"EMPTY PREMISES---EMPTY PROMISES"

by

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Introduction

As Social Workers with a special responsibility for dealing with long-stay psychiatric patients, we have been engaged in helping people to leave hospital and to move into the community. It is our experience that the difficulties surrounding discharge have increased since April 1988, and particularly difficulties in obtaining furniture and other household essentials for those who move into unfurnished tenancies.

Many aspects of the Social Security and welfare benefits system changed very considerably from April 11th 1989, and both our work with individuals and our understanding of the impending changes led us to examine very carefully the circumstances of a group of clients awaiting discharge.

This report is a description of the problems facing both the client and the social worker who is helping a person to set up home in the community.

We are very grateful for all the help given to this project by Cath Hopkins and Barbara Jarvis.

Section One

Government Policy and Community Care

The majority of people needing long-term care are looked after in the community by relatives, especially women, with only the most severely disabled or socially isolated people being maintained in institutions.

In the 1950s a number of strands began to be drawn together which resulted in a challenge to the supremacy of the large, isolated asylum as the most suitable form of care. New kinds of treatments, more liberal regimes, which permitted the unlocking of wards, and a better understanding of the harmful process of institutionalisation, led to the 1959 Mental Health Act and the 1962 Hospital Plan. Closure of hospital wards and the development of a community based service had begun.

As large residential units contracted, some of the properties began to be seen as desirable assets and were sold as country clubs or private residential homes. This asset stripping further accelerated the process. The result is that over the last 25 years the in-patient population of mental institutions in England and Wales has decreased from 145,000 to 73,000. Of these only 60,000 people are in traditional psychiatric hospitals. This steady decrease is likely to continue over the next ten years as a result of continuing Health Service initiatives and as the Local Authorities make progress with the task of providing alternative local accommodation.

Community care has therefore become a dominant policy theme, and numerous Government documents and circulars have demonstrated the Government's commitment to furthering provision within the community.

In 1974 local Joint Consultative Committees were esablished to advise their respective authorities on key services within the Health Service and Social Services. This has since been extended to include housing and education authorities as well as family practitioners and the voluntary sector in joint planning.

In 1976 the Department of Health and Social Security devised a Joint Funding scheme, which made money available to the Health Service to finance the services needed to substitute for hospital beds. (This was again extended in 1983 to include housing and education where relevant.) The purpose of joint financing is to help to get an activity established, but the ultimate objective is for the Local Authority to assume full responsibility as soon as possible.

The 1986 Report of the Audit Commission found many areas where hospital based residential care had simply been transplanted into 'the community' with the Welfare Benefits system paying the bill instead of the Health Service. Such a crude transplant entirely misses an important opportunity to generate more flexible and imaginative forms of community care. More recently the Griffiths Report has suggested way in which funds and skills in providing community care could be more effectively deployed.

Most recently of all, the new Social Fund's Community Care Grants

are specifically targetted on people leaving psychiatric hospital. Such persons form one of ten priority groups who are identified as needing extra cash help at this critical point in their lives. A Start Up Grant ~~of up to~~ £500 is available to assist those who aim to make a new home for themselves after in-patient treatment in a psychiatric hospital. This is an expression, in cash terms, of the State's continuing commitment to hospital closure and community care.

Section 2

The Development of Psychiatric Rehabilitation

Over the past 25 years the population of psychiatric hospitals in England and Wales has halved and many individuals have moved into the community after long periods of in-patient treatment. The transition from hospital to community can create many practical problems for the patient and many hurdles must be overcome if the discharge is to be a success. Psychiatric Rehabilitation has evolved over the last twenty years as a specialised activity working in this transition area, helping people to cope wth these difficulties.

It is difficult to chart with greater precision the emergence of this specialism. No figures have been collected which show how many Consultant Psychiatrists have been employed with a special responsiblity in this area. Other disciplines similarly lack historical data of this kind. In 1980 the Department of Health and Social Security invited applications for the designation of 'National Demonstration Service' in rehabilitation. By 1988 eight services had been thus designated and applications had been received from almost every Health Service Region in England.

In 1988 the Royal College of Psychiatrists establised a Section for Social Community and Rehabilitation Psychiatry, a move which further acknowledged the significance of the specialisms.

Nottingham Rehabilitation and Community Care Services

The Nottingham Rehabilitation and Community Care Service (NRCCS) was initially designated as a National Demonstration Service in 1982, to serve the whole Nottingham Health Authority, a largely urban area with a population of 610,000. Two hospital wards, a 40 place day centre and a 100 place day unit for industrial therapy formed the core of a service that was to grow steadily over the next six years. At its inception NRCCS was served by a Consultant Psychiatrist specialising full-time in Rehabilitation, one Social Worker and two Community Psychiatric Nurses.

By 1988 the client group had expanded to some 500 people who made use of residential, day care or community based support. Services are delivered by a staff team of nearly 200, working from fourteen different locations. The Social Work team now includes a Senior and six Social Workers, there are six Community Psychiatric Nurses, seven Occupational Therapists and two (vacant) posts for Clinical Psychologists.

The task facing the NRCCS is to assist people who have experienced enduring mental health problems to live as independently as possible. Services are provided to help individuals become more self-reliant and to support those who have achieved a plateau, maintaining them for a time until they are ready to progress again.

Residential Rehabilitation

The NRCCS provides move-on residential accommodation in four units which vary in terms of the particular needs of the clients they serve. All four units are deemed to be hospital wards by the Health Authority, but all require clients to participate in their active rehabilitation programme. Psychiatric nurses provide most of the staffing, along with a large input from many other professions and disciplines.

Between January and December 1987, 43 people were discharged from these four units. An examination of their experience will give us some idea of the situation likely to face the people currently in residence. Professionals in contact with the service do not perceive any significant differences between those resident in 1987 and those resident at the moment.

TABLE 1

Discharges from Rehabilitation in 1987 by gender and age

Age (years)	Males	Females
15 - 24	1	1
25 - 34	5	5
35 - 44	5	6
45 - 54	4	6
55 - 64	4	4
65 +	3	-

TABLE 2

Discharges from Rehabilitation in 1987
Number of Weeks in Residential Rehabilitation

Weeks	Clients
0 - 9	12
10 - 19	4
20 - 29	8
30 - 39	4
40 - 49	6
50 - 59	1
60 - 69	3
70 - 79	2
80 +	3

Table 2 shows the length of stay in residential rehabilitation prior to discharge. In addition, it is important to remember that many people will have had extensive periods of in-patient treatment prior to referral to NRCCS. The length of time spent in residential rehabilitation clearly varies quite considerably, but in many cases it is prolonged. On average, clients spent about 10 months in residential rehabilitation before discharge.

The cost of residential rehabilitation can only be estimated. Figures are available for the financial year 1986/87, and these provide an average for the whole hospital. The cost per in-patient week is near to four hundred and fifty pounds and this does not include the costs of doctors, social workers, occupational therapists and community psychiatric nurses who can be found on the premises every day. The total cost of residential rehabilitation must be well in excess of five hundred pounds for every week in residence and the average cost of a period of residential rehabilitation would therefore be twenty thousand pounds plus.

TABLE 3

Discharges from Rehabilitation in 1987, to type of accommodation

7 people returned to existing home
10 people moved into new unfurnished accommodation
2 people moved into new furnished accommodation
4 people moved into group homes
1 person moved into family placement scheme
10 people moved into registered homes (hostels)
8 people returned to hospital
1 person moved to prison

First it is clear that in 1987 a quarter of those discharged moved to unfurnished accommodation. They would therefore have required furniture and fittings. It is a matter of principle that every individual who enters residential rehabilitation has the right to aspire to full independence in unfurnished accommodation. It is a matter of conjecture whether the proportion of discharges into such accommodation would increase if the difficulties surrounding the provision of furniture were eased.

Of course some individuals move more than once after discharge from residential rehabilitation. The place each person was discharged to (referred to in Table 3) may be a staging post in a gradual progression towards full independence.

Second, Table 3 shows that only 7 people returned to their already existing homes. This illustrates the point that very few rehabilitation clients are actually and substantially supported by relatives. Most are profoundly isolated and have few friends or relations who could offer assistance. In most cases where individuals leave residential

rehabilitation for independant tenancies social workers have been unable to recruit help from relatives.

In short we are dealing with a group of socially isolated people who in many cases cannot count on substantial help and support from their families. They are being encouraged to leave psychiatric institutions, and to settle in the wider community. Many of them will encounter an immediate need to equip themselves with furniture and household effects, but will lack the financial resources for this substantial investment. For this, many will turn to the social security system for cash help.

Section 3

Patients and Benefits

A prime purpose of our enquiry was to examine how the changes in the social security system which came into force on April 11th 1988 might affect the sorts of people who are currently passing through the process of residential rehabilitation. This required us to take a cohort of 44 people who were in residential rehabilitation during the week commencing 11th April 1988 and to make a close examination of their benefit status and entitlement. With their permission, and with the help of a number of DHSS offices, we tried to establish this base-line information. Our findings are presented in Table 4.

TABLE 4.

Benefit status of the 1988 R.R.Population, as at April 11th 1988.

1	Income support only	3
2	Severe Disablement Allowance only	15
3	Pension + Income Support	2
4	Invalidity Benefit @ £43.90	2
	" " " @ £46.65	1
	" " " @ £49.80	19
5	Employed/Community programme	1
6	Unknown	1

Note: Severe Disablement Allowance is a non-contributory and non means-tested benefit. An applicant must have been incapable of work for at least 28 weeks and must be classed as 80% disabled (unless the incapacity began on or before the applicant's 20th birthday). This second condition is satisfied automatically if the applicant already gets Attendance Allowance or Mobility Allowance, has an Invalid Car or Car Allowance from the DSS, or is registered blind or partially sighted.
The current rate of benefit is £24.75 per week.

What benefits might be available.?

Two specific lump-sum benefits payable through the Social Security system are relevant to a patient on the point of discharge from residential rehabilitation. These are a Community Care Grant, paid out of the Social Fund, and Resettlement Benefit. These benefits are described in greater detail below, but the first thing is to establish the criteria for securing such cash help. Eligibility depends entirely upon the kind, and the amount, of benefit which the applicant receives from week to week.

Some benefits qualify a person for cash help; others disqualify. Community Care Grants exclude some groups altogether from applying, and then maintain a degree of administrative discretion in the case of those fortunate enough to be able to apply. Resettlement Benefit is paid according to precise rules of entitlement, and there is no administrative discretion. It is possible to set out the relationship between weekly benefit and these two lump-sum benefits as follows.

TABLE 5

Sources of weekly income and applicable lump-sums

1.All entitled to Income Support		Community Care Grant (CCG)
2.Severe Disablement Allowance		CCG(1) and Resettlement Benefit (RB)
3.Invalidity Benefit	@ £43.90	CCG and RB
	@ £46.65	RB
	@ £49.80	RB
4.Employed/Community Programme		-

Notes: 1. Those who receive S.D.A. may also apply for Income Support, and if entitled, they are then eligible to apply for a Community Care grant.

More about lump-sums

Until April 1988 two specific cash benefits were available, to help people meet their needs upon discharge from rehabilitation. The first was Supplementary Benefit single payments, lump-sum payments to meet special needs which could be applied for on discharge, to help ex-patients to 'settle in the community. The second, Resettlement Benefit,was a sum of money which some in-patients could accumulate, in effect as savings, from money they would otherwise have received as benefit. This 'savings scheme' came into force at the start of the second year of hospitalization, and money could be accumulated for the whole of that year, but for no longer than that.This accumulated sum, which could amount in some cases to a very substantial sum, would be paid over on discharge as Resettlement Benefit.

In April 1988, Single Payments were abolished, but those in receipt of the new Income Support, or those who would become entitled to Income Support on discharge, can now apply to the discretionary Social Fund for a Community Care Start-Up grant of up to £500. Resettlement Benefit was also abolished although anyone who had been accumulating an entitlement before the April changes could still claim it. However no new entitlement will accrue, and in time this benefit will disappear altogether.

The Governement has also recently announced the new Independent Living Fund, which provides money for personnel to assist disabled people in the community. However it does not have a brief to finance the purchase

f furniture for independent tenancies. Consequently it is not relevant to he problem under discussion here.

Our enquiries showed that out of the 44 people in our 1988 cohort, 0 could claim a sum of Resettlement Benefit amassed before April. These ums varied very considerably from only £52 in one case to as much as 1200 in another. There is also a perverse relationship between the length f stay in hospital and the relative amount of Resettlement benefit ayable. The more recently a person was admitted, the relatively larger ill be their lump-sum; this is the effect of inflation upon savings that re not invested. Two of the 10 with some Resettlement Benefit were also ligible to apply for a Community Care Start-up grant , although if their esettlement Benefit exceeded £500, then the excess might be treated as vailable capital by the Social Fund Officer, and the Start-Up grant educed pro rata.

So, from our cohort, eight persons are entirely dependent upon the very variable) payment of Resettlement Benefit, and are not eligible to pply for a Community Care Grant. But as Resettlement Benefit is phased ut, so this group's counterparts in future cohorts are likely to have ccess to no sources of lump-sum help to enable them to meet the costs of esettlement in the community.

But these eight are not alone in this respect. A further twelve embers of this year's cohort not only did not qualify for Resettlement enefit, but were also excluded form applying for a Community Care Grant. hese people would have no access to any cash help at all upon discharge rom residential rehabilitation.Together these two groups account for early half of the residential rehabilitation population.

Of the remainder, a further 20 had no accrued Resettlement Benefit, ut were eligible to apply for a Community Care Start-Up Grant. An pplication can be made for a grant up to six weeks before discharge, and ay actually be paid up to two weeks before discharge. But as we have lready seen, an average rehabilitation programme lasts 45 weeks, so that he greater part of this time must be passed without any assurance at all s to whether in the end help will be forthcoming or not.

In the final two cases we were unable to establish what their enefit status was, and remain unclear about their situation.

survey of charities

We have seen that out of 44 people,at least 12 will have no access o cash help with which to furnish a flat at the point of discharge. nother 22 must wait until a fortnight before their discharge date before he pendulum of discretion will swing and grant or withhold the five undred pounds Start Up Grant.

Where the Start Up Grant is refused to an applicant, the Social und Manual recommends Social Fund Officers to point the unsuccessful pplicant towards charities (see para 9055). Likewise, Paragraph 4059

makes the same suggestion in connection with crisis loans. Each DSS local office has been supplied with a copy of the Charities Digest, and this is presumably to assist Social Fund Officers in guiding applicants to the appropriate source of charitable money. But just exactly how broad and free-flowing is this stream of generosity?

With the help of both the Charities Digest and the Directory of Grant Making Trusts published by the Charities Aid Foundation we were able to identify a list of some 75 charitable foundations which might help our client group. A letter requesting assistance was sent out to these organisations in late May and early June 1988. By 31st August we had 25 replies to our enquiries. Of these 25 replies one charity offered support in publicising the problem and one offered financial help to one client, amounting to two hundred and fifty pounds. A further approach to a locally administered charitable fund resulted in two successful responses, of £350 and £500 respectively. One of these was to a client who recieved a payment of Resettlement Benefit well below the level of the Start Up Grant. No guarantees have been given of any further payments; indeed this particular charity notified us in January 1989 that all its funds were allocated for the financial year 1988/89, and no further help could be given.

It would seem that even after these exhaustive attempts, the most hard-pressed members of our cohort will still have no access to money on discharge.

Timetabling Troubles

Problems are not over even for those clients who are fortunate enough to obtain some cash for furniture. We have now identified three different possible sources of capital.

able 6 Sources of Capital.

	No. of Recipients		Amount
tart Up Grant	Maximum of 22	Variable	£500 (max)
esettlement Benefit	10	Variable	£52- 1,200
harities	3	Variable	£250- 500

The Start Up Grant is part of the Social Fund Community Care Grant ystem and replaces the old single payments provisions under Supplementary enefit. It is reasonable to assume that the figure of £500 available as start-up grant is considered to be the baseline minimum needed to meet a erson's needs. If this is so, then by this yardstick at least two of the esettlement Benefit payments and two of the donations from charity whilst welcomed) do not provide sufficient funds with which to furnish a lat.

There are further practical and administrative problems which our lients may then encounter.

For example, in Nottingham the City Council Housing Department and he Housing Associations usually allow a potential tenant one week in hich to decide whether to take up a tenancy. The letter offering the enancy may arrive after many months of waiting and sometimes without arning. In consequence, the client may have no more than seven days in hich to make a decision and begin the process of seeking finances for urniture before becoming liable for rent and rates. The Social Fund nvites applications for a Start Up Grant up to six weeks prior to the ate of discharge, but this sensible provision cannot be utilised in the ajority of cases due to the lack of notice of the tenancy.

Resettlement Benefit should be easily calculated by the DSS, but in ottingham there appears to be some delay in processing requests for the alculation. The local DSS offices were written to with requests for the nformation and ten weeks later we had no response in connection with six lients. In practice this could mean an expensive, time-consuming and demoralising delay in the programme of rehabilitation as we do not know he probable financial circumstances of these six persons on discharge.

Secondly, Resettlement Benefit is not payable until the day of ormal discharge from hospital. Local clinical practice has been to begin he tenancy on extended leave and retain a hospital bed for four weeks in ase the placement is unsuccessful. This has the effect of delaying the ayment of Resettlement Benefit until the patient has actually lived in he (presumably unfurnished) accommodation for four weeks.

ection 4

he Shopping Expedition

But is a sum of about £500 enough to meet the setting-up osts of one of our clients? This is certainly a very practical question o ask, but it has another dimension as well. In a market economy one of he basic activities that defines individuality is the exercise of onsumer choice in shopping. Selecting goods and paying for them out of our own purse is an activity which identifies the customer as adult, esponsible and enjoying civil rights as a consumer.

Very few psychiatric patients have substantial private means; nusually, but luckily for this research, we were able to keep a log of urchases made by one of our clients who in fact had substantial capital t her disposal, and was moving from a residential rehabilitation unit to n independent unfurnished tenancy. This lady was discharged from ehabilitation immediately prior to the members of our cohort. She shopped n April 1988 and chose new items of furniture, but selected the cheapest uoted prices available in Nottingham. Her total expenditure amounted to ver £2100. This was in fact not an extravagant expedition. The list of tems is standard and basic household stock, and no single item was of ore than average cost. Readers can judge for themselves from the list elow.

TABLE 7

Shopping List

Item	Cost (£s)
Cooker	200
Refrigerator	95
Washing Machine	200
Carpets	150
Television Set	150
Table	40
Chairs	20
Curtains	40
Curtain Rails	20
Stereo	180
Bed and Headboard	125
Bedding (two sets)	137
Crockery and cutlery	30
Kettle	20
Saucepans	20
Brooms/cleaning materials	10
Vacuum Cleaner	90
Towels/tea towels	20
Sofa	250
T.V.Licence	60
Wardrobe	50
Chest of drawers	30
Clock	10
Iron	20
Ironing Board	10
Pictures/Lamps/Ornaments	50
Housing Insurance	82.50
	£2109.50

The newer DSS Regulations do not provide a list of furniture and fittings deemed necessary, so a direct comparison is difficult. In order to obtain such a list we were obliged to turn to the old Single Payments Regulations which were in force between 1980 - 86.This gives us a list of "bare necessities". In order to attach a realistic price for these items we approached the local Trading Standards Office, where the Trading Standards Officer was concerned that vulnerable people should be surrounded by a safe environment and therefore furniture and kitchen equipment should be purchased to British Standard specifications. This resulted in ~~the following~~ a shopping basket of goods.

TABLE 8

Basic Furniture for a flat.

DHSS Regulations 1980-86	Trading Standards Recommended Prices. £
Cooker	200.00
Carpets	150.00
Table	40.00
Chairs	20.00
Curtains	40.00
Curtain Rails	20.00
Bed and Headboard	125.00
Two Sets of Bedding	137.00
Crockery and Cutlery	30.00
Kettle	20.00
Saucepans	20.00
Brooms/Cleaning Materials	10.00
Towels and Tea Towels	20.00
Sofa	100.00
Wardrobe	50.00
Chest of Drawers	30.00
Ornaments	10.00
Total	1022.00

We are driven to conclude that only one of our 42 benefit claimants will be able to furnish a flat to the most basic standard of safety and comfort. This one person can do so from the payment of Resettlement Benefit, which has, of course, been abolished. Everyone else, including those with Start-up grants, will have to risk the second hand market where mattresses and upholstery might be infested, electrical goods faulty and foam filled furniture a major fire hazard. This last point is a grave one as 31 out of our cohort of 44 (70%) smoke. A study of 100 schizophrenic in-patients carried out by Masterson and O'Shea (British Journal of Psychiatry (1984) 145, 429-432) showed 92% of male and 82% of female patients to be smokers.

Finally, it should not be assumed that second-hand goods are always readily obtainable, nor that widely sought articles of furniture will be available at moderate prices. It is our experience that £500 is inadequate, even in the second hand market.

Donated Second-hand Furniture

We have clearly established that that even for those people fortunate enough to obtain a Start Up Grant, to have an accrued Resettlement Benefit or to get a cash-donation from charity the sums involved do not adequately meet even basic requirements for safety and comfort. But we know that many of our cohort have no access to cash help of any kind for furniture.

Having exhausted the meagre sources of cash which will permit people to buy what they need, we have to explore the possibility of donations in kind. The voluntary body 'Family First Trust' of Nottingham runs an excellent second-hand furniture collection and donation service. Social Workers authorise the Furniture Service to grant furniture free or at a nominal charge to their clients. Unfortunately certain products, such as bedding, carpets or electrical items are almost completely unavailable (although the Service does handle these goods the demand is such that supply to our particular clients at a particular time cannot be ensured). Secondly, there is no way of guaranteeing the quality of such products or, more particularly, whether they are safe or hazardous to use.

These difficulties, which make it almost impossible to obtain a cooker or a fridge, have resulted in staff of the Rehabilitation Service attempting to create their own store. Some garages were available at one of the units, but they are too damp for upholstered furniture to survive more than a week or two. A request for more suitable accommodation within the hospital was unsuccessful. The Hospital Transport Service has generously agreed to move items of furniture to and from the garages, as and when their hard-pressed service allows them to take on this extra task. But this store is small and hopelessly inadequate as a reliable source of furniture for the client who has only a few days to equip a tenancy.

Most importantly, the client is denied almost all of the choice which is involved in spending one's own money. An affluent, well-established member of the community may welcome gifts, but the experience and hence the reaction of those who lack a place to sleep or eat is very different. The meek and ingratiating attitude which is an inevitable response to these gifts in kind profoundly undermines dignity and self-respect. It would come as no surprise if it were discovered that individuals who are given furniture care for it considerably less well than individuals who are given money to purchase their own furniture.

Section 4

Social workers with dirty hands

Our own extensive experience, part of which has been documented here, is that resources available to long stay psychiatric patients are demonstrably inadequate. Obtaining a cooker, or a kettle, or a carpet is often an insoluble problem for both the client and the Social Worker. Nevertheless, unfurnished tenancies are offered and the residential rehabilitation unit does discharage their residents. What happens to them?

* Facing the prospect of such an unplanned, chaotic discharge to the community, some clients deteriorate. Others select more dependent acommodation in preference to full independence. Both these alternatives have long term clinical and financial consequences.

* Some individuals have the opportunity of delaying the commencement of the tenancy by beginning to pay the rent but staying in the rehabilitation unit for a few weeks. This does little to ease the situation for those individuals who have no money and where the two sources of furniture in kind cannot oblige. For many City Council tenants it is a financial impossiblity also. 20% of general rates due after Housing Benefit has been granted, plus water rates, plus the standing charge for a district heating scheme totals in excess of ten pounds per week. By remaining in the rehabilitation unit whilst liable for rent the client only receives £8.25 per week.

* There is often no money to employ electricians to install the cooker, carpet fitters to lay the carpet or removals firms to provide transportation. Professionally qualified workers find themselves involved in such pratical tasks despite their lack of suitable tools, training or insurance.

* The task of making the best possible home when basic commodities are so difficult to locate is immensely time consuming. On one occasion when a log was kept 50 hours of professional time was invested and this is not uncommon. The hours were largely employed in struggling with the difficulties caused by lack of adequate finances at the point of discharge, rather than providing professional skills such as counselling to the client.

* Life is hard for the newly discharged member of the community. Often there is no cooker in the flat, there may be only a mattress on the floor and little by way of carpet or curtains. Some people find themselves living on their own without even a television or

radio after many months of communal living with ready access to both. Most people are too embarrassed to invite others into their accommodation, and so become even more socially isolated. With no prospect of improving their environment (weekly subsistence benefits do not provide enough to permit saving) there is little wonder that some people return to hospital.

* The Social Fund will consider granting cash help to people on the brink of re-admission to psychiatric hospital, if such a payment would prevent re-admission. The 20 people who are in receipt of either of the two highest rates of Invalidity Benefit are however, ineligible to apply for a Community Care Grant.

* If the placement in the community breaks down and the individual returns to hospital, then a £20,000 residential rehabilitation programme has not succeeded. Who has failed?

Just a local problem?

The difficulties we have described are not peculiar to Nottingham. The crux of the case is that residential rehabilitation clients who receive the top two rates of Invalidity Benefit are autuomatically excluded from the Social Fund on discharge. In consequence they have no access to cash help for furniture and find the task of equipping a tenancy well-nigh inpossible.

But perhaps the Nottingham rehabilitation population is unusual in that it has collected more patients on Invalidity Benefit than one would expect and so concentrated a problem which is generally rare. We tested this hypothesis by contacting some of the other National Demonstration Services. We found that in Birmingham, the proportion of rehabilitation clients in receipt of Invalidity Benefit was 70% whilst in Surrey and Northumberland the figure was 65%.

So if Nottingham is exceptional in any way it looks as if the proportion of those most severely affected by the Benefit arangements might be lower than the national average. Amalgamating together all the figures we have to hand produces an average of 60% of rehabilitation clients excluded from the Social Fund.

Some Concluding Questions

In an attempt to draw together some conclusions from this study, we will list a number of observations and pose a munber of questions. These may serve as subject headings for a wider debate.

1). It is a poor economist who invests £20,000 on a rehabilitation programme only to see it collapse for the lack of £1,000 at the point of discharge. The longer this situation continues, the more Health Service

money is hazarded.

2) Why were DSS staff unable to provide information about Resettlement Benefit more quickly? After ten weeks we were still waiting for details on six people. If this delay had held up the discharge (rather than merely holding up our research) it would have cost the Health Service £30,000. The final figure was provided by the DSS 22 weeks after our initial written enquiry.

3) Why was Resettlement Benefit abolished in its original form? DSS Headquarters at the Elephant and Castle London, answered a telephone enquiry about this by saying that it was replaced by the Social Fund!

4) Uncertainty about entitlement to the Start Up Grants makes planning a programme of rehabilitation very difficult. Definite information about any lump-sums available at the point of discharge should be provided to the Rehabilitation Unit as early as possible in the programme. This releases everyone from worry about furniture so they can concentrate on social and therapeutic goals.

5) If 40% - 60% of clients receive no cash help on discharge, should the residential unit even begin the process of rehabilitation? The unit could choose to admit only those on the appropriate benefit.

6) To compound the absurdity, Rehabilitation Service managers may wish to design and build facilties which circumvent these difficulties and place clients in a setting where they become eligible for cash help on discharge. Any change in Benefits provision would then nullify this exercise.

7) At present charities appear to require details of the recipients specific circumstances, such as date of discharge, particular furniture required, etc. This means clients are uncertain of financial backing until a very late stage in their rehabilitation programme. Charities could 'adopt' a unit and leave the allocation of monies to a particular client to the unit. In due course they would receive information, receipts, etc., showing how the money had been used.

8) Gaining the co-operation and support of charities is an arduous and time consuming task. Do agency managers in Health and Social Services Departments wish their staff to be employed in these duties?

9) It would be extremely helpful if Housing Departments Lettings Sections could give more warning of tenancies. Surely sufficient properties are handled to provide some guarantees, and this particular client group have been invested in so heavily to prepare them for independence, that making them a priority group seems justifiable. Having said this, it is true that Nottingham City Council staff have done all in their power to assist us to

move people quickly, and have showed great care and consideration. The most efficient administrative device has been the Homwless Persons Act 1977, but this instrument, while expediting discharge, stigmatises people with a label that they surely don't deserve. As the newly discharged client ventures out of the asylum to sample the quality of Community Care, the first role they are obliged to assume is that of a homeless person.

10) Resettlement Benefit should be inflation-linked and thus paid according to the real value of the money accrued, i.e at the most recent rates. This would accelerate the calculations at Social Security offices and obviate the need for acquiring copies of the rates payable during the 1950s, 1960s and 1970s.

11) Resettlement Benefit should be payable at the same point in time as Start Up Grants are available, i.e. two weeks before discharge.

12) Social Security officers should consider the point of discharge to be the point at which the tenant becomes liable for rent and rates. Medical Records Department in the hospital should provide this data rather than the abstract date at which the bed is notionally closed to that patient.

13) Furniture should be provided in cash, not kind,

14) The Start Up Grant should be immediately doubled to £1000.

15) Those who wish clients to give up smoking should plan their intervention significantly before or considerably after the point of discharge, as each client who moves into the community has a great many stresses to face without the additional burden of stopping smoking.

16) The employment of a qualified electrician and gas fitter should be essential to any second hand furniture service. Obviously most charitable furniture sevices cannot afford to employ these tradespeople, so funding should come from central or local government coffers.

17) At least one hospital in England has made use of a disused ward as a store for donated furniture. What are the implications in terms of fire safety, staff time, hazards to clients and so on? On the other hand, given the lack of alternative provisions, what are the implications of not offering to store donated furniture?

18) Housing Benefit Departments should treat standing charges for a district heating scheme as fully rebateable.

19) Health and Social Services managers, trade unions, professional bodies and individual workers should consider the implications of carrying out practical tasks (such as wiring cookers) without adequate training, tools or insurance.

20) Rehabilitation units should employ skilled tradespeople to assist clients, if cash is not forthcoming. Preferably cash would be available for clients to employ the tradesperson of their choice and so acquire the usual consumer protection.

21) A television set should be considered a household essential, and no longer a luxury. Licences should be priced within the reach of people on state benefits.

22) This report should be discussed by Joint Planning Teams and all others involved in Community Care.

In conclusion, the welfare benefit net has a gaping tear in it and a very high proportion of ex-psychiatric patients fall through the gap. Unless sufficient cash help is available to allow peole to equip their new homes to a safe and civilised standard, much of the expenditure involved in preparing people for life in the community will be money down the drain.