Compulsory treatment in the community: some debating issues

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Compulsory treatment in the community has engendered considerable differences in opinion, and the recent rejection of a supervision order by a Parliamentary Committee. The arguments were recently debated, at a Section meeting of the College. More detailed research and a wider discussion within the College, and between the College and other interested parties, is needed. Refining these issues, whatever the legislative outcomes, should lead to improvements in community care.

Community care for those with psychiatric illness continues to raise considerable public and media concern. Proposals for a community supervision order drawn up by a College working party (Royal College of Psychiatrists, 1993) were rejected by a Parliamentary Select Committee. Nevertheless, the government has recently introduced extended leave or 'supervised discharge' which goes some way to acknowledging the pressures for extended powers over patients who constantly relapse. Some unnecessary delays in the use of the Mental Health Act may be due to insistence on a degree of "dangerousness". Yet the phrase used in the standard Form 4, is "this patient ought to be so detained . . . in the interest of the patient's own health or safety" while that in Form 11, is ". . . that it is necessary . . . for this patient's health or safety". Both forms include a statement "the protection of other persons" and either phrase can be deleted if not applicable. Nevertheless, community treatment orders (CTO) have become established in parts of the USA and Australia (Dedman, 1990; Hiday & Scheid-Cook, 1989) and have recently been introduced in New Zealand.

Concern has also been expressed at the lack of a debate about CTO within the Royal College of Psychiatrists. If the College wishes to present further proposals, it must communicate a coherent view. Given the increasing depiction of 'community care' in a pejorative light, and the College's commitment to presenting an authoritative voice on public issues relating to psychiatry, it is surprising that opinions have not been canvassed more widely. However, at a meeting of the Social, Community and Rehabilitation Section, in November 1993, a formal debate was held on the motion 'this house believes that compulsory treatment in the community is a necessary adjunct to community care'. It seems useful to summarise the points thus made, as an outline of what will be a prolonged and contentious issue. The debate also indicated areas of practice needing more detailed research.

Arguments supporting a community treatment order (CTO)

A CTO is essential for those patients who lack insight, constantly relapse, are routinely readmitted under the Mental Health Act, yet inevitably drop out of follow-up after discharge. This is not because of failed aftercare (e.g. the care programme approach). Some patients just refuse to consider that they are ill or need help. The commonest diagnosis is paranoid schizophrenia, and repeated admissions lead to deterioration. Prevention thereof would reduce such public tragedies as the Clunis affair. Under section 41 of the Mental Health Act treatment can be imposed, but only *after* offending behaviour dangerous enough to generate the section 41. Is this a form of community neglect? Research into the imposition of a section 37/41, and into possible gains in insight over time from continued treatment, is clearly needed.

Some patients are extremely difficult to manage on a personal level. Although antagonistic and unlikely to generate therapeutic sympathy, it can be painful to see them deteriorate, despite hoping to (if possible) move them to someone else's 'patch'. Such 'challenging' patients in the community lend a powerful negative image to the otherwise genuine benefits of community care.

Furthermore the logic of the CTO is irrefutable. Why restrict patients on a hospital order to treat them, particularly when hospitals are closing down or becoming considerably smaller? Compulsory treatment, in itself, is a right to which individuals are entitled, thus the CTO is not an extension of powers. Extended leave is still used in Scotland (Chiswick, 1993) and in Jersey (Moate *et al*, 1993). A CTO is essential for a comprehensive, community-orientated service,

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and a moral necessity to avoid the return to the use of asylums.

Better follow-up arrangements would be introduced in the light of a legal requirement. Resources would be targeted to supportive services, rather than crisis admissions. A CTO was not a cheaper option, since history showed that funding generally followed legal obligation.

Previous personal commitment to community care, and misunderstanding how a CTO would work fuelled most criticism. Thus psychiatrists proposing a CTO have not carried their co-professionals (e.g. social workers, community psychiatric nurses) with them. But how representative were the public spokesmen from these professions? Many frontline workers were in favour and knowledge of the debate had been poorly disseminated. Forcible injections on the kitchen table was a typically ignorant scenario.

In particular, the legal profession cannot understand the notion of authority without sanction, whereby 'detained' patients are generally kept on open wards. Sophisticated legal arguments were not necessarily correct. A memorable phrase was "It's easy to be clever if you're not concerned about being right". The semantic mistakes of the community supervision order (CSO) were also acknowledged. The term 'supervision' was incorrect ('treatment' was required); the order should have been time-limited, and general practitioners, social workers and families were not consulted. The need for public education was paramount, since psychiatrists were more likely to be blamed for breakdowns in community care despite the evidence of government neglect.

As to practicalities, a small but clearly disabled target group could be identified. Criteria would include patients repeatedly admitted under section 3, with a reasonable response to medication. Tribunals would safeguard patient rights, and goodwill towards community treatment would improve. Although a CTO required statutory changes, why should this be a counter-argument rather than intellectual laziness? Active outreach workers generally approved of a CTO, as used even in model community care programmes (e.g. Stein & Test, 1980).

Arguments against a community treatment order

From this perspective a CTO was illegal, amoral, and unworkable, allowing community care on the cheap, and replacing personal interaction with blanket medication. Many psychiatrists were successfully practising community care without it. A core clinical skill was engaging in negotiation and a therapeutic relationship. Better education of families and patients, improved compliance training, and improved information was needed. There were effective, culturally sensitive approaches (e.g. Moodley & Perkins, 1990), despite considerable suspicion towards psychiatrists' motives in general. The call for a CTO was due to admission pressures and insufficient rehabilitation beds for relatively few difficult patients.

Furthermore, forcing people to take antipsychotic medication (the essence of the approach) was immoral, taking no account of possible side-effects. Some insightful patients with schizophrenia were willing to accept relapse. The CTO would be a form of social control, placing psychiatrists in a difficult ethical position. Did misbehaviour in public always require treatment? Practices in Soviet Russia remained fresh to the memory in considering the management of social deviancy. Better psychological treatments might reduce the need for medication. It is dangerous for professionals to state that somehow they know it all.

An especial concern was racism, particularly for those working in areas with considerable black populations. Many patients' organisations, including MIND, opposed any form of CTO, and there were increased numbers of black patients in secure accommodation. Black patients more often received ECT and drug treatment (reportedly), thus psychiatrists would be perceived as racist. Appropriate racial and cultural awareness training was not provided by the College. Broader concerns involved the European Convention on Human Rights, which would probably reject compulsion except toward those overtly 'insane'.

The practicalities of the CTO were also unworkable. Would not systems of leave and recall be extremely clumsy? Forcible treatment at home was impractical so patients would still require hospital. Would families agree? How would consent and treatment plans, and other legal niceties be clarified? Anyway, Parliament would reject such an order. Increased responsibility would devolve upon psychiatrists, with fewer actual resources. The profession would be politically exposed, blamed for over-control and scapegoated for any public tragedies.

More generally, section 3 could be more pro-active, since, unlike the USA and Australia, dangerousness was not required for admission. What was the difference between section 3 and recalling someone under a CTO? If health was at risk, should there not be a full evaluation by doctors, social workers and family rather than by one over-empowered individual?

Finally, welfare benefits and other social supports should be used more imaginatively and more assertively, maintaining psychosocial stability through positive reinforcement to stay on medication. Impoverished individuals were often left in bleak surroundings awaiting the monthly depot visit. Linking monthly sickness certificates

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to continuing treatment was already practised. Avoiding negative legal restriction would also reduce the 'power' stigma attached to psychiatrists.

What should happen now?

While not comprehensive, this outline probably represents most members of the College and wider discussion should lead to useful research questions. Do patients improve, in terms of insight and social stability, over the course of continuing treatment? What are the resource implications when CTOs operate? What are the opinions of community psychiatric nurses, approved social workers, and other relevant individuals (e.g. families, the police)? How would a CTO affect the public's critical attitudes towards community care?

Such questions need answers, and those working in the community need to inform the public about the realities of current arrangements. The likely benefits and difficulties and the relative resource implications need clarification. Unless public and Parliamentary opinion has been informed and canvassed, the College would be foolish to request a CTO whatever the pressures and under-resourcing in mental health. Nevertheless, this very process might usefully shape Parliamentary thinking. Libertarian concerns might insist that, for example, psychiatric manpower at all levels of qualification is significantly improved.

Acknowledgements

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