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Is compulsory community treatment ever justified?

On the evening of 23 February 2000 at the Maudsley Hospital in London the motion 'This house believes that compulsory community treatment is not justified' was debated in front of an audience of mental health professionals, carers, service users and other members of the general public. Peter Campbell, a mental health system survivor, and Dr Frank Holloway, consultant psychiatrist at the South London and Maudsley Trust, supported the motion. Cliff Prior, Chief Executive of the National Schizophrenia Fellowship (NSF), and Professor Tom Burns, professor of community psychiatry at St George's Hospital Medical School, opposed it.

The need for compulsory community treatment (CCT) has been considered in the past (Department of Health and Social Security, 1976), particularly since the judgements in 1985 (R *v* Gardner, 1985; R *v* Hallstrom, 1985) made it unlawful to use extended leave to supervise a patient in the community. The College produced a discussion document on community treatment orders in 1987, but the membership was divided over whether to proceed with the proposals (Royal College of Psychiatrists, 1987). In 1993 the College approved a report recommending the more limited Community Supervision Order (Royal College of Psychiatrists, 1993). The issue of compulsory treatment in the community was debated at the College in 1994, with Frank Holloway and Tom Burns participating, before an audience largely consisting of psychiatrists (Turner, 1994). A vote was taken; the audience of approximately 80 people voting three to two against the introduction of CCT. Since then a series of inquiries (Petch & Bradley, 1997; Appleby *et al*, 1999) have kept the issue of CCT firmly on the political agenda, culminating in a proposal that a new Mental Health Act should include a compulsory order allowing any treatment sanctioned by an independent tribunal to be enforced outside hospital (Department of Health, 2000; Richardson, 1999). The Maudsley debate addressed itself not just to the Government's proposals, but the issue of CCT more broadly.

The Maudsley debate was audiotaped and transcribed in full. We describe here the themes emerging during the debate, and discuss how these have changed in the 6 years since the CCT debate at the College.

The argument against CCT

> "I think . . . patients won't have the authority to negotiate at all their medication regimes and people will end up being pumped with sedative effects and zombified." (A comment from the floor of the debate)
>
> "We are increasingly, as professionals, expected to act as agents of social control on the mythical basis that in some way community care and deinstitutionalisation has put the public at increased risk. And there is actually quite good data to show that that simply is not true." (Extract from Frank Holloway's speech)

The use of CCT was described as a quick fix; a panic response to the wrong problem; a further step towards a custodial approach to community care; destructive of therapeutic relationships; discriminatory; drastic; and unethical. A recent statement by a government minister that ". . . non-compliance with agreed treatment programmes is not an option" was challenged (Department of Health, 1998). Nine out of 11 comments made from the floor were against the extension of compulsion and questions included: how will compulsory orders be enforced?; how will they be regulated and effectively monitored?; and how will staff who abuse their powers be held accountable?

Opponents of CCT saw it as a negative development for everyone involved with mental health services. The focus upon mental health care treatment and support would be replaced by a greater emphasis upon control, restraint and threat. It was recognised that some service users are non-compliant with treatment plans. However, Frank Holloway suggested that attempting to solve this by legitimising forcible treatment failed to address several fundamental issues. First, there are reasons why service users are non-compliant with medication, and other treatment strategies, and these need to be addressed. Second, the introduction of compulsion might drive patients away from services, causing delayed presentation of symptoms, leading to worse outcomes. Ethnic minority groups are likely to be targeted for CCT and may develop increased fears and avoidance of psychiatric services. Third, a fundamental ethical problem is raised if people with mental health problems who have the capacity to refuse medication and other treatments have no right to do so, while other groups in society retain this right.

It was argued that CCT may come to be seen as 'the easy option'. Less emphasis will be placed on the

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therapeutic relationship between professional and service users, which itself will be damaged when the relationship is legally imposed. There will be less incentive to invest in non-drug therapies and the role of in-patient care will be degraded to the treatment of last resort. In practice, compulsion may be far from easy to enforce. Concern was raised over how professionals would 'keep tabs on' users' compliance with all aspects of the care plan. Finally, it was suggested that the culture of coercion might deter potential nurses, doctors and social workers from entering mental health professions, with both patients and professionals being stigmatised by the use of compulsion.

The focus of discussions about the proposed compulsory order on medication compliance raised concerns for several service users. One individual noted that the ability to negotiate a treatment regime with the consultant psychiatrist would be weakened under a compulsory order and this is unhelpful, particularly when older neuroleptic drugs are used, which have disabling side-effects. The government has tried to reassure service users that people will not be forcibly "injected on the kitchen table". Peter Campbell did not find this reassuring,

> "The question is not where we are when the needle goes in, but why this injury is happening at all. . . . If treatment compliance is desirable, it should be achieved through cooperation and consent."

It is not only medication that will be enforced through the use of CCTs, but all aspects of the care plan, such as day centre attendance.

The argument for supporting CCT

> "When I have lost myself I pray that someone will get me the treatment I need because I cannot ask for it myself." (A patient's comment reported by Cliff Prior, NSF)
>
> "I am opposed to the motion for one reason and one reason only. It is because acute wards are so bad." (A comment from the floor of the debate)

Against the motion, it was argued that CCT is justifiable on the grounds that it is preferable to treat an individual with severe mental illness in the least restrictive environment, avoiding the disruption and damage caused to an individual's life by repeated hospital admission. Compulsion in the community enables service users to have as much freedom as possible while receiving the treatment that they need. Moving compulsory treatment into the community from the hospital is also desirable because it increases professional accountability. Tom Burns stated:

> "The issue facing us is whether compulsory treatment should remain behind the walls of hospitals or be allowed also to be used outside hospitals. . . . I am always sceptical of what people do behind closed doors."

Cliff Prior described a survey carried out by the NSF in which 58% of respondents (carers, service users and professionals) reported that compulsory treatment in the community was a good idea (NSF, 1999). Respondents accepted the place of CCT where it could prevent relapse and ensure services were accessed before people deteriorated to a state where they required a hospital admission. This treatment could be life saving, and ". . . When we discussed this within the NSF, two user members said . . . they would not be alive to enter into the debate about the powers of compulsion had they not been subject to it when at their most ill." However, NSF survey respondents were also concerned about the possibility that people with mental health problems could be subject to excessive and unregulated use of compulsion, which would deter people from making contact with services initially. While defending the need for compulsory treatment in principle, Cliff Prior suggested that the Green Paper proposals for a compulsory order were inadequate; increased compulsion should not be introduced without reciprocal rights to care and treatment. Other important safeguards would include monitoring of the orders, which should be time-limited, by an independent body and restriction of the orders to people who would otherwise have been in hospital.

When presenting arguments in favour of CCT Tom Burns emphasised that in proposing the introduction of compulsory powers in the community ". . . we are talking about compulsion, we are not talking about force". Damage to the therapeutic relationship was challenged; a compulsory order would require a relationship with the service users, based at least in part on mutual respect and trust, in order to work. In countries that use CCT the number of individuals affected is small (see, for example, Torrey & Kaplan, 1995; Power, 1999), as are the numbers currently subject to supervised discharge (Section 25) and guardianship in this country. CCT would not be used to 'sweep the streets' of people who are determinedly non-compliant.

While acknowledging that some people do have bad experiences of mental health services, Tom Burns defended the skills of clinicians and their role as users' advocates. If clinicians are given additional powers to enforce treatment this does not mean they will stop using their judgement and many years of professional training to maintain therapeutic relationships when people are having difficult times. Compulsion will not replace the use of other therapeutic strategies in the community, it is a humane alternative to hospital admission for a small group of individuals.

Discussion

Many of the points made in the Maudsley debate have changed little over the 6 years since the topic was debated at the College (Turner, 1994). On the one hand it is suggested that CCT provides a humane, ethical and essential way of managing difficult relationships in community-based mental health services. Opponents argue that it is a form of social control that will undermine therapeutic relationships and substitute it with blanket medication with damaging side-effects, denying autonomy over treatment decisions in a way that discriminates against users of mental health services.

Turner (1994) concluded his summary article of the College debate by calling for further research on the effectiveness of compulsion to ensure that the decision to introduce compulsion in the community was evidence-

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based. Some research has been carried out in the ensuing years and was discussed at the debate. Out-patient commitment in the USA has been evaluated and reviewed, but studies have reportedly produced conflicting results (Swartz *et al*, 1999). A critique of the out-patient commitment randomised controlled trials in the USA concludes that their results do not support the contention that CCT can reduce hospital admission (Szmukler & Hotopf, 2001). The presumption that mental illness is linked to dangerous behaviour has been particularly prominent in media coverage of community care in recent years, and has been central to the drive for reform of the Mental Health Act. Participants in the debate cited evidence showing that over the past 38 years the proportion of homicides committed by people with a mental illness has fallen (Taylor & Gunn, 1999). It appears that it is not research evidence that is the driving force behind the possible introduction of compulsory community powers.

The introduction of CCT legislation in England and Wales will be a controversial decision and although the consultation period for the Green Paper on Mental Health Act Reform (Department of Health, 2000) has ended, the debate on CCT will continue. Any introduction of compulsory community powers is likely to divide professionals, patients, carers and other members of the general public as was shown at the Maudsley debate. Research on professional attitudes towards CCT suggests that professional groups vary in their support for compulsory treatment with community psychiatric nurses, who will be closely involved in implementing these powers; most opposed (Burns *et al*, 1995). Research on supervised discharge shows that the use of compulsory supervision varies nationally (Pinfold *et al*, 1999), in part a reflection of professionals' attitudes towards the effectiveness, and ethics, of using compulsion in community settings.

Have attitudes to CCT changed since the College debate in 1994? The Maudsley debate audience were asked to vote on the motion both before and after the arguments had been heard. At the end of the debate 116 (57%) supported the motion, 69 (34%) opposed it and 19 (9%) abstained. Although the College and Maudsley audiences were different, the Maudsley debate being open to the public and including service users, carers and a range of professionals, the two-thirds majority against CCT was similar at both debates. Though public and political concerns about risk may have increased, it does not appear that a consensus about its acceptability or effectiveness has been achieved.

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