family planning services within the NHS. This article therefore provides some background information about the family planning services which will enable the issue of payment to be seen in context. The information is not comprehensive, and a list of useful references at the end should help anyone who wants to investigate the subject further.

1930 Minister of Health responds to pressure from voluntary organisations active in the birth control field by empowering local authorities to provide advice on birth control to limited classes of women on strictly medical grounds.

1930 National Birth Control Council formed to coordinate the work of voluntary organisations in this field. In 1939 it changed its name to the Family Planning Association (FPA).

1948 National Health Service introduced. Doctors could provide free advice to any woman who requested it, but free contraceptive supplies could only be prescribed for those who required them on "medical" grounds. A charge was made if the supplies were needed for "social" reasons.
FPA and other organisations continued to run clinics providing advice and supplies, but they had to charge for their services.

1967 Family Planning Act passed. It removed the distinction between "medical" and "social" reasons for requiring birth control advice and supplies in respect of local authority provision only. Local authorities were thus able to provide free advice and prescribe supplies. Some provided the buildings and part of the clinic running costs while the FPA provided the doctors and nurses. Others staffed their own clinics and there were also some other organisations (Brook's, Stopes) which ran private family planning clinics.

1970 FPA negotiated with some local authorities to provide free contraceptive supplies from the clinics.

1974 April Reorganised National Health Service came into effect. Mrs Castle announced that family planning would, from April 1st, be available at NHS clinics free of any charge whatsoever to all who asked for it, irrespective of age or marital status. She said there were some difficulties in extending the free service to supplies prescribed by general practitioners. While negotiations were continuing, the GPs would continue to provide advice without a charge but would charge for issuing private prescriptions in "social" cases and the patients would pay the chemist the full cost.

May DHSS issued circular HSC (IS) 32 Family Planning Service and the Family Planning Service Memorandum of Guidance. The introduction to the memorandum says: "The intention is that all who need advice and help in family planning should be able to receive it within the reorganised National Health Service and be free to choose their source of advice; the family planning service being available to men and women, the married and the unmarried." The circular stated that health authorities would take over and maintain the clinic and vasectomy service provided by (or on behalf of) local authorities. They were to extend the clinic facilities; develop the domiciliary services; arrange for training of district nurses, midwives, health visitors etc.; remove any bar to the provision of the service to the unmarried; and arrange for adequate publicity of the service. DMTs were advised to establish a multi-disciplinary group to advise them.
The circular also announced that the DHSS and FPA had agreed that the AHAs should take over the agency arrangements made with the FPA by many local authorities and that these agencies should be terminated by October 1976, as the activities were progressively transferred to the NHS.

1975 June Agreement reached between the general practitioners and the DHSS such that doctors who provide a family planning service will receive an annual fee to cover advice and examination, prescribing and the fitting of female contraceptive appliances where appropriate. The ordinary fee is £3.50 per annum, but £10 will be paid for a year in which the doctor fits or replaces an intrauterine device.

July Negotiations between the DHSS and consultants' representatives over a new form of contract for NHS work had started over 12 months earlier. Some of the difficulties were resolved by abandoning the new contract and negotiating changes to the existing one. The DHSS conceded that family planning work should be paid a special fee. This is a quotation from the British Medical Journal, (19th July 1975): "The profession's negotiators and the DHSS have agreed a scheme for the provision of family planning services, for all F.P. work, whether of medical or social origin. The fees take account of the medical aspects in family planning services which would be part of the NHS contractual obligation. The Department and the neogtiators agreed that it would be difficult to distinguish the medical and social aspects. So all such work will attract a fee but the amount has been discounted to reflect the medical element of the work.

Consultants will be able to participate in the scheme outside their NHS contracts, though the work may be done during normal sessions so long as his usual amount of NHS work is not affected. Other hospital doctors will be able to undertake such work when the consultant directly supervises his juniors as a part of training, he would receive the fee. Surgeons and gynaecologists (consultants of "first instance") will have to enter into an annual arrangement with the AHA on the amount of time and resources which each area will be able to devote to FP work."

The schedule of agreed fees was set out in the British Medical Journal (26th July 1975):

		£
1.	Fee per case of male sterilisation performed:	
	as a separate procedure	16.25
	during the course of another procedure	11.00
2.	Fee per case of female sterilisation performed:	
	as a separate procedure	22.00
	during the course of another procedure	14.00
3.	Fee for the reversal of male sterilisation	25.00
4.	Fee for the reversal of female sterilisation	35.00
5.	Fee per case for the insertion of intra-uterine contraceptive device	
	as a separate procedure	11.00
	during the course of another procedure	7.30
6.	Fee per case for examination and report on pathological specimen referred in connexion with NHS family planning cases	3.00
7.	Sessional rate (half day)	18.70

October — In reply to a question from Mr. Nigel Spearing, Dr. David Owen answered on 13th October that "The new scheme was introduced after lengthy negotiations with the medical profession throughout which they refused to participate in the expansion of hospital based family planning unless they received separate payment for it .... "

SELECTED REFERENCES

Family Planning in Britain, Office of Health Economics, London, 1972.

British MedicalJournal, July 19th 1975, p.196.

British Medical Journal, July 26th 1975, p.2.

Health Service Circular HSC (IS) 32 Family Planning Service, DHSS, May 1974.

Family Planning Service Memorandum of Guidance, DHSS, May 1975

NOTES

NEW DENTAL AND OPTICAL CHARGES

Effective from 1st January 1976

DENTAL CHARGES

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course of treatment (not including dentures):	£ 3.50 (used to be £10.00)
course of treatment (including dentures): MAXIMUM CHARGE	£12.00
dentures:	
1, 2, or 3 teeth	£ 5.40
4 to 8 teeth	£ 6.00
more than 8 teeth	5 6.60

OPTICAL CHARGES

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frames:	
cost as supplied to the optician	(these prices have risen)
lenses:	
single vision (one lens)	£2.25 (used to be £1.20-£3.20)
bifocal (depending on the type)	£4.25 or £5.00 (used to be £2.45-£3.50)

EXEMPTIONS

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plastics single vision lenses for children with poor eyesight	(at present only the heavy 'pebble' glass lenses are available to them free)
contact lenses for children for clinical reasons, supplied through the hospital service	
the margin above supplementary benefits level taken into account in assessing the incomes of people claiming help with NHS charges will INCREASE:	from £1.50 to £2.50
The amount of earnings disregarded has already RISEN:	from £2.00 to £4.00

FUTURE STEPS

1. Discussions with the industry on production of sufficient adult type plastics frames, so that these may be available free to children (at the moment they can only have wire or wire-ended frames free).

2. Discussions with the industry on the provision of a choice of attractive modern frames at reasonable cost under NHS arrangements.

3. Prices for privately supplied frames and lenses including contact lenses will be studied by the Price Commission.

4. The registered blind and partially sighted will be exempted from optical charges under future legislation.

STERILISATION OF CHILDREN UNDER 16 YEARS OF AGE

Discussion Paper, DHSS, November 1975

Appendix 3 of this discussion paper sets out a summary of the case of an 11 year old girl who had certain handicaps. She was made a ward of court following the announcement of a consultant's intention to perform a sterilisation operation on her, with her mother's consent. In the judgement of Mrs Justice Heilbron, the operation was neither medically indicated nor necessary, and would not be in the girl's best interests.

This case (and others) have received considerable press coverage, and in the House of Commons on 25th June 1975, Dr. David Owen said that the whole issue should be studied in consultation with professional opinion. (His speech forms part of Appendix 1 of the discussion paper.)

In November 1975, CHCs were asked to comment on a discussion paper issued by the DHSS. The paper summarises some circumstances in which sterilisation of minors may be considered, the question of who needs to be involved and how arrangements are made, and it puts forward two possible procedures which might help to protect the best interests of a child where a consensus view on the proposed sterilisation could not be reached. Either there could be a statutory requirement that the sterilisation should be approved by an independent local ethical committee with lay and professional membership (set up perhaps by the AHA); or the Secretary of State could be empowered to appoint a committee with such professional and lay members as she might deem appropriate to consider the particular case.

The issue of sterilisation of minors is extremely complex, and the discussion paper presents CHCs with a difficult task. There are, however, some additional points to consider. The central question is: What controls, if any, should be imposed in situations where fertility, conception, pregnancy or parenthood are thought to be undesirable states for children under 16 years of age, for whom temporary forms of contraception are unsuitable or unacceptable ?

In the speech referred to, Dr. Owen said that the decision to sterilise a child was of such moment that it should not be made without all the available information from as wide and from as

specialised an information base as could possibly be established. It would be difficult to lay down any strict criteria which could have a universal application - each case would involve different considerations. Regrettably, he said, there would be circumstances where the sterilisation of a child under 16 would be necessary. Parliament had a duty to ensure that those decisions, when they were made, were made in a manner which would be acceptable to public opinion as a whole. This was not to say that the right of doctors to make their own clinical judgement should be challenged, but that they should be asked to see that their clinical judgement was part of an overall professional judgement, and to weigh the opinion of others when they formed their view. In the vast majority of cases the views of the parents were in the best interests of the child, he said, but there were times when the public duty and Parliament's social duty was to ensure that the interests of the child were given a fair hearing - and that might not always come only by listening to the views of the profession or the parents.

In Appendix 3 it says that the child's mother had known a family who had had the misfortune to have 3 mentally retarded children, and this gave impetus to her concern about her own child's future. She was especially worried lest her daughter would be seduced and possibly give birth to a baby which might also be abnormal. She consulted the doctor about sterilising her daughter when she was older, but the doctor advised her that it could be done "now". One of the experts who was called to give an opinion to the judge said that ".. it was wrong to perform this operation on an 11 year old, on a pretext that it would benefit her in the future."

It appears to be important to distinguish clearly between those cases where some form of contraception is urgently required, and those where a delay until the child is at least 16 years of age (and could, therefore, give or withhold his/her consent) should be made.

Another point is the state of advancement of medical knowledge at any one time. What is thought today to be fatal or incurable may not always be so. Furthermore, in the future, techniques for detecting congenital abnormalities ante-natally may be developed.

It is the view of at least one consultant gynaecologist that the best solution to the problem is to refer doubtful cases to a judge in chambers. This would ensure privacy for the family, a legal safeguard for the doctor and the decision being made by a publicly recognised institution. General procedural guidelines would not be thought appropriate, since each case would have to be evaluated individually, and doctors would probably be unwilling for their actions to be controlled by an ethical committee.

The discussion paper itself does not mention in detail the issue of sterilisation for boys under 16. Some observers think that the question of the ability of a child with certain handicaps to be a suitable parent applies equally to males as to females, although the paper does not raise this point.

A further point which has been raised is the way in which CHCs have actually been asked to comment on the issue. The text of the paper is quite short, and it does not explain or defend a number of the assumptions it employs. The appendices contain valuable information, but in the main this refers to one particular case, and it would not necessarily be wise to generalise from that one.

These are only a selection of points that can be raised in discussing the issue, and they are noted here to assist CHCs in their discussions, but there are many other points of view, (some of them put forward in the discussion paper) which should also be taken into account.

CLOSURE OR CHANGE OF USE OF HEALTH BUILDINGS

Health Service Circular (Interim Series) HSC (IS) 207 October 1975

This circular sets out the procedure that should be followed by the Area Health Authorities (in most cases) in relation to the closure or change of use of health buildings. They have to obtain the formal agreement of the community health council (or in some cases, more than one CHC) to any proposal. In order for a proposal to close or change the use of a health building to be acceptable, it must demonstrate that:

(a) the service can be undertaken, or provided more efficiently elsewhere;
OR (b) the facility is no longer required because of new developments;
OR (c) a redeployment of the available manpower and finance is essential;
OR (d) outside factors, such as road development proposals, require the closure or change of use.

The range of consultative and advisory bodies, including CHCs, should be clear about any intentions to close or change the use of a building, and should be asked for their general reaction before being required to make a formal commitment. This step forms an important part of the overall planning system, but if a proposal arises suddenly or unexpectedly, an AHA may miss out the informal stage of consultation.

When a firm decision on a proposal is required, the AHA is obliged to formally consult according to the following procedure:

1. Consultation Document. The AHA should set out the reasons for the proposal, evaluate the possible uses of the redundant facilities for other purposes or the disposal of the site, suggest alternative employment for the staff, put this proposal in the context of other development plans, and state the implications for patients.

2. Comment. CHCs should be given three months to comment, as will the many other consultative and advisory bodies. Local MPs, the RHA and the DHSS should be informed, and a statement given to the press.

3. CHCs' Special Responsibility. The CHC should see all the comments that have been received by the AHA together with the AHA's observations on them. The AHA should then pay special attention to the views of the CHC and in the light of them reconsider the proposal. This stage should be completed not more than six months after the consultation document was issued.

4. If the CHC Objects. A CHC must, if it objects, submit a constructive and detailed counter-proposal, and the AHA should provide any information that the CHC may reasonably require in its preparation. The AHA then forwards this to the RHA with its recommendations. If the RHA cannot accept the CHC's views, it needs to have the Secretary of State's approval before it can announce its decision that the closure or change of use should proceed.

5. Other Arrangements. This full procedure need not be followed by AHAs in certain cases. If partial or temporary closure or change of use is involved or where hospitals, not managed by DMTs, health centres or DHSS-initiated schemes are the subject, special instructions for the correct procedure are set out in Appendix B to the circular.

PARLIAMENTARY QUESTIONS

COMMUNITY HEALTH COUNCILS

Mr Rooker asked what developments had taken place regarding the setting up of a national body for CHCs, on 4th December 1975. Mrs Castle replied: "Earlier this year I set up a Steering Committee, representative of community health councils throughout the country, with the task of working out, in consultation with councils, proposals for the constitution of a national body for community health councils. The Steering Committee has now informed me that its consultations with councils have shown that the majority is in favour of setting up a national body. The Committee recommends that a meeting of all councils should be called in the autumn of 1976 and the Committee should continue its work with a view to putting to that meeting proposals for a national body. I accept these recommendations. I would like to take this opportunity of welcoming community health councils' recognition of the need for the utmost economy at the present time and of their wish to keep the costs of a national body as low as possible. The King Edward's Hospital Fund has given valuable support to the Steering Committee and in addition has provided community health councils with a regular newsletter and an information service which I know has been much appreciated."

GP/PATIENT DISPUTE

Mr John Cartwright asked the Secretary of State if she would bring forward proposals to give community health councils powers to conciliate in disputes between patients and their general practitioners which do not relate to the technical competence of the doctor.
Dr David Owen, in the course of his reply, said that there is an agreed procedure operated by many FPCs, under which a lay member of the service committee with a medically qualified member to assist him, is appointed to deal informally with complaints against general practitioners where, at any rate initially, it appears that a formal investigation may not be necessary or appropriate.
He explained the agreed procedure operated by a number of FPCs for informal investigations of complaints where there is no allegation of a breach of the terms of service. He said the Government's view was that CHCs would not be appropriate bodies to deal with disputes between individual GPs and their patients. At the same time, he hoped the FPCs would work closely with the CHCs. He said that CHCs could be of great assistance in explaining to members of the public the operation of the family practitioner services and by ensuring that individual patients' complaints, both formal and informal, were passed promptly to the FPS Administrator. CHCs could also help the FPCs by advising them of public feeling on more general issues affecting the availability of general practitioner services in each district. (10th November 1975)

HEALTH EDUCATION

Mr John Cartwright asked the Secretary of State if she would give additional support to the promotion of health education. Dr Owen replied that he attached considerable importance to health education and to the preventive services generally, and that the DHSS had issued a comprehensive circular about the promotion of health education services in March 1974 (HRC (74) 27) and intended to publish a consultative document on preventive medicine in early 1976. Its aim will be to inform and provoke discussion and Dr Owen hoped it would encourage the NHS to give preventive medicine, including health education, greater priority when considering future plans and in allocation resources. The work of the Health Education Council would continue to be fully supported. (10th November 1975)

HOUSE OF LORDS DEBATE ON THE NATIONAL HEALTH SERVICE

On 3 December 1975 there was a full debate on the NHS in the House of Lords. Lord Hayter gave an account of the constitution of CHCs, and the way they go about their work. He explained the work of the Steering Committee and even mentioned CHC NEWS ! Towards the end of his speech he said, "The touchstone for community health councils in the future is the extent to which they come to terms with primary care; the extent to which they come to terms with social service ...; the extent to which they come to terms with the problems of local authorities ....; and the nature of community health councils themselves. Finally, Lord Hayter said, "What will emerge, if it has not already done so, is an institution which will never satisfy the demands for instant solutions to our health problems but on the other hand, provides the means of bringing about change by consent. It is an institution worth preserving by, I hope, any Government when they come to power."

Lord Wells-Pestell, in his speech at the end of the debate said "... we too would like to express our gratitude to community health councils. We would accept all that (Lord Hayter) has said on this matter. They are at the beginning stage, but we are expecting great things of them, which we feel certain will come."

FORTHCOMING EVENTS

LONDON COMMUNITY HEALTH COUNCILS CONFERENCE

Wandsworth and East Merton CHC are calling a conference of London CHCs for Saturday 24th January 1976 from 10.00 to 4.30 p.m. at the Polytechnic of Central London, New Cavendish Street, London W1. The cost is £4.00 per head.
There will be discussion on the London Coordinating Committee, the allocation of resources to the Thames regions, and the current state of the National Health Service in London.

For further details apply to Ms Caroline Langridge, Secretary, Wandsworth and East Merton CHC, 1 Balham Station Road, London SW12 9SG. 01-673 8820/8829.

CHILDMINDING AND DAY CARE

The Royal Society of Health are planning a one-day symposium on this subject for 11 March 1976 at Central Hall, Westminster, London SW1. There will be speakers from a social services department, the Childminding Research Unit, the DHSS, Gingerbread and the Community Relations Commission.

For further details apply to: The Conference Department, Royal Society of Health, 13 Grosvenor Place, London SW1X 7EN. 01-235 9961.