editorial

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# Care and compulsion in community psychiatric treatment†

Involuntary out-patient treatment was introduced in many parts of the world in an attempt to slow the 'revolving door' status of certain psychiatric patients and to permit effective community management. Involuntary out-patient treatment includes all forms of compulsory out-patient treatment, ranging from community treatment orders to conditional discharge and guardianship. Recent controversy has focused on community treatment orders and court ordered involuntary out-patient commitment. Proponents argue that such treatment reduces hospital recidivism, improves medication compliance and permits better use of community resources. It should be noted that few jurisdictions permit forced medication in the community as part of involuntary commitment.

Much has been written about the ethical and human rights issues raised by involuntary out-patient treatment (McIvor, 1998; Miller, 1999). Critics have argued that such orders infringe civil liberties, extend unwarranted coercion into the community and may actually drive people away from treatment (Mulvey *et al*, 1987; Moncrieff & Smyth, 1999). As yet, very little information is known about who might benefit from involuntary out-patient treatment, or the extent to which out-patient commitment affects compliance and treatment when essential community services, such as intensive case management, are consistently applied (Swartz *et al*, 1995).

## Efficacy of involuntary out-patient treatment

In this issue O'Reilly (2001) reviews the clinical efficacy of involuntary out-patient treatment in the light of recent research. In a field dogged by methodological difficulties, findings have been conflicting and, regarding efficacy, the jury is still out. Swartz and his group in North Carolina (Swartz *et al*, 1999; Swanson *et al*, 2000) have published the largest randomised controlled trials to date. The authors did not dwell on their most significant finding, which showed those undergoing out-patient commitment did not differ significantly from controls in terms of hospital outcomes. They did, however, focus on the results of a complex *post hoc* analysis showing those who spent greater than 6 months on the order had fewer admissions and spent less time in hospital. Similar findings were found regarding incidence of violence. Despite this positive gloss, the authors stress that involuntary out-patient treatment operates only when it is sustained and combined with relatively intensive community contact, and appears to be most beneficial in those suffering from non-affective psychoses disorders. The findings suggest that involuntary out-patient treatment might work only when the principle of reciprocity, the right to adequately resourced care in exchange for further infringement of civil rights, is applied (Eastman, 1994) and when emphasis is given to service provision, such as the mental health teams' ability and willingness to deliver required care (Geller, 1990). Lack of resources is an important issue in a system that is already strained at the seams in many inner-city areas.

## Reform of the Mental Health Act (1983) and involuntary out-patient treatment

Because of the perceived failure of community care (Warden, 1998), the present Government seems set to proceed with new legislation increasing the use of coercion in psychiatric practice. Governments in the past have shied away from compulsory powers because community and professional support was lacking (Thornicroft, 1993; Eastman, 1997) and such legislation was thought to be inconsistent with the European Convention on Human Rights (Department of Health, 1993). A recently published Green Paper, *Reform of the Mental Health Act 1983 – Proposals for Consultation* (Department of Health, 1999*a*), outlines root and branch reform and presents a new legal framework within which mental health care may be delivered. The document includes proposals for "extending the powers of compulsory care and treatment beyond hospitals", including the initiation of a compulsory order without prior admission to hospital. Initial reaction has been critical (Szmukler, 2001; Szmukler & Holloway, 2000).

An expert committee, made up of professionals drawn from psychiatry, nursing, community care and law, was asked to advise on Mental Health Act reform and comment on initial Government proposals. Their report (Department of Health, 1999*b*) helped formulate the proposals in the Green Paper. Unfortunately, the proposals set out by the Expert Committee appear to

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editorial

have been misrepresented or modified to suit the aims of the bureaucrats. While both propose compulsory community treatment, the Expert Committee recommends a highly constrained order and emphasises the importance of non-discrimination, patient autonomy, reciprocity and capacity. The Green Paper regards risk as the key factor on which compulsion should turn and provides criteria for compulsion that are so broad as to include virtually anyone who suffers from mental disorder. While the Expert Committee is clear that forced medication could only be given in a hospital environment, the Green Paper is non-committal and does not appear to address the question directly. Most alarmingly, the Green Paper proposes that a tribunal could prevent discharge of patients from compulsory orders when this is against the wishes of the clinical supervisor. Together with proposals that untreatability will no longer be an impediment to continued compulsion, members of the mental health team may increasingly be placed in the unenviable position of being social supervisors rather than treating clinicians.

## Future options

In the current political environment, little enthusiasm has been generated for alternatives to involuntary out-patient treatment, such as advanced directives (Halpern & Szmukler, 1997), the use of crisis cards and joint crisis plans (Sutherby & Szmukler, 1998), stimulating case management efforts, mobilising supportive resources and improving individual compliance. Under current UK legislation clinicians already have considerable powers in compulsory community treatment, albeit for a limited period and with the requirement of compulsory admission to initiate it. Additional options, such as using or modifying existing powers more imaginatively through greater use of leave of absence provision or guardianship, or linking compliance with social welfare benefits, have not been explored fully (Dyer, 1998; Sugarman, 1999).

Where used, the negative impact of compulsory treatment orders, predicted by critics, has not materialised (Burns, 1999). Therapeutic relationships tend to be maintained and re-hospitalisation not excessive. However, despite recent research findings, there is not yet enough evidence to demonstrate that involuntary out-patient treatment is significantly and consistently better at ensuring adherence to community treatment and reducing hospital usage than a fully functioning and well-resourced community service. If it is to be introduced in the UK, community clinicians and relevant stakeholders must be at the forefront of the legislative process, ensuring a capacity based approach and emphasising non-discrimination and autonomy. Involuntary out-patient treatment is not an alternative to service development or appropriate education and support, and should be designed in such a way as to have the support of treating clinicians.

## References


BURNS, T. (1999) Invited commentary: community treatment orders. *Psychiatric Bulletin*, **23**, 647–648.

DEPARTMENT OF HEALTH (1993) *Legal Powers on the Care of the Mentally Ill in the Community. Report of the Internal Review.* London: Department of Health.

— (1999*a*) *Reform of the Mental Health Act 1983 – Proposals for Consultation.* London: Department of Health.

— (1999*b*) *Report of the Expert Committee. Review of the Mental Health Act 1983.* London: Department of Health.

DYER, J. A. T. (1998) Treatment in the community in the absence of consent. *Psychiatric Bulletin*, **22**, 73–76.

EASTMAN, N. L. G. (1994) Mental health law: civil liberties and the principle of reciprocity. *BMJ*, **308**, 43–45.

— (1997) The Mental Health (Patients in the Community) Act 1995. A clinical analysis. *British Journal of Psychiatry*, **170**, 492–496.

GELLER, J. L. (1990) Clinical guidelines for the use of involuntary outpatient treatment. *Hospital and Community Psychiatry*, **41**, 749–755.

HALPERN, A. & SZMUKLER, G. (1997) Psychiatric advance directives: reconciling autonomy and non-consensual treatment. *Psychiatric Bulletin*, **21**, 323–327.

McIVOR, R. (1998) The community treatment order: clinical and ethical issues. *Australian and New Zealand Journal of Psychiatry*, **32**, 223–228.

MILLER, R. D. (1999) Coerced treatment in the community. *The Psychiatric Clinics of North America*, **22**, 183–196.

MONCRIEFF, J. & SMYTH, M. (1999) Community treatment orders – a bridge too far? *Psychiatric Bulletin*, **23**, 644–646.

MULVEY, E. P., GELLER, J. L., ROTH, L. H. (1987) The promise and peril of involuntary outpatient commitment. *Psychologist*, **42**, 571–584.

O'REILLY, R. L. (2001) Does involuntary out-patient treatment work? *Psychiatric Bulletin*, **25**, 371–374.

SUGARMAN, P. (1999) New community mental health law: the conditional discharge model. *Psychiatric Bulletin*, **23**, 195–198.

SUTHERBY, K. & SZMUKLER, G. (1998) Crisis cards and self-help crisis initiatives. *Psychiatric Bulletin*, **22**, 4–7.

SWANSON, J. W., SWARTZ, M. S., BORUM, R., *et al* (2000) Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, **176**, 324–331.

SWARTZ, M. S., BURNS, B. J., HIDAY, V. A., *et al* (1995) New directions in research on involuntary outpatient commitment. *Psychiatric Services*, **46**, 381–385.

—, SWANSON, J. W., WAGNER, H. R., *et al* (1999) Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomised trial with severely mentally ill individuals. *American Journal of Psychiatry*, **156**, 1968–1975.

SZMUKLER, G. (2001) A new mental health (and public protection) act. *BMJ*, **322**, 2–3.

— & HOLLOWAY, F. (2000) Reform of the Mental Health Act. Health or safety? *British Journal of Psychiatry*, **177**, 196–200.

THORNICROFT, G. (1993) Community supervision orders. *BMJ*, **307**, 1213.

WARDEN, J. (1998) England abandons care in the community for the mentally ill. *BMJ*, **317**, 1611.


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