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issue. There has been a progressive reduction of long-stay beds in health service facilities. This change in service provision has been a natural consequence of the Care in the Community Report and continuing nursing care services are now often provided within a community setting. The point at which social service provision takes over from health is not clearly stated and anomalies can arise. This HMSO publication describes the case of a man who fell between health service and social service stools.

In December 1989 a 53-year-old man suffered a serious cerebral haemorrhage and was admitted to a neurosurgical ward in the General Infirmary at Leeds. After acute treatment measures he was found to have major residual impairment and required help and supervision for all self-help skills. He remained on an acute medical ward for a further 22 months, although the need for medical care after the first few weeks was minimal. No suitable facility could be found within the NHS and in September 1991 the patient was discharged to a nursing home at a cost of over £15,000 a year.

The case was referred to the Health Service Commissioner for England who found that the failure to make available long-term care for the patient within the NHS was unreasonable and constituted a failure in the service provided by the health authority. The Commissioner was also concerned that no indication had been given to the patient's wife about who should pay the nursing home fees before discharge from hospital.

As a result of this judgement those health services responsible apologised for the shortcomings identified and agreed to pay the patient's wife for the past and future nursing home costs already incurred.

Similar cases have been reported previously to the Health Service Commissioner. This is not surprising to those working in this field. Although very adequate provision is available within the NHS for the acute treatment of those who sustain head injury from whatever cause, facilities within the NHS for the continuing care of such individuals has always been meagre. Long-term beds for patients over the age of 65 are still available and those who sustain brain damage before the age of 18 are provided for by the learning disability services. Suitable care for those between these poles of the age spectrum is often not available as I was made painfully aware when I worked in a neurology rehabilitation unit with boxers, jockeys and others who had sustained repeated head injuries and were unable to live independently. This is despite the fact that the National Health Service Act of 1977 states that "it is the Secretary of State's duty to provide such facilities for . . . the after-care of persons who have suffered from illness . . . as part of the Health Service . . ." Furthermore in correspondence between the Health Commission and the Chief Executive of the NHS Management Executive the latter wrote in 1991 "if in a doctor's professional judgement a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge." Although in the same correspondence the Chief Executive stated that "consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care." The area health authority concerned in this case agreed with the Health Service Commissioner's judgement and refunded costs.

Treatment and care of those suffering from the after effects of a severe brain injury require the services of doctors, physiotherapists, speech therapists and psychologists. It is cost-effective to provide such treatment facilities on hospital sites. The need for such units has been apparent for some time and with the pressure of purchasers in the new NHS reorganisation, NHS trusts are now providing facilities for the treatment of these patients to supplement those that already exist in the private sector. The judgement of the Health Commissioner will support the development of these units and is to be welcomed.

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Philosophy, Psychiatry and Psychology

This new journal was launched with its first number appearing in June of this year. While published by the Johns Hopkins University Press, its founding Editor is Bill Fulford whom members of the Royal College of Psychiatrists will know as the leading light behind the Philosophy, Ethics and Psychiatry Special Interest Group.

Volume 1 Number 1 is a heady introduction to the topic. The three main streams of psychiatry are represented, those with an interest in biological psychiatry and phenomenology will enjoy an article 'Self-consciousness, Mental Agency, and the Clinical Psychopathology of Thought Insertion', those whose interests lie more in the psychotherapeutic field will be attached to 'Affect, Agency, and Engagement: Conceptions of the Person in Philosophy, Neuropsychiatry, and Psychotherapy' and the social dimension is not ignored with 'How Should We Measure Need? Concept and Practice in the Development of a Standardized Assessment Schedule'.

The neophyte to philosophy may find himself agreeing with what he reads and therefore commentaries on these three papers are very welcome putting forward differing points of view from those of the original authors.

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Two more abstract papers are presented 'Cognitive Science and Hermeneutic Explanation: Symbiotic or Incompatible Frameworks?' and 'Connectionism and Psychiatry: A Brief Review'.

For those whose appetites are whetted by reading this journal there is a very full section of 'Concurrent Contents' with references of interest in journals and books. For those who wish to take their interest several steps further there are details of conferences in six European countries and beyond to Israel and the States.

Interest in philosophy and psychiatry continues to increase as evidenced by the very active national and local groups (including one in Scotland with strong links with the Scots Philosophical Club – all academic philosophers in Scotland) and with an interest being taken by the College in the place of philosophy in undergraduate and post-graduate training, and in continuing medical education. Thus the time for the launch of this journal is most appropriate and I would commend it to any psychiatrist with whatever degree of interest in the subject.

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Guidelines for the Management of Schizophrenia. Developed from a meeting of an independent working party. Available from Dr André Tylee, Senior Mental Health Education Fellow, Unit of General Practice, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE.

At any given time probably more than 80% of schizophrenic patients are living outside hospital. Their management in the community presents many difficulties, not least how best to co-ordinate care. Guidelines as to management are being developed by working groups of CSAG (Clinical Standards Advisory Group) and CRAG (Clinical Resources and Audit Group, Scotland); their reports are expected in late 1994 or early 1995. In the meantime we have this booklet produced by an 'independent working party'.

It is a curious little document. It apparently arises out of an informal meeting of 17 people, all interested in schizophrenia. These included, for example, two professors of psychiatry, the chief executive of SANE, the director of the Afro-Caribbean Mental Health Association, a carer and a user. Provisional guide lines were developed and a satellite tele conference held with 177 health care professionals. The result was 12 principles or guidelines.

Four of the eight pages of text contain a brief description by Professor Lader of schizophrenia – its symptoms, course, diagnosis and treatment. This is unremarkable stuff – the sort of basic information that all health professionals interested in schizophrenia should know about. The next two pages, by Tylee, a senior mental health eduction fellow at St George's (sponsored I think by the Royal College of General Practitioners), focus on the interface between primary and secondary care. He briefly outlines the care programme approach, highlights the fact that most GPs have never worked in psychiatry and comments on the failure of community psychiatric nurses to meet the needs of all schizophrenic patients.

The last two pages contain the management guidelines. The first two 'general' guidelines emphasise the need for shared care and a management plan. The next four, headed 'Drug Treatment', emphasise compliance and the limited benefit of either high or low doses. The last, 'Personnel and Facilities', emphasises the role of the key worker, the need for GPs to be given as much information as possible on the day of the patient's discharge from hospital and the availability of different types of accommodation.

My principal difficulty with the booklet is to decide who it is aimed at. I think it must be mainly GPs. If so, they might well find it a useful *aide memoire* when discussing with their hospital and other colleagues the best way to manage schizophrenic patients in the community; also lay managers might find it a useful introduction to the care of such patients. However, for a more definitive statement about the best way forward we must await the reports from CSAG and CRAG.

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