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Is supervised community treatment ethically justifiable?

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ABSTRACT

Ethical viewpoints for and against the use of supervised community treatment (SCT), also known as outpatient commitment and community treatment orders, are examined. The perspectives of writers on civil liberties are considered. This paper argues that while civil liberties are an important concern SCT is ethically justifiable in the circumscribed population of 'revolving door' patients it applies to. This is on the grounds that it enables individuals to actualise their positive liberty. The issue of insight into mental illness is also considered and it is concluded that a further argument in favour of SCT comes from evidence that insight relates to neurobiological deficits. Limits to the ethical justifiability of SCT are considered with reference to individuals with substance dependency. The paper concludes that SCT is ethically permissible only in those with severe mental illness who have a history of losing capacity to consent to treatment and/or admission.

Supervised community treatment (SCT) was introduced in England and Wales in November 2008 with the amended Mental Health Act 1983 (2007) (MHA). SCT has been defined as 'a compulsory community-based treatment order (which) requires a patient to comply with a set of conditions, such as taking their medication, while allowing them to live in the community' (p 8).¹ With regards to SCT in England and Wales, only patients who have been detained under the treatment section of the MHA, section 3, or certain forensic sections, may be put on SCT, and SCT is applied for when the patient is in hospital on the section.² No treatment may be given in the community using force except in life-threatening emergencies in incapacitous patients.² SCT patients may be treated in hospital when recalled. Recalled patients may be detained in hospital for up to 72 h if they do not meet the conditions of the order or alternatively if there are concerns that they are relapsing.² These concerns may be raised by the patient's relatives or carers or may be from mental health professionals involved in the patient's care. The responsible clinician involved in the patient's care makes the decision to recall the patient.² The community treatment order (CTO) gives the legal authority for the responsible clinician to initiate recall to hospital.

The public debate on SCT has recently focused on concerns that there are many more patients being placed on SCT than predicted before its introduction.³ In this article I consider the ethical values underpinning SCT and the arguments of its detractors. Much of the literature on SCT comes from the USA and Australasia where CTO were

introduced in the 1980s and 1990s.⁴ The Churchill Report reviewed the international studies on SCT and found inconclusive evidence for any benefit.⁴ It is important to bear in mind that the design and setting of the studies and their quality varied markedly.⁵ In addition, the clinical criteria and powers of SCT vary between jurisdictions.⁴ I consider capacity, consent and coercion in relation to SCT. Other important areas are paternalism and insight and we will discuss these with reference to the argument. My argument relates to the case of patients whose capacity to consent to treatment fluctuates over weeks or months leading to the patient stopping their medication and/or disengaging from mental health services. SCT was designed for such patients who have been termed 'revolving door patients' because of their frequent relapses and readmissions. These are often involuntarily enforced under the MHA 1983.⁶ I show that it is ethically justifiable to place such patients on SCT in addition to giving ethical justification for placing patients lacking decision-making capacity on SCT. The detailed criteria for placing a patient on SCT are beyond the scope of this paper and can be found in the MHA Code of Practice.² They include the need for treatment for mental disorder for the patients' own health or safety or for the safety of others.² I discuss evidence that patients who lack insight into their mental health problems and need for treatment have neuropsychological deficits that are part of their mental illness and impact on their decision-making capacity.⁷⁻⁹ Concerns have been raised about SCT from the perspective of civil liberties and the right of individuals to refuse treatment.¹⁰ I hope to show that in the relatively circumscribed population of patients it applies to that SCT is ethically justifiable.

The concept of insight in psychiatry refers to a patients' awareness of their illness.¹¹ This ties in with a patient's decision-making capacity in that someone with no insight into their illness or symptoms will generally be unable to weigh the information given to them regarding treatment, for example, because they do not believe this information. I examine Rawls' argument justifying paternalism and examine this in relation to SCT.¹² I consider the case of people with severe mental illness and with a history of relapse and readmission and argue that SCT is ethically justifiable to enable them to lead lives that are meaningful for those individuals on their terms. I consider limits to the use of coercion in psychiatry including the case of patients with substance addiction, and examine why it would not be morally permissible to coerce treatment in such patients. I conclude that it would

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be morally permissible to use coercion in stopping patients with severe mental illness using substances through SCT. My overall conclusion is based on the argument about positive liberty¹³ taking into account issues related to insight.

CAPACITY AND SCT

Ethical justification for treating incapacitous SCT patients comes from the need to consider their best interests. An incapacitous patient lacks the capacity, as set out in the Mental Capacity Act¹⁴ to make specific decisions and requires others to make those decisions. Inability to make a decision is defined in the Mental Capacity Act when the person has an impairment or disturbance of their mind or brain and cannot understand, retain, use or weigh or communicate information relating to the decision to be made as a result of that disturbance (p 45).¹⁴

Concerns have been raised that consent to treatment of patients on CTO may in effect be given under duress. If the capacitous patient believes or is led to believe that they will be recalled unless they consent to medication then it can be argued that this is not true, meaningful consent. Van Staden and Kruger¹⁵ point out that informed consent requires more than capacity alone, for example, a trusting therapeutic relationship and lack of coercion. We now consider coercion, concerns raised in the literature about it in relation to SCT and its ethical justification.

COERCION

Smulker¹⁶ discusses coercion in the context of mental healthcare as 'a spectrum of pressures ... exerted to gain the patients' cooperation with treatment' (p 457). This spectrum ranges from persuasion on the one hand to what Smulker¹⁶ refers to as 'interpersonal leverage' in which the patient may want to please their mental health worker and through to 'a vague threat of something valuable being lost, for example, the key professional's support' (p 458). We shall consider justifications for coercive practices in mental health care but first it is important to look at the objections to its use. Objections to the use of coercion have been mainly based around its violating the principle of autonomy, which has come to take the central place in medical ethics.¹⁷ Coercion is described as 'infantilisation of a sort inconsistent with respect for human agents as autonomous, self-creating creatures' (p 268).¹⁸ Coercion represents a serious infringement both on one of the key principles underpinning ethical conduct and on the individuals' integrity. As Smulker¹⁶ notes, 'the more an intervention moves in the direction of persuasion to compulsion', we could add coercion here, 'the stronger must be its justification' (p 460).

THE CIVIL LIBERTIES PERSPECTIVE

Fulop¹⁰ writes about civil liberties concerns arising out of the US equivalent of SCT. These include an individual's right to refuse treatment. Fulop¹⁰ writes that patients who no longer meet the criteria for inpatient commitment should simply be 'discharged from the institution with no strings attached' (p 295) instead of being placed on SCT. In England and Wales the criteria for detention on an SCT are almost identical to those for detention on the inpatient treatment section, section 3 MHA, the difference being that in the criteria for section 3 mention is made that the treatment is received in hospital.² So this criticism does not apply to SCT in England and Wales. However, assuming this was not the case it is difficult to view it as right that patients with a history of severe mental illness, including possible suicide attempts or life-threatening self-neglect, should be discharged

with 'no strings'. The MHA Code of Practice states that 'After-care for all patients admitted to hospital for treatment for mental disorder should be planned' (p 251) and highlights the statutory requirement to follow up patients detained under specified sections of the MHA (p 250).² So even if SCT was not in existence it can be seen that discharging vulnerable patients at risk of relapse and suicide with no requirement or encouragement to engage with psychiatric services is morally impermissible as well as contravening the guidance described above.

Fulop¹⁰ elaborates on the right of individuals to refuse treatment and civil libertarians such as Miller's concerns about the loss of privacy in the involuntary administration of medication.¹⁹ The right to privacy is enshrined both in the US Constitution and in the European Convention on Human Rights, in article 8. In England and Wales and as mentioned above, treatment against an adults' wishes cannot be given in the community under any circumstances. The only exception is when there is a life-threatening emergency in the case of an incapacitous patient, and this applies in the case of patients on SCT as for any other patient.

Paternalism has been defined by Dworkin²⁰ as 'the abridgement of an individuals' liberty or other rights in order to promote his or her interests, good, happiness, needs, values or welfare'. Waithe²¹ argues that Mill would have supported paternalistic interventions, Munetz *et al*¹¹ hold that this can be extrapolated to SCT. Waithe²¹ writes that 'Mill held that paternalism was permissible when the prospectively paternalised cannot be held to be morally responsible, or as Mill says, "blameworthy" for his action' (p 103). Rawls¹² defends paternalistic intervention 'to protect ... against the weakness and infirmities of their reason and will in society' (p 219).

ETHICAL JUSTIFICATION FOR SCT

Ethical justification for coercive practice in SCT comes from a number of sources. I discuss the argument put forward by Blake¹⁸ writing about state coercion and autonomy that some form of state coercion is necessary in order for citizens to pursue their projects autonomously. Rawls' justification for paternalism in relation to the original position and veil of ignorance is used to argue that Rawls would be in favour of SCT.¹² Further ethical support comes from Dawson's view that SCT protects the positive liberties of patients on CTO¹³ using Isaiah Berlin's idea of positive and negative liberties.²² Additional evidence in favour of SCT is from research that indicates that loss of insight, which is a cause of incapacity, has a biological basis and is related to the patients' mental illness.⁷⁻⁹

Blake¹⁸ and Danekan²³ write about state coercion in the judicial system, which, in both civil and criminal courts, uses coercion in enforcing its judgements. Blake¹⁸ turns to Rawls' original position as being a way in which certain forms of coercion could be justified. Rawls¹² writes about a position in which everyone required to make decisions about justice is behind a 'veil of ignorance' and does not know where they will be in society or their attributes and disadvantages.¹⁸ Rawls¹² states that the veil of ignorance includes individuals behind the veil in the original position not knowing 'their conceptions of the good or their special psychological propensities' (p 11). They would therefore not know whether or not they would value liberty of choice above paternalistic interventions such as SCT once the veil has been lifted. It could be argued that if decision-makers were put in the original position they would opt for such treatment as SCT themselves should they require it, and likewise that individuals with severe mental illness would agree to

SCT were they in the original position. Rawls¹² gives two stipulations in his justification of paternalistic intervention. In addition to the need for 'evident failure or absence of reason or will' the paternalism must be guided by principles of justice and 'what is known about the subject's more permanent aims and preferences' (p 219).¹² Rawls makes the point that if little is known about the paternalised individual he or she may be treated 'as we would act for ourselves from the standpoint of the original position' (p 219).¹² It may be that without treatment the preferences of the severely mentally ill person cannot be known because of the effect of the mental illness on that person's ability to communicate and act in accordance with them, and this adds further weight to the argument that a Rawlsian account would support SCT. Treatment under SCT may help the patient recover and realise their permanent aims and preferences. This brings us on to an account of positive liberty. An example of impermissible coercion is given as using the power of the state to enforce one particular view of the good life.¹⁸ This ties in with Rawls' limits on paternalism, that it should not be used to allow an assault on the integrity of the person. Rawls¹² makes it clear in his account that the person should be free to pursue their final ends.

POSITIVE LIBERTY

Dawson¹³ provides ethical justification for SCT in both capacitous and incapacitous individuals. Dawson uses the concepts of positive and negative liberty originally discussed by Isaiah Berlin.²² Negative liberty, which is said by Dawson to be the most important principle in the common law system, is the 'right to be left alone, or refuse treatment' (p 8).¹³ Positive liberty on the other hand refers to 'the capacity for self-governance, self-directed activity, and maintaining important relationships' (p 8).¹³ Dawson comments that rights to negative liberty are deeply enshrined in the common law tradition. Whereas negative liberty does not make any comment on the ends that ought to be pursued, positive liberty refers to the 'capacity to set goals and have some chance of meeting them, without being dominated by internal constraints that prevent that occurring' (p 8).¹³ Dawson points out that helping patients to recover functioning so that they can achieve their goals is one of the central aims of mental health practice.

So, in addition to the assertion that some degree of coercion is required and would be acceptable under Rawls' original position we have an argument around coercive elements in SCT protecting patients' positive liberty, enabling them to set their own goals and pursue them unimpeded by the symptoms of mental illness and their sequelae. SCT in the case of severe mental illness can be argued to be permissible because the individual has a treatable condition that is impinging on their ability to set and achieve goals, to actualise their positive liberty. A limit on coercion to enable people to actualise positive liberty, as mentioned above, would be when one particular conception of the good life is enforced.

An example of impermissible coercion in the context of mental health practice would be when a person has alcohol dependency, or is addicted to another substance in the absence of mental illness. The addiction is preventing the person from achieving the goals they might otherwise have wanted to achieve. Coercion in the form of SCT would be impermissible, however, for a number of reasons. These relate to differences in symptom profile and the degree of voluntariness between severe mental illness and substance dependency. With regards to the symptom profile, it is clear that there is an element of choice

involved in substance misuse and dependency. The autonomy of an addicted person is impaired to the extent that their behaviour and motivation comes to be dominated by the drive to use the substance to the exclusion of other activities, but it is unlikely to be viewed as being absent. That is, the addicted individual is unlikely to be viewed as lacking decision-making capacity (assuming there is no cerebral damage resulting from the substance misuse). However, it seems that in some individuals with severe mental illness the impairment in their autonomy is qualitatively different to the case of dependency. The symptoms of mental illness, whether delusions, hallucinations, or the absence of insight, mean that the person periodically lacks the capacity to consent to treatment. Why would it be morally permissible to stipulate as a condition of a CTO that a patient should refrain from drinking alcohol or using illicit substances? One answer would be that the treatment conditions form part of the package of care for the treatment of mental illness; the CTO patient using drugs or alcohol has a so-called dual diagnosis, and substance use may be related to relapse and increased risk. Individuals may use substances to 'self-medicate', to attempt to decrease their mental distress. Alternatively, alcohol and illicit substance misuse may precipitate a relapse of mental illness. So, treating the substance misuse coercively in these cases leads to a positive effect on their mental health. Medication is also used in substance misuse disorders but it could be argued that the main purpose of treatment, both with medication and psychotherapy, is to enable the patient to learn not to use the substance, or to use it in a controlled way that does not cause harm. In the case of those with severe mental illness the intention in prescribing medication is in alleviating the symptoms of the mental illness. Therefore, the purpose of medication and treatment is different in each case. From this it can be concluded that SCT is ethically permissible only in those with severe mental illness who have a history of losing capacity to consent to treatment and/or admission.

With regards to coercive interventions in individuals who indulge in risk-taking behaviour, Kleinig²⁴ puts forward an argument regarding autonomy and personal integrity. Kleinig's view is that some paternalistic intervention at the population level is justified. His example is seat belt legislation, but we could equally give measures to curb problem drinking such as banning happy hours in bars and pubs or increasing the price of alcohol. Kleinig²⁴ states that any imposition that these coercive measures make will be minor and will not 'interfere with the individual's significant pursuits' (p 73). They will, however, 'impede or prevent risk-taking activity' (p 73).²⁴ Coercing an individual with alcohol problems to stop drinking through SCT could be construed as a major interference and would not be justified by Kleinig's argument. Regarding coercive legislation designed to tackle risk-taking behaviour, we can conclude that the coercion is justifiable only at the population level.

INSIGHT

Another argument in support of SCT comes from evidence relating to insight in severe mental illness. Patients without insight may lack the capacity to decide on treatment or on admission if they are unable to appreciate that they have mental health problems. Insight may be viewed on a spectrum; one patient may accept her voices as a symptom of schizophrenia but refuse to accept treatment only for agitation. Other individuals may not accept that they have any mental illness and refuse all treatment. Swartz *et al*²⁵ note that in some studies there is no relationship between insight and the degree of mental

illness. There is evidence that lack of insight is caused by a neurobiological deficit in schizophrenia and in other psychotic disorders.^{7–9} Coercive treatment with SCT is justified in these individuals on the basis that ‘their brain disorders prevent them from making an informed decision’ (p 205).¹¹ Individuals who periodically lose insight into their mental health difficulties and/or need for treatment could be argued to have a biological deficit when they lose insight. It may be the case that lack of insight in other severe mental illness has a biological basis. These points would require further study. Assuming individuals lacking insight have neurobiological deficits, SCT seems justified in the case of patients who respond to psychotropic drug treatment and whose level of insight fluctuates according to whether or not they are receiving treatment. This adds further justification for coercive practice in SCT.

CONCLUSIONS

The argument presented is that in a relatively small group of patients with severe mental illness, risks to themselves or others and repeated relapse and readmission cycles, SCT is ethically justified. The argument relates to the moral acceptability of coercion in psychiatry, and therefore SCT, for incapacitous patients and for patients with a history of incapacity with regards to consent to treatment and admission. Coercion has been shown to be an implicitly accepted part of everyday life in contemporary society in terms of systems of justice and taxation. With reference to Rawls it was concluded that coercion in SCT would be acceptable in incapacitous individuals. This adds to the justification on the grounds of best interests. Considering the currently capacitous who have lost decision-making capacity in the past, the link between loss of insight, incapacity and positive liberty was discussed. It was concluded that SCT is morally justified in such individuals to enable them to achieve their goals in a supportive environment. We considered limits to the use of SCT in terms of substance misusing patients. In people who had never lost insight or capacity SCT would be morally impermissible. Other questions that are beyond the scope of this paper relate to whether SCT in its current form in England and Wales is working, and whether there are any potential adverse effects on other aspects of mental health services.

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