Module:
Mental Health in the Community

Week 2
Current conceptualisations of mental health

Topic in Action 1
Coercion in mental health care

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Lecture transcript

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We're going to begin by discussing the oddity of mental health practice. Now I'm a doctor who worked in England, a psychiatrist approved under Section 12 Mental Health Act in 1983, as amended, which is our mental health legislation. Together with another doctor, and an approved mental health professional, I can make an assessment, complete a statutory form, and detain a person in hospital for assessment and treatment of their mental disorder.

Indeed, I'm in a building that houses many doctors, and myself and a mate can go out, and if we've got the friendly amp, we can go into the nearby street, come up to someone and say, 'You look a bit odd, sign a piece of paper-- three pieces of paper' and that person will effectively be detained. They're deprived of their liberty during detention, and can be treated against their will. That's a very unusual situation for any doctor to be in, and it's almost unique amongst doctors in England.

There are powers to detain people suffering from infectious diseases - probably rarely, if ever, used. But these people in England can't be treated against their will, unless they lack decision-making capacity, which isn't a factor in the decision-making process as far as detention is concerned in England and Wales.

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So as an approved clinician, that's a legal status I've been granted. I can become a responsible clinician for a detained patient and be in charge of their treatment during their period in detention, which effectively includes all aspects of their life. Some aspects of treatment, which is a very broad concept in mental health law, is subject to statutory review by a second opinion appointed doctor, where a patient lacks capacity or doesn't agree with their treatment. And the SOAD can certify the treatment plan of responsible condition, or can require changes. This applies to medication for mental disorder and electroconvulsive therapy.

The detained person has rights of appeal to a three-member mental health tribunal which comprises of a judge, a psychiatrist and a specialist layman. This reviews whether the statutory criteria for detention are met, and if they're not, the patient's discharged. Now, I happen to be an approved condition, SOAD and a tribunal doctor-- although obviously not for the same person, since the SOAD and tribunal doctor roles are for independent oversight.

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When we're talking about compulsory treatment in mental health care, it probably conjures up a number of pictures in your mind. So available pictures I've found recently was One Flew Over the Cuckoo's Nest. So, people being kept in a state mental hospital in the United States, and rather brutally coerced.

We also have horrific footage of the ill treatment of people with learning disability in a small learning disability hospital in Bristol called Winterbourne View, which shocked the nation. So that's a picture of what happens to some people when they're being compulsorily treated.

There are more appealing pictures. So for example there are documentaries showing people who are being treated for mental health problems, and are even benefiting from it. So I mean a nice picture of Beth, who has anorexia and is living with that and being treated for her eating disorder.

Now is there a conceptual difference between the people in Winterbourne View, people detained in state mental hospital, and Beth, between what they've experienced? Or is it all coercive treatment?

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Now when we think about compulsory treatment in mental health care, we get different views. So this is a quote from the textbook on mental health law. 'One of the hallmarks for civilised societies is the way it caters for those who require help as a result of mental health problems. In providing the legal structure within which people are detained and treated against their will, a balance must be struck between the right of an individual and the need to protect the individual and society at large from adverse effects of mental disorder.' So they're saying compulsory treatment is potentially a good thing, but it's a matter of striking a balance between different groups.

And there's a counter argument here. And I'm quoting, 'Abolition of involuntary mental hospitalisation. 'Involuntary mental hospitalisation is imprisonment under the guise of treatment. It is a covert form of social control that subverts the rule of law. No one ought to be deprived of liberty, except for a criminal offence after a trial by jury guided by legal rules of evidence... No person ought to be detained involuntarily for a purpose other than punishment.'

That blast comes from Thomas Szasz in his summary statement in the manifesto. So in his counter-argument, Szasz is explicitly equating compulsory treatment with slavery, and he sees it as a form of human rights abuse.

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Now it has to be said the significant historical precedent in pyschiatry being complicit in the abuse of human rights, most grimly in Nazi Germany where there was judicial killing of a minimum of 70,000 hospital inmates, and of course in the use of psychiatry in suppressing dissidents in the Soviet Union. So you have documentary evidence of Adolf Hitler stating that 'Reich leader Boulher and Doctor Brandt are entrusted with the responsibility of extending the authority of physicians designated by name so that patients who are considered incurable can be granted mercy death after a definitive diagnosis.' And in a similar vein, a propaganda poster from 1938 says, '60,000 Reichsmark is what this person suffering from their hereditary defect costs the people's community during his lifetime. Fellow-citizens, that is your money, too.'

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What about the patient survival user perspective? I read recently recent press release - looking in the internet for interesting material - on a psychiatric survivor pride day held in 1999 in Toronto. And it tells us at about 5:00 PM, 45 ex-patients and supporters marched to a nearby park carrying signs protesting false psychiatric treatment, including proposal for outpatient treatment community treatment orders-- or CTO's-- as curious, going home rush-hour commuters looked on. And one

banner reads 'Arbitrary incarceration, harmful drugs, physical restraint, electroshock treatment-- psychiatry is cruelty.'

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And indeed contrasting views on compulsory admission and treatment of mental disorder, are nothing new. So John Perceval and colleagues in 1845, in their manifesto surrounding the founding the Alleged Lunatics Friend Society, state, 'It's founded for the protection of the subject from unjust confinement on the grounds of mental derangement.'

Whilst in 1898, the Journal of Mental Science, which subsequently became the British Journal of Psychiatry which is the UK journal of record for psychiatry, states, 'The public should be clearly instructed that the annual recurring and possibly increasing horrors and the crimes of lunatics at large are the price it pays under the existing lunacy law-- the protection from illusory danger-- to the liberty of the subject.'

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If we take a step back and think about how to justify compulsory treatment in mental health, there are a number of ethical principles that underlie health care. Beauchamp and Childress have put forward four specific principles.

The first is autonomy - indeed the basis of health care is no intervention without consent, which means capacitor's consent.

The next principle is beneficence-- do good.

And that needs to be balanced by a further principle of non maleficence-- first do no harm.

Our final principle is justice, which in Beauchamp and Childress's perspective means fair shares for all.

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So autonomy is a very strong judicial principle. So a judge said a pregnant woman may put her own life and that of her unborn child at risk if she has capacity. But what if I lack capacity? Involuntary treatment involves a balance being struck between autonomy and beneficence. So that balance says that goods and harms are often quite finely balanced in psychiatric practice, and begs the question, good for whom? What's good for whom?

Equity plays a part in the ethical debate about the allocation of scarce resources. For example, decisions by NICE about supported and non-supported interventions. And perhaps it also plays a part in day to day tacit decisions as to how professionals spend their time, although that is in turn at odds with the traditional approach that professionals have of doing the best possible for the patient in front of you.

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If we try and understand coercion in mental health care, there is a spectrum. So there's a spectrum between persuasion - which we might call an appeal to reason; interpersonal leverage - wanting to please someone you value; inducements - if you will do this, you'll get that; vague threats - if you don't do this, that will happen; coercive threats - if you do do this, I will do that; and then finally compulsion - the law says you must do this.

Now it's quite clear: persuasion is legitimate. Most people would feel leverage is quite legitimate. You're trying to get somebody to do things because they trust you. Potentially inducements are legitimate, although they're perhaps on the borderline. Vague and coercive and threats are perhaps

less legitimate. This analysis comes from George Leclerc writing in Textbook on Psychiatric Ethics.

Let's give examples.

So, persuasion. 'Here is the evidence for you to make your own choice.'

Leverage. 'Trust me on this. Give it a try.'

Inducements. If you're taking treatment, we can support you move on to your own flat.' You give us a choice there, even though it's a slightly coerced choice.

Vague threats. 'If you stop your medication, you're coming back to hospital.'

Coercive threats. 'If you don't come into hospital, we will section you.' That's to say detain you in hospital. That's our English jargon. Or 'If you don't take your medication, we will have to section you.'

And then compulsory. 'You are detained under section three of the Mental Health Act, and therefore X, Y, and Z follow.'

So again, to ask the question, where is the dividing line between providing factual information and illegitimate inducements and threats.

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Think about what justifies coercive interventions. There are two broad justifications. The first is paternalism - so that's legitimate action by the state where a person lacks capacity. And here, if you act, this action must be in the person's best interests.

The second justification is on the ground of public safety. So actions to prevent harms by person to others who is deemed to be dangerous, usually after some form of judicial assessment. And this can also extend to preventing the person's harm to themselves, because the state doesn't particularly like people harming themselves, particularly if they're unhappy.

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In Europe, we operate under the framework of the Human Rights Act, and that itself is an incorporation of the European Convention on Human Rights directly into UK law. Again, European Convention of Human Rights take us back to 1950, and the UK has been a signatory since 1951. And it's got its own in court in Strasbourg-- the European Court of Human Rights. All public authorities in the United Kingdom have to follow the Human Rights Act. And therefore the ECHR, and the ECHR job provides rights that are absolute - so for example the protection from torture, limited - so for example, the right to liberty can be taken away, and qualified - and freedom of expression is the example there. example there. Interference in ECHR rights must demonstrate proportionality. Now that is defined as, is it necessary in a democratic society? Which means it must fulfil a pressing social need, and pursue a legitimate aim, and be proportionate to the ends being pursued.

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Now there are a number of rights that are relevant to mental health care. Article 2 provides the right to life. Article 3, an absolute right that prohibits torture. And specifically it says, 'no one should be subjected to torture, or to inhuman or degrading treatment or punishment.' Article 5 is that right to liberty and security. Article 6 provides a right to a fair trial. And Article 8, a right to respect the private life and family life.

So as I said, I work in the United Kingdom, which is signed up to the ECHR.

Article 5, as we mentioned, provides a right to liberty and security. But importantly it legitimates

deprivation of liberty in specific circumstances subject to local judicial processes. And Article 5(1)(a) allows for detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants. And it's that phrase, 'persons of unsound mind' that provides the backing for our Mental Health Act, 1983, as amended in 2007. Incidentally, in UK we choose not to detain alcoholics or drug addicts solely because of their addiction.

So where is the Human Rights Act engaged? Well Article 2, the right for life is engaged potentially by the suicide of a patient. So health services, mental health services have an operational duty as far as possible to ensure that a patient's right to life is not breached, and the suicide of a patient potentially is a breach of that right.

Potentially compulsory treatment, restraint and seclusion might be construed as torture, or inhumane, or treatment, although the case law is fairly permissive. Compulsory treatment, and a lot of other aspects of hospital care, profoundly affect one's Article 8 right to respect for private and family life and correspondence. So when we're detaining someone, we are taking away some of his right to liberty under Article 4 (1)(e) and that's trampling all over our Article 8 rights. And that has to be balanced. There has to be a balance between what allows us to do one thing, and what says we shouldn't do something else.

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In Wales, we work under a Code of Practice for our Mental Health Act, and that tells us that we have to be aware of people's human rights, and be aware of the implications on human rights of our actions under the Mental Health Act. But that if we follow the legislation in good clinical practice, we will have avoid incompatibility. We will practise safely, but we will not invade people's rights unjustifiably, illegitimately.

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Let's talk a little bit about the evolution of mental health legislation England and Wales. From 1890 there were a number of seminal acts. So the Lunacy Act of 1890, Mental Treatment Act in 1930, Mental Health Act in 1951, a new one in 1983, amendments in 1995 and 2007. Now the law reflects the concerns of society at the time. In fact, the Mental Health Acts from 1959 were all variations on a common theme.

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And so the 19th century legislation was concerned about issues of harm to people who were unjustly detained in hospital. Remember that picture of James Norris chained up. We also have Daniel McNaughton, a Tory gentleman who was tried for the murder of the Prime Minister's private secretary in 1843. And that trial led to a codification of an insanity defence. In 1992 a man called Christopher Clunis killed Jonathan Zito in the context of untreated psychotic illness. And that led to the development of community treatment orders in England and Wales.

Michael Stone was convicted of the killings Lin and Megan Russell, which occurred in 1996. And this led to changes in the definition of mental disorder in the Mental Health Act, and the elaboration of specialist services for people with dangerous, severe personality disorders, the narrative being that Michael Stone had been allowed to roam the streets untreated, because he had an untreatable psychopathic disorder.

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So 1890 we have close textured law, the major concern being to ensure appropriate admission, and this was overseen by Magistrates. For the first time in 1930, we have informal admission and community care being enabled. In 1959 we get compulsory admission and treatment under professional control and the institution of mental health review tribunals-- a legal forum to ensure that detention is lawful. In '83 onwards we get increased safeguards for patients and specific provisions

governing oversight of their consent to treatment. In 2007 we get community treatment orders. We get a broad definition of mental disorder, concepts such as appropriate treatment and deprivation of liberty safeguards, which are all specific technical changes to the law.

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So where are we in England and Wales now? For adults, there are two statutes that govern the care and treatment of people suffering from mental disorder: the Mental Health Act in 1983, and the Mental Capacity Act, 2005. Both of these were significantly amended in 2007. That included the introduction of specific deprivation of liberty safeguards. The Mental Health Act of 1983, the Mental Capacity Act of 2005, and Deprivation of Liberty Safeguards, all have specific community practice attached to them.

All countries have similar sorts of legislation. So we have in Wales laws surrounding the care and treatment of people lacking capacity, and we have laws surrounding the care and treatment of mental disorder.

These two concepts overlap, because many people admitted to hospital who are treated for mental disorder lack capacity at the time of admission. The Mental Capacity Act 2005 doesn't in fact allow you to deprive someone of their liberty. To do that, you either have to use the Mental Health Act, or special Deprivation of Liberty Safeguards, which are a separate provision.

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So what does the Mental Health Act do? It legitimates deprivation of liberty in the hospital. It includes a very broad definition of mental disorder. It provides procedures for civil detention under Part 2, and procedures for the detention of offender patients - including those presenting a risk to the public under Part 3 - and then sets out procedures surrounding compulsory treatment of patients liable to detentions; so treatment provisions under Part 4, procedures surrounding appeal and detention, and legal review of detention - that's Part 5.

So the specific criteria for detention we use in England and Wales are, is there a mental disorder present? Is that disorder of a nature or degree that warrants or necessitates admission to hospital, assessment, and/or treatment? Is admission to hospital in the interests of the person's health, their safety, or the protection of other people? And in the case of longer-term detention, will there be appropriate treatment available?

And again jurisdictions have very similar sorts of provisions. We will note in Wales we can detain on the grounds of a person's health. That will justify detention. Not merely the safety or protection of others. So risk per se is not a necessary criteria.

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Now some data. In England and Wales in 2014/2015, we have 58,399 episodes of long-term detention. That's a 10 per cent increase in a year, and a 50 per cent increase since 2003. So we're enthusiastic detainers in England and Wales, although not the most enthusiastic in Europe, incidentally.

At any one time, there were nearly 20,000 patients detained in hospital. That's on the 31st of March 2015, which is approximately 70 per cent of all inpatients being detained. Also a significant number of patients, more than 5,000, were under community treatment order at the end of March 2015.

Of those people who were detained in hospital, 14,000 had visits from second opinion appointed doctors to review medication or ECT. And there were no less than 17,635 hearings by mental health tribunals. So detention, on the service side, is, to say the least, a big business in England and Wales.

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Many jurisdictions provide for community treatment orders. But these vary in detail and the 'teeth' that they possess. All seek to ensure that certain patients are followed up in the community, and also to varying degrees they are encouraged, persuaded, coerced, compelled to accept treatment-- which usually means medication-- and possibly other conditions.

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It's an interesting question as to whether community treatment orders work. And we have in England a recently reported study called the OCTET study-- the Oxford Community Treatment order Evaluation Trial, which to its author's satisfaction tells us community treatment orders don't work. In reality, at the very best or the worst we can say the evidence for and against community treatment orders is completely, utterly equivocal.

So there are varying views on CTOs-- firstly, that they're the least restrictive option for some people who would otherwise be in hospital, and therefore helpful for some people in staying well and out of hospital. Another view is that they're unacceptably coercive, they're ineffective, and unethical. I have my own views, which are based on my experience, and reading with the science. But I'm not going to tell you what they are.

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So to go back, compulsory treatment of care conjures up many different ideas in people's minds. Is it a bad thing inevitably? Personally, I think not. But others might have different views.

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From a service user's perspective, there's a significant amount of first-person literature on the experience of being detained in hospital against your will, which dates back to the 18th century. There's also some literature on specific coercive experiences in hospital - for example, seclusion and restraint episodes - and that's led to attempts to decrease the use of restraint, and improve patients' outcomes following restraint-- including, for example, using debriefing of patients following serious instance that they've been the perpetrators of.

It is the case that some people find clear boundaries positively helpful, and there's also some objective literature on coercion in compulsory hospitalisation.

Understandably, compulsory treatment as an inpatient is perceived as coercive, although for some, voluntary inpatient treatment is also perceived as coercive. Indeed the outcomes may be worse than compulsorily detained patients' outcomes.

Objectively, coerced patients can nevertheless be reasonably satisfied with their treatment experience, particularly if their symptoms improve. It's notable that compulsion is less upsetting if it's set in a framework of procedural justice-- that is to say, if the processes around compulsion appear to the person to be fair and understandable.

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