Comments on the Discussion Document of the Royal College of Psychiatrists regarding Community Treatment Orders

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(1) I make these comments as a solicitor who specialises in assisting patients detained under the Mental Health Act 1983. The purpose of this article is to point out some of the practical difficulties that would almost certainly arise if a law was passed along the lines proposed by the Royal College of Psychiatrists.

(2) If these proposals became law, no doubt some people would be helped in exactly the way anticipated by the Royal College of Psychiatrists, which I think can be set out in the following example: a patient of 27 lives at home with his elderly parents. He has been diagnosed as suffering from schizophrenia and has been an in-patient at his local hospital eight times since he was 14. His illness is well-controlled by depot medication, but although he is willing to take medication when he is in hospital and also for some months after discharge, he always ends up believing that he can manage without it. He stops injections and over several months he becomes unkempt, suspicious and abusive. He threatens his parents and frightens the neighbours. He refuses to accept that injections will improve the situation, so everyone has to wait until he is so ill that he can be re-admitted to hospital. Once in hospital, he quickly recovers and acknowledges that the medication is essential and so on.

(3) Under these proposals, a Community Treatment Order would be made either when the patient refused to take his medication voluntarily, or at the point when his parents told the psychiatrist that he was starting to relapse. The Order having been made, the patient would comply with its requirements and take his medicine with a good grace.

(4) The legislation proposed would certainly enable this patient's problems to be dealt with in a humane way. The Royal College of Psychiatrists rightly claims that many patients will comply with such an Order once it has been rightly made. The fact of the matter is, however, that the Order is designed not only to persuade the persuadable but also to compel the unpersuadable and when one considers the proposals as far as these people are concerned, the flaws become obvious immediately.

(5) It seems to me that the language of the discussion document is misleading on occasions: most importantly in the use of the word 'treatment'. The Royal College of Psychiatrists defines 'treatment' as it is defined in the Mental Health Act 1983 and it is their use of this definition that I say conceals the truth rather than revealing it. I would suggest that 'treatment' in the terms of a Community Treatment Order could mean nothing other than the administration of depot injections. It is not possible for it to mean nursing, care, habilitation and rehabilitation because none of these can be provided in the community against the wishes of the patient. This is in contrast to those presently held under the Mental Health Act 1983.

(6) If a person subject to an Order under the Mental Health Act 1983 is not willing to comply with the terms of the Order, then eventually force will be used if it is thought essential that the terms should be fulfilled. The person who refuses to go to hospital will be taken, perhaps in handcuffs, by the police. The person who refuses an injection will be held down by nurses while the injection is administered. I expect that the person who refuses to eat will be force-fed. This can all be justified by pointing out that the person is overtly seriously mentally ill and that such actions need to be taken in the interests of that person.

(7) If a patient were to be subject to a Community Treatment Order, it is inconceivable that the police would be called in to take him to an occupation therapy class or to a group therapy session at the hospital. It is inconceivable that the police would stand over him while he washed and dressed. It is also inconceivable that the police would break down his door every morning so that a community psychiatric nurse could see how he was getting on. Obviously, the only possible part of 'treatment' that could be compulsorily administered is that part where the patient is injected with appropriate medication. So let us have no more talk of compulsory nursing in the community, compulsory care in the community or compulsory habilitation and rehabilitation in the community.

(8) The discussion document acknowledges that in the case of the obdurate, hospital admissions will be necessary to administer injections. This conjures up the image of the police going to Mr X's house each month, breaking down his door and taking him to hospital. I find it impossible to believe that this could constitute good clinical practice and the likelihood is that no doctor would continue to insist that somebody remains subject to a Community Treatment Order in

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these circumstances. The patient would either have to be admitted to hospital or the Order would be allowed to lapse. It would be difficult to admit a patient to hospital if it was agreed that he did not need hospital treatment but equally it might be difficult to let the Order lapse because of the legal implications.

(9) It may be argued that patients who have been admitted to hospital seldom continue to resist physically the administration of injections. However, the situation for people in hospital and people out of hospital is very different. It does not take very long for most patients to realise that the best way of getting out of hospital is to co-operate with the medical and nursing staff. Equally, it will not take very long for such patients to realise that if they co-operate with a Community Treatment Order there is no reason for it ever to end. In these circumstances, I think we can expect to see numbers of patients totally refusing to co-operate with a Community Treatment Order.

(10) There are other possibilities which do not appear to have been considered by the Royal College of Psychiatrists.

(11) The criteria for making a Community Treatment Order include previous illness, known responsiveness to treatment and substantial likelihood of relapse.

(12) Paragraph 3.1 states "Previous in-patient detention would not be a requirement...". This is rather ambiguous. Does it mean that "severe mental illness" referred to in the previous sentence need not have resulted in compulsory hospital admission at any time, or does it mean that a Community Treatment Order can be made even if someone has been out of hospital for some considerable time? I think the Royal College of Psychiatrists means the latter, but if they mean the former, I find it alarming that they believe a Community Treatment Order could appropriately be made in respect of a person who has never been compulsorily admitted to a psychiatric hospital. This means that somebody who had agreed to go into hospital on a voluntary basis, possibly for a not very serious condition, runs the risk of being liable to a Community Treatment Order. I wonder how many people will think twice about seeking appropriate hospital treatment if they know they run this risk? Is it right that person should be liable to be subject to a Community Treatment Order who has never been ill enough to require compulsory hospital treatment?

(13) Let us assume that in fact the Royal College of Psychiatrists intend that a Community Treatment Order should only be made on someone with a history of compulsory in-patient treatment. They say that there must be evidence of response to treatment and evidence of a substantial likelihood of relapse. How many responses or relapses would be needed to justify a Community Treatment Order? Surely not just one, for this would imply that a single hospital admission, followed by a relapse when treatment is discontinued, could put somebody at risk of lifelong Community Treatment Orders. Some people who have been in hospital two or three times eventually manage to stay out of hospital and off medication. Will they have the chance in the future?

(14) How will the doctors know when someone is relapsing? Some patients will go on attending the day hospital even when they stop medication, but others will only attend injection clinics and will have no other contact with health professionals. When they stop medication, how will the doctor know that a Community Treatment Order should be applied for? Patients treated by way of depot injections generally take some time to start showing signs of relapse when they discontinue medication and are likely to take some time to stabilise when it is recommenced. Will the doctor apply as soon as he becomes aware that the patient cannot be persuaded to continue medication or will he wait for reports or signs of relapse?

(15) If the doctor waits for reports of relapse, more problems arise. The reports will be from family and other carers who, quite justifiably, have a vested interest in the patient staying well. Will they be over-sensitive in looking for early signs of relapse? If the symptoms of relapse are slight and intermittent they may not be evident when the doctor visits. Does he rely on the word of the family or does he wait for the relapse to proceed far enough for it to be evident to him? The Royal College of Psychiatrists say that the wording of s.3 will be followed. This means that the doctor or approved social worker will have to be satisfied that the patient is suffering from mental illness. If the patient is symptom free (when the doctor and approved social worker are there) and off medication (even though the residue is still in his body) I think that there might be some difficulty in claiming that someone is suffering from mental illness. One can say that they have suffered and maybe that they are likely to suffer but to say that because they have suffered they must now be suffering seems insupportable. It denies, for instance, spontaneous remission and the illness burning out in old age.

(16) It seems to me, therefore, that no Community Treatment Order could properly be made unless signs of relapse are visible to the doctor and approved social worker, by which time the patient will undoubtedly be unstable. Let us assume that a Community Treatment Order is made at this point and the patient complies with it. Let us also assume that the doctor requires the patient, under the Order, to attend at his next injection clinic at the hospital. This the patient duly does. The doctor who had seen him for less than an hour to make the diagnosis two days before, sees him for ten minutes in the injection clinic and tells him to come back in three weeks time for another injection.

(17) The patient was unstable before the medication was administered because he was in the process of relapsing into his illness. He has then been given powerful anti-psychotic medication which will gradually affect

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him over a period of weeks, not necessarily in ways that can be foretold. Can it really be good clinical practice to send him home to his mum and dad or to his after care hostel, or, quite likely, to his bed & breakfast accommodation?

(18) It seems a heavy burden to place on community psychiatric nurses to monitor the progress of these people and, as I have already pointed out, there is no way that a patient can be compelled to accept monitoring from a community psychiatric nurse.

(19) How will Community Treatment Orders ever end? Will doctors allow drug-free periods? Will these be long enough for the patient to stabilise or will medication be resumed as soon as signs of relapse occur?

(20) What about people who move from one area to another? If they have a psychiatric history in one area and they move to a new area, can a Community Treatment Order be justified on the basis of notes from an unknown doctor?

(21) The reference to Mental Health Review Tribunals is a red herring. The Royal College of Psychiatrists are proposing that a Community Treatment Order will be appropriate if somebody has had severe mental illness and there is a substantial likelihood of relapse if they do not continue medication. If an Order is made in such a case and the person requests a Tribunal, all the doctor needs is to bring evidence of past illness and past relapse to justify the Order. At the moment Tribunals can discharge even if they think the patient is ill so long as he does not need to be in hospital. Under a Community Treatment Order the only grounds for discharge will be that the patient is not ill. It is notoriously difficult for a patient who is apparently well and is on medication to convince anybody that he would be equally well without medication. When the first Community Treatment Order is made on a patient there may be some symptoms but, after two or three years of continuous Community Treatment Orders, who will be able to tell if somebody still needs medication?

(22) If these proposals became law then there are a number of easily identifiable people who would immediately become subject to Community Treatment Orders. However, after a fairly short period of time it would be much harder to identify these people because there will no longer be mental health 'recidivists'.

(23) I think the Royal College of Psychiatrists should also consider the rod that they are making for their own backs in proposing this new power for themselves.

(24) The power to make Community Orders will bring with it a duty to make a Community Treatment Order when necessary. Doctors are presently responsible for injury done to patients in their care through their negligence. It seems to me quite likely that if doctors are in a position to make Community Treatment Orders, then doctors will continue to be responsible for patients even after the patients come off Hospital Orders and doctors will have a duty to impose Community Treatment Orders if necessary. Obviously, this will be a matter of clinical judgement, but what would happen if the parents of an ex-patient of a particular doctor rang the doctor and said that the ex-patient was relapsing and was threatening them in a way that he had done prior to his first hospital admission? If the ex-patient injured somebody (or himself) before the doctor had taken steps to see if a Community Treatment Order was appropriate, I think it is quite likely that civil proceedings might be issued in High Court. With this in mind, how long would it be before doctors started practising defensive medicine—automatically applying for Community Treatment Orders on patients who can fit the criteria or whom the criteria can be made to fit?

(25) If the lack of Government funding for care in the community continues (and why should it not) there will come a time when community provision will consist of little more than a couple of community psychiatric nurses bicycling round with a caseful of syringes each. It will not take the accountants long to work out that a Community Treatment Order provides much better value for money than the provision of staff and facilities to build up trust so that people take medication voluntarily. Thus, it will come about that even those mentally ill people who wish to take advantage of community facilities will have those facilities withdrawn from them.

(26) I am sure that the psychiatrists who drew up the discussion document have personal experience of chronically ill people who apparently cannot be helped under the present law, and that it is their intention to try and help such people. I fear, however, that they will not only gain power over many people who they would presently not wish to have power over but would also, eventually, run the risk of damaging those that they sought to help in the first place. For example, let us think what might be the position of the young man I mentioned at the beginning of this article in 20 years' time.

(27) After the Mental Health (Community Treatment) Amendment Act 1988, came into force, the patient remained constantly on Community Treatment Orders. His treatment consists of monthly injections at the injection clinic of the hospital where he was an in-patient so many years before. The consultant who knew him when he was an in-patient has long since died and all the junior doctors who knew him then have moved elsewhere. There are one or two nurses at the hospital who would still remember him, but they never see him because they work on the wards and he only goes to the clinic. The medication that he takes keeps him 'symptom free' but he is unable to work because of the side effects of the medication and he spends most of his time sitting in the TV lounge of the hostel where he moved after his parents died. He cannot go to the day hospital any more because day hospital places are now reserved for those who have received in-patient treatment within the last ten years. There are many people in his hostel who are in the same

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position as him. Community Treatment Orders have been so successful in keeping people out of hospital that there are now very few in-patient facilities, either acute or long-stay. Unfortunately, the money saved has not gone into the provision of suitable community facilities but has simply gone into the general pool of National Health resources. It is up to the local authorities to provide community facilities which many of them have neither the inclination nor the ability to do.

(28) He did apply once or twice for a Tribunal in the early years, but it is years since he has bothered. The evidence of his original illness and repeated relapses is so clear that no Tribunal can say that he is not somebody who should be subject to a Community Treatment Order. Of course, they are frightened to discharge him from the Order 'just to see what happens', because there are no facilities for helping him to deal with the withdrawal symptoms that would undoubtedly follow such a long period of medication.

(29) Or imagine another person subject to a Community Treatment Order. She is not like the first patient just referred to who is willing to take medication if the law says he must. She loathes the medication that she is forced to take. She believes that it conceals her true personality and she avoids taking medication whenever she can. When she is off medication she feels that she is her true self and even though this might be a rather wild and difficult self for other people to deal with she would much rather be like that than the drug-stunned person that she feels herself to become when she is subject to a Community Treatment Order. She is religious, and feels that she has a duty to bear witness. She too was in and out of hospital for many years prior to the coming into force of the 1988 Act. She would take her medication whilst in hospital, and would quickly become fairly well but she always made it quite plain that she would stop medication as soon as she was legally entitled to do so. She knew that under the 1983 Act the length of time she could be made to take treatment once she had been discharged from hospital was strictly limited, so it was just a matter of waiting for that period to end and then gradually feeling her true self returning to her.

(30) She was one of the first people to be made subject to a Community Treatment Order. She also went through the normal channels of trying for a Tribunal and appealing to the Hospital Managers to no avail. She was legally represented on a number of these Tribunals, and one of her solicitors had told her about s.18 of the 1983 Mental Health Act. She was aware that this section also applied to patients subject to Community Treatment Orders under the 1988 Act and as her only obligation under the 1988 Act was to attend once a month for her injection she knew that if she failed to attend and was not apprehended within 28 days then her Community Treatment Order would lapse. For many years, therefore, she had led a peripatetic existence. She had run away from her hostel soon after her first Community Treatment Order was made. She had saved up a bit of money because she knew she would not be able to claim Social Security for at least a month; otherwise she might be traced. Her savings did not last her for a month so for the last few days she was sleeping rough. Eventually, she got herself sorted out and found herself a bedsit where she stayed while the effect of the medication gradually wore off. In due course her behaviour became so bizarre that she was admitted to hospital. She did not let them know that she had been in hospital before and indeed she was so vague about herself that the doctors thought she was more ill than was actually the case. They were impressed at how quickly she recovered with medication and she was soon discharged to 'community care'. The doctors had advised her to continue with medication but she stopped as soon as she left hospital and in due course she was re-admitted. This time a Community Treatment Order was made after she had been discharged. At that point she moved on again to a different area and started the whole cycle again.

The trouble with the discussion document is that it attempts to equate the position of a mentally ill person in the controlled environment of a hospital with the position of the same person in the uncontrolled environment of the outside world. What are appropriate powers in one situation are either dangerously inadequate (in terms of suitable treatment) or too restrictive (in terms of civil liberties) in the other situation.

(31) When the 1959 Mental Health Act came into force, large numbers of elderly patients emerged blinking into the world from the back wards. When the 1983 Act came into force, another group of patients whose cases had not been reviewed for years, found themselves being placed back in the community. This proposed legislation will be a retrograde step, in that it will be creating the forgotten people of tomorrow.

I have dealt here only with some of the practical consequences of the proposed legislation. I have done so because I hope there can be little argument about the undesirability of these consequences. I also object to the proposals on philosophical grounds. I believe that they breach the civil liberties of the individual to an unacceptable extent and extend the powers of psychiatrists to a level that many people would find undesirable.

The College is at present collating the wide range of comments it has received on its discussion document on Community Treatment Orders and a formal document will be completed in due course.

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