An ethical analysis of the policies of British community and hospital care for mentally ill people

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Authors' abstract

Scant consideration has been given to the ethical implications of the policy of closing down psychiatric hospitals in favour of community care. The recent adherents of this policy in government have been enthusiastic in encouraging its implementation. This paper has three sections: a brief resumé of the history and principles of community care for the mentally ill; a discussion on the merits and de-merits of psychiatric care in the hospital and in the community; and an outline of some preliminary categories for ethical analysis.

'Human history is full of examples of 'simple solutions' to moral problems. Usually this has resulted in some group or other being despised, exploited or liquidated, because they did not fit well into someone's master plan' (1).

The thorough and well-informed ethico/legal debate preceding implementation of the 1983 Mental Health Act contrasts starkly with the lack of such discussion about the contemporary movement of the mentally ill from institutional care to the community. A wide-ranging and ethically informed public debate about this matter is urgent while there is still a choice. Many psychiatric hospitals are still open and functioning today. This may not be the case in ten years' time.

The history and principles of community care

In 1961 Enoch Powell made community care for the mentally ill government policy and proclaimed the demise of the psychiatric hospital (2). Powell's plans received little effective opposition, rapidly coming to be regarded as logical, progressive, liberal and, above all, humane. The succeeding two decades have seen a steady growth of the impetus towards community care. Although only one large psychiatric hospital had closed before 1981 the pace of closure has speeded up recently, particularly since the publication of the document *Care in the Community* (3) which sought to

implement the definitive plan for mentally ill people in the community *Better Services for the Mentally Ill* (4).

Perhaps the most remarkable feature of the policy of community care is its lack of any coherent rationale or principles. Walker points out that

'there has been no sustained attempt to define and measure the need for community care to set policy goals and then to relate the goals to the scale of need and the allocation of resources' (5).

General vagueness about the nature and underlying principles of community care allows this comment:

'To the politician, "community care" is a useful piece of rhetoric; to the sociologist, it is a stick to beat institutional care with; to the civil servant, it is a cheap alternative to institutional care which can be passed to the local authorities for action – or inaction; to the visionary, it is a dream of the new society in which people really do care; to the social services departments, it is a nightmare of heightened public expectations and inadequate resources to meet them. We are only just beginning to find out what it means to the old, the chronic sick and the handicapped' (6). The policy of community care has never been required to justify itself ideologically, rationally, practically or ethically. Since its inception it has been accepted on the basis of its common-sense appeal which precluded rigorous examination and justification. While it may be true that often common sense and ethical scrutiny come to the same practical conclusion, this is not always the case. The common assumption amongst the majority of health professionals and lay people that care in the community is self-evidently the best way of dealing with the needs of mentally ill people therefore requires critical evaluation.

A comparison of hospital and community care

It is widely believed that the psychiatric hospitals, many of which were built before the turn of the century, have failed as caring institutions. They are old and outmoded, isolated and often separated by many miles from the areas which they serve. Most of them were built for custodial rather than therapeutic care

Key words

Care of the mentally ill; hospital v community care for the mentally ill.

and a lack of resources has prevented many of them from being substantially up-graded.

Public fear and indifference has been confirmed by evidence of cruelty and neglect (7), as well as the proposition that these gaunt asylums or warehouses with their rigid routines may actually damage their stigmatised inmates, helping to make them chronically ill and dependent (8, 9). At the same time, it has been argued that pharmacological advances in psychiatry and a decline in the numbers of the chronically mentally ill make the survival of large institutions for containment purposes both unnecessary and undesirable (6). Many British observers of the psychiatric hospital would readily assent to Talbott's perception from the USA that 'the State hospitals, as they are currently constituted, do not work, seem designed not to work, and have never worked . . .' (10).

A more positive perspective on psychiatric hospitals shows a more tolerant environment where basic human needs such as adequate accommodation and nutrition, companionship, social interaction, employment and leisure activity are at least to some extent ensured (11). Because of their centralisation of resources, the hospitals can provide many different types of therapeutic facilities and patients are not confined to treatment by medication or other physical methods alone. Centralisation also saves money through efficiency, an important factor in a time of economic recession. By the same token many jobs are provided for health-care staff and this has a significant economic impact on the localities of the hospitals concerned.

Economic recession is likely to be accompanied by a rise in the incidence of mental illness which results in greater demands on psychiatric resources at a time when there is little surplus public money for new facilities in the community (12). It should also be noted that, despite the optimistic prognostications of the 1950s and 1960s, a new corps of chronically mentally ill people, needing long-term care and asylum, has come into existence (13). Furthermore, it should not be assumed that psychiatric hospitals are under-used. The so-called 'revolving door' policy of multiple short-stay admissions means that hospitals are even busier than they were when they dealt mainly with a stable long-stay population (14).

Some defenders of psychiatric hospitals have pointed out that there is a danger of condemning these institutions because they do not conform to the values of middle-class observers (15). This view is confirmed by the satisfaction all types of patients expressed about staff, social activities, the hospital grounds, treatment and the security they felt the hospital gave them, in a study of British psychiatric hospitals undertaken in the early 1970s (16).

Lastly, it should be noted that, as the number of in-patients has fallen and staff complements have increased, psychiatric hospitals are approaching an ideal patient-staff ratio where they can start to perform the function they were originally conceived to

undertake, that of offering intensive personal treatment to mentally disordered people. It seems ironic that at the moment when these hospitals might actually begin to function well their demise should be contemplated (17).

The potentially positive aspects of hospital-based care for mentally ill people may be set alongside negative features of community care policy which tends to be vague and inconsistent. Further, more practical, criticisms of community care can be made. In the first place, the assumptions of this policy have not been confirmed by research. For example: that people are happier, better looked after and more likely to develop their potential in a community setting and that it is cheaper than hospital care. Mechanic suggests that all mental health policies may be evaluated in three ways: the subjective responses of patients to the effects of the policy, patients' quality of life and performance in response to the policy, and the economic and administrative costs involved (18). It seems legitimate to expect that any major policy change which is ethically responsible should be based on considerable research demonstrating its value and validity (19). In the case of community care almost no research was extant before Powell adopted the policy and there has only been a limited amount since that time. A Department of Health and Social Security (DHSS) study on the topic in 1981 (20) was only able to cite four studies on the effects of a community care policy in Britain yet this was published simultaneously with *Care in the Community* which proposed the more rapid implementation of community-based policies in this country.

It may be that the lack of British research in this area has meant that some of the problems which have afflicted the same type of policy in the USA have not been fully recognised in this country. Much of the American experience provides serious grounds for concern. It has, for example, been noted that chronically mentally ill people may be discharged into poor and deprived areas of cities where they receive few services and where the community is unreceptive, uncaring and resistant. There are signs that newly inaugurated community-based services fail to pick up recently discharged chronically ill patients, and that there is duplication and lack of co-ordination between agencies dealing with their care (21, 22). It has also been found that it is almost impossible to transfer money tied up in psychiatric hospitals to community services (23).

British proposals for community care do recognise some of these difficulties, particularly with regard to the financial organisation and transfer of patients from National Health Service (NHS) to local authority care (24). It is doubtful, however, whether the lessons of recent American and historic British experience of community neglect of the mentally ill have really been learnt. Even now there is evidence of patients discharged from hospital ending up living rough on the streets or in hostels for the homeless (25). So far,

adequate provision of resources in the community has lagged well behind demand (26). Even where residential care is situated in the community it can be just as negative in atmosphere, and just as institutionalised and separated from the wider community as that available in hospitals (27).

As welfare expenditure declines local and health authorities may be less able and willing to make extra new provision for mentally ill people, despite the priming money made available for this purpose. It has always been possible within the health service to divert money away from the mental illness sector into more prestigious fields (28) and despite overtly expressed governmental intentions there is informal evidence that new projects are not being initiated at the local level (29). The frequent re-organisations of the NHS in the last decade have not facilitated co-operation between local authorities and the NHS in providing community psychiatric services (30).

To the practical potential difficulties with the policy of community care must be added semantic, evaluative and theoretical aspects inherent in the very concept of community care (31). In modern bureaucratic society community is almost always favourably contrasted with institution. The usage of 'community' is loose and variable to the point where different users may be talking about completely different things (32, 33). The reality of fragmented urban communities which perceive themselves to have no particular responsibility to the mentally ill people billeted in their midst must be used to confront positive evaluative nuances of community which imply a superior brand of personal care to that which might be available in institutions.

The policy of community care has many difficulties and drawbacks which have been ignored or minimised by its protagonists. An American critic concludes his examination on a warning note:

'We have learned what we should have known but missed in our enthusiasm for change. Community life is no panacea unless the patient's suffering is alleviated and social functioning improved. We have learned that community life, without adequate services and supports could be as dehumanising and debilitating as the poor mental hospital. We have learned that if the patient is sufficiently disturbed and disoriented . . . residence in the home or community can cause innumerable difficulties for family and others and may result in a general outcome inferior to good institutional care' (33).

The foregoing analysis makes it clear that it is by no means obvious that the policy of community care for mentally ill people is unequivocally the most appropriate as against hospital care. Both hospital and community care have advantages and disadvantages and their potential effects need to be evaluated from an ethical standpoint (amongst others) before a decision is made as to which, and to what extent, either or both policies should be adopted. Community care currently

enjoys greater favour as an option but this has risks and dangers, for it is largely untried in this country. The hospitals, with their long history, have at least revealed their practical inadequacies and their potential for harm so there is the possibility of changing them on the basis of knowledge and experience to be more beneficial in their effects in the future. The history of the hospitals also provides a warning for those facing the intractable problem of caring for mentally ill people with new policy options, for the asylum movement itself was once regarded as innovative, progressive and humane (34).

Leighton points out the fashionable rather than objectively validated nature of many of the innovations which are suggested:

'These are always represented as progress, a moving away from out of date notions to improve insights and truer understandings. But it is change itself (marked by such prestigious words as creative and innovative) that carries weight, not objective evidence' (35).

Policy options and ethics

So far, an attempt has been made to expose the difficulties inherent in regarding any policy for the care of mentally ill people as simple, unproblematic and common sense. This means that each policy option must be carefully examined and, from an ethical point of view, a comparison of the values which might be promoted or denied by a particular policy or combination of policies must be undertaken. Such an examination would begin by assessing and assembling all available evidence on each policy in a much more systematic way than has been possible here. It might then proceed using some of the headings outlined below.

(A) INTERESTS

Who should benefit most from a particular care policy? It is often assumed that policies of care for mentally ill people are principally made for the benefit of mentally ill people themselves. History, however, suggests that this is not always the case. Frequently society as a whole or particular interest groups in that society appear to have gained more than mentally ill people from policy options.

A policy may function as a facade for hidden interests. Proponents of a particular policy, even professionals who purport to place the interests of their client group first, may have vested interests or hidden intentions which should, as far as possible be exposed. Government, for example, might covertly favour a policy because it appears to be potentially cheaper rather than for its overt reason of wanting the best for mentally ill people (22). By the same token, hospital ancillary workers might oppose hospital closures overtly because they feel that hospitals provide a better service for mentally ill people, but covertly because they fear for their jobs. Neither of these attitudes is necessarily in itself culpable or wrong, but clarity as to

the nature of the argument and the nature of the real interests involved can only facilitate a proper ethical discussion of the options.

(B) POWER

The issue of power enters into an ethical consideration of policy options in two ways. Firstly it may be asked how much power to influence policy each component group or individual in our society actually has, and the effects of this may then have to be ignored or modified so that less powerful groups or individuals can exert an influence. Government, for example, has more power and influence than, say, a voluntary organisation or a mentally ill individual, but in particular circumstances it may not have a moral right to impose its will and policies on others. Secondly, with regard to the actual effects of a policy, it may be asked whose power, influence and autonomy will be enhanced by a particular policy option. The transfer of patients from hospital to community-based care, for example, may enhance the power of social workers who operate in both settings at the expense of that of nurses whose power is greater in hospital settings. It is very possible that the relative power and influence of the patient may not vary whatever the treatment setting. Mentally ill people themselves might well exchange being powerless and at the mercy of professionals in hospital for a similarly weak position in a community setting.

(C) FREEDOM

Within British and American thinking about the position of mentally ill people there is a long and honourable tradition of legal and ethical concern about the rights and freedom of the individual. The individual liberty of the subject requires that people should be subjected to the bare minimum of socially imposed restrictions and encumbrances. Libertarian thinking such as that of Szasz (36) has fuelled and legitimated the call for de-institutionalisation and community care for mentally ill people who may be thought to have a greater chance of exercising their rights and freedoms outside a hospital setting. Such thinking would see the closure of the psychiatric hospitals as a bold strike for liberty. Libertarian enthusiasm may, however, disguise the more complex nature of freedom.

An elementary philosophical distinction in the concept of freedom is often made between freedom *from* and freedom *for* (37). This is the difference between freedom negatively defined as the absence of restraint and freedom positively defined as actively enabling people to fulfil their desires. It should not be uncritically assumed that community care will give mentally ill people more freedom of either type than hospital care and it may give them considerably less positive freedom.

If freedom is conceived as being no more than a matter of non-intervention and *laissez faire* with no provision of facilities and opportunities, it will be of

little value to mentally ill people. Indeed, it could be argued that they would receive more real freedom in hospital. It is easy to assume that institutionalisation and separation from the wider society must represent a diminishment of liberty, but insofar as hospitals meet human needs and provide opportunities, they can be places where rights and freedoms are restored (15).

Further considerations can also be offered under the heading of freedom. These concern whose freedom should be enhanced by a particular policy towards mentally ill people. The freedom and needs of patients must be weighed against those of other affected parties. The freedom of taxpayers is presumably enhanced if a welfare policy is cheaper than its predecessor while it might diminish the freedoms enjoyed by mentally ill people. Similarly, a community care policy might be held to enhance the freedom of patients while at the same time greatly restricting their families, friends and relatives in terms of emotions, financial resources and personal activities.

Finally, it should be noted that underlying this discussion on freedom is the issue of care versus control. If the psychiatric services are primarily required to provide restraint and social control of a troublesome minority deviant group it is not to be expected that positive freedom for mentally ill people will play a greater part in policy decisions and provisions. If, however, society wishes to promote the well-being, potential and positive freedom of patients, that is to exercise care, far greater resources will have to be expended whatever the policy advocated, for care is generally more costly than control. It is important to be clear about the primary function of policies so that a policy of control is not disguised as one of care which is inadequately funded. The psychiatric hospitals have suffered badly in terms of resources because of this unresolved ambiguity (13).

(D) JUSTICE

The concept of justice brings to the fore the question of what is owed to the various parties affected by a specific policy towards the mentally ill, particularly mentally ill people themselves. Three core principles of social justice which differ radically and may conflict with each other can be identified: a *conservative* principle which advocates distribution according to means; an *ideal* principle which advocates distribution according to deserts; and a *prosthetic* principle which advocates distribution according to need (38). Policy towards mentally ill people will be radically different in practice according to which of these core principles predominates in the thinking of its proposers. Proponents of prosthetic justice, for example, are more likely to be interested in providing excellent and adequate facilities for needy people than those who believe that people must be rewarded only according to desert.

This raises the matter of what right mentally ill people have to social justice. There is a real difficulty

here because in practice mentally ill people have often been treated as less than full members and citizens in British society. As deviants they have been relieved of many of their responsibilities but the corollary has been an accompanying diminishment of rights also. Until very recently, for example, hospitalised mentally ill people with no external address were not allowed to vote in elections.

A discussion of the claim of mentally ill people to social justice is necessarily *prior* to a more detailed consideration of the principle of justice under which they should be treated in any particular policy option, for a specific principle adopted may well reflect to a great extent an implicit judgement on the status and rights of the mentally ill people. Adoption of either *conservative* or *ideal* principles of justice in relation to them, for example, might well imply that they should receive little provision from government as they make no contribution directly to the economy and so are not qualified either by means or deserts. As non-persons economically, mentally ill people would only be eligible for charity. Adoption of the *prosthetic* principle of justice would tend to the implication that mentally ill people should be seen as legitimate claimants on social resources and should receive the services they require as a matter of right.

Conclusion

At the time of writing, policy towards mentally ill people in Britain stands at a crossroad. Two main options are available, hospital and community care, and, for the present, a *de facto* decision appears to have been made to allow both to run in tandem. (This in itself may be unfortunate in that it may lead to underfunded community services existing alongside second-rate hospital care in outmoded institutions suffering from an uncertain future, no investment, low-calibre, demoralised staff and a chronically ill clientele.) This allows time for the value of the respective policies to be discussed and evaluated before one supplants the other.

Since 1981 there has been an increased impetus towards closing down the hospitals in favour of community care. This policy presents as a simple solution to an intractable social problem. An attempt has been made in this paper to question the wisdom of such a move without more careful ethical reflection. The assumed superiority of community care over hospital care has been examined and found to be problematic and it has been suggested that in the light of this both community and hospital care need to be exposed to an ethical analysis.

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(continued on page 142)

evident in some cases. The 'community care' approach has already demonstrated severely adverse effects as well as beneficial ones (2), but who is ready to undertake the responsibility of correcting them?

The authors' valuable endeavour in highlighting several important questions about the principles of community care would be strengthened by reference to some more recent literature, including the crucial role of the Maudsley, Exeter, Hackney and Worcester experiments in initiating alternatives to mental hospital care for example (3) in bolstering arguments for trying to multiply and extend these special and qualifiable successes on a massive scale. There is also a need for a more detailed examination of the assumptions implicit in community care policies in the United Kingdom, as was usefully undertaken by Hawks in 1975 (4) who concluded, very much in line with Pattison and Armitage, that 'the movement towards community care has many of the attributes of a moral enterprise which, unless substantiated by benefits to the patient or his family, may be the latest diversion of the psychiatric conscience from the care and treatment of the chronic mentally ill'. The authors' attempt at an ethical analysis needs to be extended to show how specific issues about the implementation of policies in a particular place may, in the light of factual evidence, be broken down into identifiable and answerable questions. Without this there is a great danger (as I have repeatedly experienced) that the importance of ethical debate is dismissed as hopelessly vague, imponderable and negatively obstructive by those impatient to get on with the job of closing hospitals (and to meet directives with important implications for career advancement). Broken down into more particular questions about the estimation of benefits and risks for particular mentally ill people in particular localities, the ethical (as opposed to the financial, geographical, architectural and other issues which crowd in on any discussion of 'community care') can be seen a bit more clearly as difficult but essential and examinable issues, for which ordinary general,

rather than specifically medical, standards of humanitarian concern and objective truth provide guidance.

When I see the squalor and degradation in which many mentally ill patients disowned by hospitals and local authorities currently live, when I hear that our precious nurses (now condemned in the newspeak of 'community care' as 'custodial' and 'institutionalised') are leaving a hospital identified as due to close, or when I read some of the vacuously simplistic proposals about the new services envisaged, I fear it may already be too late. The property speculators must be rubbing their hands.

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Editor's note

The editor has been unable to obtain a commentary arguing the case tending to favour closure of mental hospitals and reliance instead on 'community care'. Perhaps publication of the preceding articles will evoke such responses.

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