BJPsych | The British Journal of Psychiatry (2011)
199, 90–91. doi: 10.1192/bjp.bp.111.091876

Editorial

Pressures to adhere to treatment: observations on 'leverage' in English mental healthcare†

Tony Zigmond

Summary
Coercion in psychiatric practice appears to be increasing. Is this in patients' best interest? Is it good medical practice?

Declaration of interest
None.

Tony Zigmond is a consultant psychiatrist, Leeds Partnerships NHS Foundation Trust and an honorary senior clinical lecturer, University of Leeds. He has a long-standing interest in mental health law, served the Mental Health Act Commission for many years and is the Royal College of Psychiatrists' lead on mental health law.

Coercion in psychiatric practice appears to be increasing. In 1987/88 there were approximately 19 000 formal compulsory admissions to hospital (including individuals admitted informally and then detained).[1] Twelve years later this had risen to just under 50 000. In addition, there were over 4000 community treatment orders initiated in 2009/10.[2]

These numbers represent a lot of individuals being made, by force or coercion, to take medication they do not want. Some of these people will have been incapable of making decisions about the medical treatment they need but, even among individuals who are detained, many will be taking medication under protest. In 1983–85 there were 4000 statutory second opinions,[3] rising in 2008–10 to 18 000 (of whom over 5000 were recorded as refusing medication). For individuals with a community treatment order, all of whom require a second opinion if they are prescribed medication for a mental disorder, over 55% were described as having 'insight' and 20% were described as 'refusing' medication.[4] This despite the fact that capacitous individuals subject to community treatment orders cannot be forced to accept medication while in the community.

Burns and colleagues[5] in this issue of the *Journal* discuss the concept of leverage, using the term interchangeably with coercion (as Szmuckler said 'substantial work is still needed to develop a useful vocabulary of "coercion" and related concepts'[6]). Their research shows leverage/coercion is much more extensive than official figures suggest. It might be argued that, in the absence of any legal framework and with no right of appeal or arbitration, these patients are in an even more vulnerable position than those subject to the Mental Health Act 1983. This is the business of every doctor. As the General Medical Council states (p. 19):[7]

> Ensuring that decisions are voluntary – Patients may be put under pressure by employers, insurers, relatives or others, to accept a particular investigation or treatment. You should be aware of this and of other situations in which patients may be vulnerable. Such situations may be, for example, if they are resident in a care home, subject to mental health legislation, detained by the police or immigration services, or in prison. You should do your best to make sure that such patients have considered the available options and reached their own decision. If they have a right to refuse treatment, you should make sure that they know this and are able to refuse if they want to.

There are a number of issues to consider. Are patients in the community, whether subject to community treatment orders or 'leverage' in relation to housing or benefits, really consenting to take their medication? The Welfare Reform Act 2009 specifically forbids making the paying of benefits contingent on accepting medical treatment (although it does authorise that people who misuse drugs and/or alcohol may be required to attend for assessment and monitoring of their misuse). Yet many individuals who are detained say they consent to taking medication because of a (correct) belief that to do so will lead to earlier discharge from hospital or increase their likelihood of success in a tribunal. Consent, according to the Mental Health Act Code of Practice, is the 'voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent' (pp. 188–189).[8] Life, however, rarely permits choice without consequences. Patients may weigh up the pros and cons, the advantages and disadvantages of the package as a whole, the treatment and all the consequences of adherence or refusal, and come to a decision that is right for them. The same way as anyone may decide to behave in a particular way, for example to spend evenings working for exams, not because one wishes to but because it is 'a price worth paying'. Importantly, unless detained in hospital, capacitous individuals cannot be made to take medication without their consent. Even when taking medication is a condition attached to a conditional discharge (from a restriction order, Mental Health Act 1983)[9] or community treatment order,[8] it would be unlawful to recall the individual solely because the individual decided to refuse the medication.

There has been discussion over many years about coercion in relation to physical treatment. Should individuals with alcohol-induced liver disease who continue to drink alcohol be offered a liver transplant or people who are grossly obese have hip replacements? Leaving aside the arguments as to whether these questions arise from issues relating to medical benefit as opposed to morality, there is really no comparison with the nature of the coercion applied to people with mental disorders. These are requirements for patients to change their behaviour before treatment is offered. There is no suggestion that individuals should accept medical treatment they do not want.

Some psychiatrists may argue that coercion is in the individual's best interests, but does this stand up to scrutiny? In law, 'best interest' authority can only be used if the person lacks capacity to make the decision. Further, in assessing 'best interest' the law states that (the assessor) 'must consider the person's past

†See pp. 145–150, this issue.

and present wishes and feelings'. If an individual says they do not want medication but would like a place to live, then making the latter conditional on the former cannot be said to be acting in the person's best interest. But there is a much more serious problem than what some may regard as a legal technicality, that is, harm to the patient's physical or mental health. The purpose of the coercion, whether in relation to people who are detained in hospital, subject to a community treatment order or need housing or other benefits, is to make the individual take medication in order to modify their behaviour. This may be directly such as to reduce a person's alcohol consumption or indirectly by modifying an individual's experience of or response to hallucinations or delusions. But why would a capacitous individual not willingly consent? Psychotropic medications commonly cause obesity, diabetes, impotence, lethargy or movement disorders (and have many other less frequent adverse effects). People may reasonably complain that the drugs make them feel ill or cause them significant physical harm. In addition to adverse effects, the National Institute for Health and Clinical Excellence gave further reasons for people not taking prescribed medication including 'patients' disagreement with the need for treatment', 'a treatment regimen that does not fit in with the patient's daily activities' or 'the lack of a decision process that takes into account values and beliefs of the patient'.[10] Is it right; is it the proper practice of medicine, to force or coerce people to accept treatment which, from the individual's point of view, is worse than the disease?

Suppose the choice is staying mentally symptom free and out of hospital but obese and impotent, or relapsing once or twice a year requiring, let us say, 2 weeks in hospital each time but feeling fit and functioning well the rest of the time. Would the patient and the psychiatrist come to the same decision about whether or not the individual should continue to take medication? And, if not, who should have the final say? Perhaps, most importantly, one might also wish to consider whether the question would ever be posed in any other branch of medicine.

Tony Zigmond, FRCPsych, Newsam Centre, Leeds LS14 6WB, UK. Email: azigmond@doctors.net.uk

First received 14 Feb 2011, final revision 5 Apr 2011, accepted 27 Apr 2011

References

1 Department of Health. *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, Annual Figures, England 1987–88. Statistical Bulletin.* Department of Health, 1988.

2 The NHS Information Centre for Health and Social Care. *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, Annual Figures, England 2009–10.* NHS Information Centre for Health and Social Care, 2010.

3 Mental Health Act Commission. *The First Biennial Report of the Mental Health Act Commission*. HMSO, 1985.

4 Care Quality Commission. *Monitoring the Use of the Mental Health Act in 2009/10.* CQC, 2010.

5 Burns T, Yeeles K, Molodynski A, Nightingale N, Vazquez-Montes M, Sheehan K, et al. Pressures to adhere to treatment ('leverage') in English mental healthcare. *Br J Psychiatry* 2011; **199**: 145–50.

6 Szmuckler G, Appelbaum PS. Treatment pressures, leverage, coercion, and compulsion in mental health care. *J Ment Health* 2008; **17**: 233–44.

7 General Medical Council. *Consent: Patients and Doctors Making Decisions Together*: 19. GMC, 2008.

8 Department of Health. *Mental Health Act Code of Practice.* TSO (The Stationery Office), 2008.

9 *The Queen on the Application of SH v Mental Health Review Tribunal QBD (Admin) (Holman J) 3/4/2007 3rd April 2007* [2007] EWHC 884 (Admin).

10 National Institute for Health and Clinical Excellence. *Medicines Adherence Involving Patients in Decisions about Prescribed Medicines and Supporting Adherence.* NICE, 2009.

https://doi.org/10.1192/bjp.bp.111.091876 Published online by Cambridge University Press