

Compulsory treatment in the community: considerations for legislation in Europe

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In late 2008, the Regional Office for Europe of the World Health Organization (WHO, 2008) issued a report based on a survey of the policies and practices for mental health within its area of operation. Forty-two European states were examined and a great diversity in practice was recorded. Almost everywhere, the report suggested, policy making and legislative initiatives were seen; since 2005, some 57% of the countries studied had adopted new mental health policies and 48% had introduced new legislation. Many countries were reported to be closing mental hospital beds and replacing them with community-based services. In some countries, however, the report suggested, desks in ministries were collapsing under the weight of policies that had never been implemented, and compliance with legislation by planners and psychiatrists was distinctly variable. The WHO felt that even the role that general practitioners played in treating people with mental illness was limited in many European states and that the availability of home treatment options, assertive outreach for people with complex mental health needs and community-based early intervention was not only variable but often severely limited. Given the wide discrepancies of procedure and practice, it was difficult for the WHO to gain any clear perspective on such legislative matters as arrangements for compulsory care in the community.

In this respect, the European Union may offer a more manageable focus. The Section of Psychiatry of the Union Européenne des Médecins Spécialistes (UEMS) is a body of delegates acting as representatives of their respective national medical associations and presenting the views of the medical specialty of general adult psychiatry to the European Commission. Mindful that Europe has a great diversity of legal systems and that arrangements for the development and implementation of mental health law vary widely, it has issued a guidance document (UEMS, 2008) on the principles it suggests should underpin the introduction of legal measures associated with compulsory treatment in the community. This has met with considerable medical and legal interest.

Research findings underpin this document. Pinfold & Bindman (2001) explored whether compulsory community treatment can ever be justified. A Cochrane review by Kisely *et al* (2005), based on the few available trials on involuntary out-patient commitment in the USA, held that the benefits in the management of dangerous individuals are limited. Applebaum (2001), also using US evidence, was more positive concerning its role for those with schizophrenia, bipolar disorder and other serious illnesses, but only where this was not primarily related to the prevention of acts of violence and only if there was an appropriate plan of care. In summary, the current evidence

base for the efficacy of this form of intervention is limited. Kisely & Campbell (2007) have further questioned, on the basis of Australian and US studies, whether compulsory community treatment really reduces the 'revolving door' nature of care. If it does not, they suggest, the argument that it can be regarded as a less restrictive option is open to challenge.

While taking these reservations concerning compulsory community care into account, the UEMS felt that, particularly at this early stage of legislative change for many countries, it would be helpful to offer some suggestions and to propose some points of guidance for those considering the matter. It took as a template many of the recommendations made by the expert committee advising on mental health law reform in Scotland (Millan, 2001).

Criteria and conditions

With the development of effective psychotropic medications and increased sophistication in the delivery of safe mental healthcare, it has long been widely realised that community care offers a less restrictive option than the in-patient institution. The preference for less intrusion into the lives of patients has often been the motive for legal reform, to enable such care to take place outwith the hospital. Where reform has taken place, the focus has usually been on those service users who have benefited from treatment in the past but who have repeatedly been unable to adhere to it in the longer term, resulting in relapse. The dominant view, which the UEMS endorses, is that the level of mental disorder to be considered for compulsory out-patient treatment should equate to that otherwise necessitating in-patient compulsory admission.

Compulsory community treatment, however, is not envisaged by the UEMS as a first-line intervention for an acute care episode, for which in-patient assessment and stabilisation remain the approach of choice. It is also not favoured if adopted simply on the grounds of being the cheapest option.

In considering treatment and care, the UEMS found, the focus of discussion can all too readily rest on medication alone. Although this is often an essential if, from a service user's perspective, contentious component, legislation, as Millan indicated, also needs to take into account wider factors. These may or may not need to be specified as part of a treatment plan, depending on least restrictive necessity. Consideration needs to be given, for example, to access arrangements for care providers and supervisors, such as medical professionals, community psychiatric nurses, social workers and general carers. Thought is also required on specialised housing needs, such as sheltered housing or

residential care in the community for people who are severely incapacitated. Arrangements may have to be made so that the location of the service users is made known to their carers should their address change. If some form of community care service, such as a day unit, is needed, this too may require specification, as does where, and at what intervals, the patient is required to attend if medication is to be deployed. Service users and their representatives expressed grave concerns to Millan about the potential abuse of their home environment should medication be administered there under such an order. It seemed preferable, therefore, for administration of medication to take place instead at another location, such as a day unit, out-patient clinic or local general practice surgery.

In summary, compulsory community intervention, as envisaged by the UEMS, ought to maintain service users' well-being and avert deterioration and risk to self or others. The intention is to reduce the likelihood that the service user will again require in-patient commitment. In practice, this means that legislation needs to have the flexibility to account for the individual's needs and to place under duress only those elements which are least restrictive and considered essential for the effective implementation of the clinical and social care plan. This inevitably renders application of the law significantly more complex, as negotiation is entailed.

Process

As a compulsory care order is potentially a major restriction on civil liberty, it would seem appropriate for there to be more than one applicant. In Europe, it seems generally agreed that at least one of these must be a fully trained psychiatrist and that a second opinion should also be sought. Options favoured by the UEMS include a second psychiatrist, a general medical practitioner, a social worker or an experienced community psychiatric nurse. In many European legislatures, carers or relatives are drawn directly into the application process to sign documents. But there is evidence that this is often associated with later recriminations and damage to family relationships and many feel it is best avoided. Nonetheless, a mechanism whereby the views of carers are taken into account is widely thought essential and has usually been incorporated into the process.

Such legal measures clearly require an appeals procedure. To facilitate this, both the service user and carers may need access to advocacy services, to guide and support them through the process, and to legal assistance, to effect proper representation before legal authorities. The costs of these arrangements should not, in the UEMS's view, be borne by the service user or the carer. How appeals are heard varies greatly in Europe. Some states utilise the opinion of a judge; others devolve matters to a panel consisting of legal, medical and other expertise.

In practice, a degree of cooperation from the service user is required for a community treatment order to operate smoothly. Without this, the process is likely to fail. The question then arises as to what should be done if the service user is non-compliant. Alternative strategies have been considered, including compulsory readmission to hospital. Since, however, the criteria for out-patient and in-patient compulsory measures often differ, a process of clinical reassessment and legal review is inevitable in such circumstances.

Attitudes

Mental health law presents unique challenges to those involved: the lawyer, psychiatric practitioner, service user and carer. Particularly as, at times, it may be difficult to reconcile their approaches, an agreed set of principles to be used in the application and administration of such laws would seem important. The recommendations made in relation to Scottish law reform set out by the Millan Committee (Millan, 2001) were considered and adapted by the UEMS in its report (UEMS, 2008). Basically, both reports sought to embrace the fundamental principles of medical ethics, namely justice, autonomy, beneficence (seeking to do good) and non-maleficence (avoiding doing harm).

Crucially, the principles outlined centre on 'least restrictive practice'. Any necessary care, treatment and support services, in this view, should be provided in the least invasive and least restrictive manner and in an environment compatible with effective care that takes into account the safety of both the patient and others. The principles also include the commitment that any legislative intervention on behalf of the service user should be likely to produce benefit for that person which cannot be achieved by other means. Where society imposes an obligation of compliance with a programme of treatment, a parallel obligation must fall on health and social authorities to respond with the necessary care and service provision, including follow-up care.

Changes ahead

The debate on compulsory care, especially in the community, is ongoing in Europe. The Netherlands, for example, is in the process of reconsidering its provisions, as it is now felt that treatment options under current legislation have been restrictive. Turkey is likewise in the process of discussions on reform. But it seems already agreed that, inevitably, all legislatures will have to reflect on the realities of local psychiatric care systems and legal structures. A wholesale adoption of strategies from other legislatures or from any centralised source would not be appropriate or effective. The healthy diversity for which Europe is renowned is not under threat.

Declaration of interest

Dr J. G. Strachan is President of the European Board of Psychiatry of the UEMS and was a member of the Millan Committee.

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