Community care - same problems, different epithet?

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Abstract

A negative image of community care prevails. This method of care is perceived to be a relatively novel phenomenon and has received mixed media coverage. The negative image of community care has led to the growing belief that this care method has failed. This failure has largely been ascribed to the lack of powers available to control patients in the community and to the method's relative novelty. However, this paper contends that there are two flaws to the above assertion: first, community care is far from new, and second, the inherent problem is not the lack of powers available to control patients in the community, but, essentially, the absence of a secure and stable environment within the community.

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The community environment

In order to set this discussion in context, it is necessary to outline the main features and principal problems which have affected the practical introduction of community care. The provision of community care is founded upon two elements: the theoretical development of the concept and its practical implementation. Each component has a vital role to play and without sufficient practical support, the scope of community care as an adequate replacement for institutional care is severely restricted. In recent years there has been much documented evidence suggesting that the practical implementation of community care has fallen short of what is required.¹⁻² Such failures have presented themselves in many forms, such as oversights in care plan provision, inadequate housing provision and inadequate day-to-day support from mental health services. The community cannot maintain the same levels of security as that of an institution, and without the required support, community care faces a much greater challenge. Although greater provision of facilities, services, staffing and money would aid the implementation of community care, this is not to say that such provision would make all its problems vanish. However, unless adequate provision is made, the community represents an environment

which does not have the qualities needed to care for vulnerable people.

The framework of the 1995 act

The Mental Health (Patients in the Community) Act 1995 amends the Mental Health Act 1983 by providing a new category of patients who can be subject to after-care under supervision. The act creates extensive powers for psychiatrists to determine the terms in which a patient will be allowed to live within the community. These powers are supported by sanctions.

A psychiatrist may apply for a supervision order if the patient is suffering from a mental disorder and there is a substantial risk to the health or safety of the patient or to others, or there is a serious risk that the patient may be open to exploitation if no supervision is provided. If the application is successful, both health and social services departments are empowered to determine a specific place of residence for the patient, they can require the patient to attend rehabilitative centres and they must ensure the patient's case is kept under regular review.

Entitlement to, and failure of, community care

Community care is now fully operational. Many patients have been living in the community for many years and the evidence available suggests that certain failings in the concept are creating difficulties for patients and third parties. During the 1990s a succession of violent incidents occurred, sparking a series of inquiries and mass media interest. The outcomes of the reports have been depressingly similar, their conclusions being, that certain factors have an impact upon the patient living in the community.

Where patients fail to continue their medication after discharge, their mental state deteriorates and it is then that they become a danger to themselves and to others. However, ensuring medication is taken relies upon an adequate framework of care within the community, maintaining communicative links with patients and making sure they have access to medical services. Ensuring this network

continues depends upon sufficient resources. Without an adequate framework, communication links and patients' access to medical services, obtaining a stable environment of care is difficult, so that the opportunity for patients becoming lost to the caring framework increases.

Perhaps the cause of most concern can be found in the confidential inquiry of the Royal College of Psychiatrists, which observed that although all the reports have formulated very similar conclusions, the problems remain. "...This leads us to the alarming conclusion that these individual reports make little lasting impact on services for mentally ill people..."³ How many reports have to be commissioned before more than mere acknowledgement of the inadequate arrangements for community care is made? How many people have to be hurt or killed? How many patients have to live on the streets, suffering perpetual cycles of their untreated disorders without steps being taken to provide a more all-encompassing system of care?

Guardianship and less restrictive care

Guardianship, which was provided in the Mental Health Act 1959, offered a non-institutional form of care, however, the institutional attitude of more traditional methods of care continued. It was hoped the use of a less restrictive technique of care would lead to fewer institutionally dependent patients needing care in the future. The guardian's powers were wide: the guardian could prevent the patient from leaving home, and from giving up employment, could restrict or prohibit social interaction and could even prevent the patient adopting anti-social behaviour. Although the central theme of the 1959 act was the encouragement of guardianship and less restrictive care, the ideology of institutionalisation was still predominant. Segregation was the result of this attempt to achieve a satisfactory balance between third party protection and patient welfare. The 1959 act's provisions illustrated the increasing insight into differing methods of caring for the mentally disordered. However, the model maintained a highly paternalistic approach.

Essential powers

It was this inherent paternalism, found within the early guardianship provision, which led to the changed emphasis in the 1983 act. Liberalism was considered to be the key to a successful guardianship order and as such, rather than a plethora of powers being granted to the guardian, a number of essential powers were adopted (section 8): the power to ensure the patient "...reside[s] at

a...[certain]...place..."; the power to require the patient to attend places for the purposes of medical treatment, and, the power to require access to the patient.⁴

Although this new attempt at finding a successful guardianship provision placed heavy emphasis upon liberalism, the guardianship provision within the 1983 act continues to suffer from a number of problems. It can no longer be charged with being too paternalistic and thus compromising the patient's freedom. However, by adopting a liberal approach, difficulties have emerged from the other extreme. A fundamental flaw is the lack of sanctions available to the guardian when trying to enforce his or her "essential powers". Within the community, it has proved difficult to ensure the patient cooperates and difficult to detect when the patient has ceased to fulfil the requirements attached to community living. Therefore, "...[I]n essence, the effective use of compulsory powers is inherently linked to the institutional context; the awkward reference to the person living in the community as the 'patient' revealing of the contradictions of the power..."⁵ Ethically, it is difficult to justify the provision of sanctions within the community environment as this leads to a contradiction of the inherent ideology of less restrictive care so that the effectiveness of guardianship is impeded.⁶

Guardianship's effectiveness is reliant upon patient cooperation. Those patients who are willing to accept the guardian's directions, as Gunn observes, are likely to be cooperative, and therefore, the guardianship order is "...almost redundant..."⁷ The lack of sanctions has led to guardianship being disregarded as a potential method of care. Guardianship, since 1983, has been viewed as unworkable because of the extreme change in the balance of powers. By adopting a patient-based ideology, the 1983 act has failed to achieve the necessary balance between patient liberty and third party protection that is essential for the successful working of community-orientated provisions. This failure has resulted in practitioners looking at other provisions within the 1983 act to provide the desired scope for community care.

Extended leave

Extended leave makes available a "...medically controlled power to impose treatment in the community which does not involve the cumbersome decision-making procedures of guardianship..."⁸ Section 17 of the 1983 act provides for a patient to be granted leave of absence from the hospital where he has been detained. The period of leave can be for a specified time or an indefinite period

(section 17(2)) as long as this is within the six-month detention term (section 20(1)). Section 17(3) incorporates a "safety test" for it enables the responsible medical officer (RMO), when granting the patient's leave of absence, to direct that the patient must remain in custody during this period of leave if it is necessary in the interest of the patient or for the protection of other persons. As the patient is still liable to be detained, he is still subject to the consent-to-treatment provisions in part four of the 1983 act. This flexibility allows the patient to live within the community whilst allowing for the additional safeguard of having the consent-to-treatment provisions available.

The principal aim behind the use of extended leave is patient rehabilitation. Extended leave has, therefore, been used as a preliminary measure to establish the extent of patient needs once in the community. However, extended leave should only be available to patients who still require in-patient care. Therefore, the application of leave of absence is restricted to patients who can still be said to fulfil the section 3 admission-for-treatment criteria, but who may be well enough to experience a less restrictive method of care. If the patient is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment, and/or treatment is considered appropriate and detention is necessary for the health or safety of the patient or for the protection of third parties, the patient may be detained under section 3. The increasing use of extended leave illustrates the gradual acceptance of the community care concept as an alternative method of care.

Variations upon a theme?

(A) THE 'LONG LEASH' TECHNIQUE AND THE HALLSTROM RULING

In addition to the preferred use of extended leave, psychiatrists developed their own form of community care. The adopted practice was based upon the use of extended leave where leave was granted to the patient with the condition that the patient cooperated. If the patient did not fulfil the conditions of the order, leave would be revoked and the patient would be recalled to hospital. Once the six-month period of leave had almost passed, psychiatrists would recall the patient to hospital for a nominal time so that a further application could be made for the period to be renewed (section 20(2)). This arrangement became known as the "long leash" technique and became a popular method of care because it could be continued *ad infinitum* but the patient could still become subject to in-patient care if necessary. The "long leash" enabled the patient's right to liberty to be

satisfied, yet also established a strong infrastructure of control within the treatment method sought to enable the protection of third parties. This scope was appreciated by the medical profession and therefore, the "long leash" was widely practised until the decisions of *R v Hallstrom, ex parte W* (No 2) and *R v Gardner, ex parte L* were made.⁹

Both Miss W and Mr L had a history of mental illness and although each had had long periods of hospitalisation, at the time of the actions both were living within the community. McCullough-J observed at page 310 that under section 20, the renewal provision could only be used where it was believed the patient's mental condition necessitated further in-patient care.⁹ In both cases, the RMOs recalled the patients so that their detention periods could be renewed and leave could be granted for a further six months. McCullough-J said at page 317, "...[p]arliament did not intend that the provisions for renewal should embrace those liable to be detained but not in fact detained..."⁹ So use of the renewal provision for anything other than to administer in-patient treatment is contrary to the purpose of the act.

Arguably, the *Hallstrom* decision was one factor which added to the pressure to create a community care order. If *Hallstrom* had not been decided, the sudden interest in finding alternative ways of controlling patients in the community may not have emerged. The use of extended leave and the renewal provisions were adapted so that long term community care could be established, unofficially providing the advantage of the patient remaining subject to the mental health legislation whilst also providing more patient freedom. However, *Hallstrom* provided that no adaptation could be justified as this was not the intention of the act and although, on the surface the "long leash" appeared to offer the patient greater freedom, in reality, as the "long leash" could be continued indefinitely, the patient's liberty could be compromised. The taking of this stance by the court has led to further unofficial changes in treatment techniques to counter-balance the effect of the decision.

(B) THE NEUROLEPTIC DRUG DEPOT TECHNIQUE

Although *Hallstrom* made the use of the "long leash" technique unlawful, arguably, a similar procedure continues to be carried out. For schizophrenics, one method of treatment is to use long term neuroleptic drug depots. The depots may last up to four weeks. Patients detained under section 3 have been treated in this way and have subsequently been granted leave of absence. A condition of the leave is that they receive further

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injections, so maintaining their treatment. The use of such depots is effectively a variation of the traditional leave of absence provision. If the patient does not comply, he will either be persuaded to have the injection at home or if he refuses to cooperate, under section 17(4) his leave may be revoked. The legality of neuroleptic drug depots is questionable and could arguably, be said to resemble the "long leash" technique. The patient can be treated in hospital without his consent under part four of the act and then granted leave of absence into the community. For up to four weeks, the patient can live in the community fully medicated yet is still ultimately subject to the mental health legislation. Therefore, the paternalistic and restrictive ideology of the 1983 act may still be applied to the patient in the community. Ethically, the use of depots also raises difficulties. The treatment technique allows the patient to live in the community so that he does not become institutionally dependent, however, the technique has the potential to create a false sense of security. On the surface the patient maintains his liberty but he does not regain his autonomy, for his decision-making capabilities are coloured by the requirement to receive drug depots, so subjecting him to further control. The use of drug depots has gained popularity with the advent of the official community care policy and as the concept has become more fully implemented and the failures have emerged, drug depots have been relied upon. Drug depots circumvent the need for more staffing, facilities and money, for the technique provides the mental health care system with a window of time when the patient can live without intensive support. Drug depots provide an alternative care method which avoids the problem of patients discontinuing their medication. However, it adds to the problem for no steps are being taken to solve the problems of community care which are outlined in recent reports.

Coercion

The use of extended leave in all its manifestations appears to have suffered difficulties with its practical workability, leading to its ultimate failure. The failure of the extended leave provision and the "long leash" provision can be linked directly with the requirement that for the provision to be applied, the patient must fulfil the section 3 admission-for-treatment criteria. The "long leash" was declared unlawful in *Hallstrom* because such requirements were not adhered to. The "long leash" technique glossed over this, which led to many patients being subject to control within the community. The use of drug depots equally fails because the patient is similarly controlled within

the community. These techniques work on the basis of coercion and do not have the same safeguards that can be derived from the extended leave provision. The threat of having the leave revoked if medication is not taken has proved to be enough for many patients. Equally, if *Hallstrom* made the "long leash" technique illegal, should the use of neuroleptic drug depots not be assigned the same label? For the inherent foundation of this technique is the same as that of the "long leash" technique.

Conclusion

The attempts to use the 1983 act's provisions to meet the new challenges of community care have either failed, been declared unlawful or simply do not provide the patient with the safeguards he needs. As these attempts are merely a way of counter-balancing an ever-changing position, the additional safeguards placed within the 1983 act cannot be used effectively in conjunction with these attempts and as a result, the patients involved are left open to abuse. The use of these community-orientated provisions on an unofficial basis has led to patients being left unprotected by the legal system.

Community care has been a continually developing concept, having been given a legislative footing with the enactment of the Mental Health (Patients in the Community) Act 1995, which has been heralded as a solution to the problems which beset the community care concept. Although such a stage has been reached, it has to be accepted that the theoretical basis for the concept has been present for many years. However, even with this knowledge, the practical problems of the community-orientated provisions which have persisted in the past could potentially still permeate the workings of mental health care practice today and in the future, if steps are not taken to rectify past problems. It is hoped that the supervised discharge order introduced by the 1995 act may be able to counter-balance the problems found in the past and provide a more fully operational community care provision. The introduction of the supervised discharge order was intended to place community care on an official footing, providing the psychiatric patient with more freedom whilst also ensuring the protection of third parties. However, the practical implementation of community care in its present form illustrates a number of failings and these failings are influencing the philosophical construction of the 1995 act provisions. Without the practical support which is vital for successful implementation, supervision in the community is developing libertarian characteristics. If the patient fails to co-operate with the

requirements attached to the supervision order, what can be done to change this? If the patient decides to leave the dwelling he has been assigned, how can the authorities trace him? How can the authorities prevent the patient becoming lost to the mental health system? It seems that community care only has a good chance of success when there is a strong framework of care, a healthy legislative position, and the provision of plenty of community facilities. The legislative position does not appear to be strong since the same mistakes which have dogged past provisions seem still to be present. Equally, the provision of facilities and services has been severely restricted. Care in the community as a theoretical concept is beginning to re-focus towards caring by the community in practice and as such the burden of care has begun to shift towards the relatives of mentally disordered people. The problem of the relationship between theory and practice appears to have been seriously underestimated. Without practical provision working in unison with theory, it is little wonder that the supervised discharge order has been operated so as to allow the adoption of more liberal tendencies. The success of care in the community is dependent upon the inter-relationship between theory and health care practice. The balance of power between those involved in mental health care, whether seen from the perspective of

either the user or the provider, could be more adequately achieved if the necessary practical support in all its realms, from housing through to assistance with social security benefit applications, was provided. Realistically, all the required assistance may not be provided because of lack of funds. However, by appreciating the necessity for adequate community support, the scope of the supervised discharge order may be improved.

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References

- 1 Woodley L *et al.* *The Woodley team report*. London: East London and the City Health Authority and Newham Council, 1995.
- 2 Ritchie J *et al.* *The report of the inquiry into the care and treatment of Christopher Clunis*. London: North East Thames and South East Thames Regional Health Authorities, 1994.
- 3 Steering Committee of the Royal College of Psychiatrists. *Report of the confidential inquiry into homicides and suicides by mentally ill people*. London: Royal College of Psychiatrists, 1996.
- 4 Mental Health Act 1983: section 8.
- 5 Fisher M. Guardianship under the mental health legislation: a review. *Journal of Social Welfare Law* 1988: 316.
- 6 Miller RD, Fiddleman PB. Outpatient commitment treatment in the least restrictive environment. *Hospital and Community Psychiatry* 1984: 142.
- 7 Gunn M. Mental Health Act guardianship: where now? *Journal of Social Welfare Law* 1986: 144.
- 8 Fennell P. *Treatment without consent - law, psychiatry and the treatment of mentally disordered people since 1845*. London: Routledge, 1996.
- 9 R v Hallstrom ex parte W (no 2) and R v Gardner ex parte L [1986] 2 All ER 306.