

# Community treatment orders – a bridge too far?

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Compulsory treatment in the community is high on the agenda in the current review of mental health legislation and the government has already announced its intention to introduce a 'community treatment order' (CTO; Department of Health, 1998). Concern about the implications of community care has been gathering momentum over the last decade, spurred on by tragedies such as those involving Ben Silcock and Christopher Clunis in the early 1990s. The notion that community care has failed has taken deep root with the media and the government (Department of Health, 1998). This is despite the lack of any evidence to suggest that mental illness is less effectively treated (Johnstone *et al*, 1991; Anderson *et al*, 1993) or that violence attributable to the mentally ill is rising (Taylor & Gunn, 1999). It also indicates a tendency to ignore the fact that patients prefer to live in the community (Tyrer, 1998). Psychiatrists, who are increasingly implicated in this purported failure of care, feel besieged. In such a climate, the promise of more power is understandably attractive. However, we feel that psychiatrists should resist pressure for this sort of 'quick fix' and reflect upon some of the dilemmas involved.

## Ethical objections

Groups representing psychiatric service users such as Survivors Speak Out and Mind, are implacably opposed to CTOs, which they perceive as a further erosion of their civil liberties (Mind, 1998). It was concern for patient rights that underscored the move away from the asylums earlier this century. The provision of medical and social care in the community was intended to enable people with psychiatric disorders to maintain the status of ordinary citizens except at times of acute crisis requiring hospitalisation. CTOs represent a new and discriminatory departure from this position. CTOs will mean that people who are living and surviving in the community, who have committed no crime, and who are deemed competent enough to marry, vote and enter into business contracts, will be deprived of certain basic

human rights enjoyed by the rest of the population. In particular, they will be unable to determine what happens to their own bodies and are likely to be forced to ingest psychotropic drugs on a long-term basis, against their wishes.

Being part of a tolerant society means recognising that sometimes people will not do what others feel is best for them. Psychiatrists should respect their patients' decisions about how to live their lives and be prepared to help manage the consequences, such as providing care during relapses or exacerbations, if these occur. By differentiating between the human rights of people who have been psychiatric patients and the rest of the population, CTOs will add to the stigma attached to the notion of mental illness which the Royal College of Psychiatrists is trying, laudably, to combat (Byrne, 1999).

## Practical objections

The rationale for CTOs consists largely of the idea that adequate drug treatment can provide a solution to the problems posed by severe mental illness. Indeed, empirical research has found that psychiatrists view CTOs primarily as a means of enhancing adherence (Senksy *et al*, 1991). However, the effectiveness of drug treatment is limited. It has been estimated that at least one-fifth of patients diagnosed as suffering from schizophrenia fail to respond to antipsychotic drugs in the first place (Kane, 1988). Nor do drug treatments reliably prevent relapse if remission occurs. Fifty per cent of drug-treated patients with schizophrenia relapsed over two years in one prospective controlled trial (Crow *et al*, 1986), and this proportion may be higher in everyday practice. Naturalistic follow-up studies of patients with bipolar disorder also suggest high rates of relapse despite long-term drug treatment (Moncrieff, 1997). CTOs therefore provide no guarantee of reducing psychiatric morbidity and are likely to increase the number of people on long-term medication who derive no benefit from it.

Recent evidence also questions whether the more intensive monitoring that CTOs will

facilitate has any advantages over the standard care that is delivered in the UK currently (Wykes *et al*, 1998).

Even if drugs always cured or controlled mental illness, dangerous behaviour by current or former psychiatric patients would not be eradicated. The propensity to violence arises from a composite of factors and dangerous behaviour is much more strongly predicted by demographics and substance misuse than by the presence or otherwise of mental illness (Wallace *et al*, 1998). In addition, factors that predict violence in the general population also apply to people with schizophrenia (Wessely *et al*, 1994). As long as there is violence in society, it is unrealistic to expect that dangerous behaviour among people with psychiatric diagnoses can be eliminated. However, if CTOs are introduced there will be an expectation that such violence can be reliably controlled. In such a situation psychiatrists will be more vulnerable to criticism if, inevitably, untoward incidents occur.

### Harmful effects

CTOs are likely to result in increased consumption of neuroleptic medication, since some patients who would formerly have exercised their right to refuse such treatment, will be unable to do so. These drugs are well known to cause occasional life threatening complications, a myriad of unpleasant side-effects for the patient, and irreversible neurological defects in a significant proportion of long-term users. New antipsychotics are associated with their own dangers and adverse effects and neither are they completely free of the extrapyramidal side-effects typical of older neuroleptics (Cohen, 1994). Thus, CTOs are set to increase the level of iatrogenesis attributable to psychiatry.

Perhaps the most damaging consequence of CTOs is that they are likely to further alienate patients, especially those with the most complex problems. Much of the current dissatisfaction expressed by psychiatric service users emanates from their experience of compulsion (Rogers *et al*, 1993). A predictable consequence of more control is that it will lead to further conflict. CTOs may therefore have the effect of undermining the possibility of building constructive therapeutic relationships and of working in partnership with patients towards recovery.

### Comment

CTOs are the wrong answer to the wrong question. The right question is not how psychia-

try can control antisocial behaviour, but how to address the gulf that exists between patients and professionals in mental health services. Psychiatrists should be concentrating on ways of improving relations with patients and should oppose legislation which is likely to damage this process. As professionals we must resist the invitation to use the notion of treating illnesses, or preventing violence, as a pretext for a political endeavour to enforce conformity of lifestyle and behaviour.

### Acknowledgements

This paper was informed by discussions involving a number of psychiatrists who are campaigning to oppose the introduction of CTOs. We would like to particularly thank Phil Thomas and Pat Bracken who collated the results of these discussions. The authors can provide details of the campaign for anyone who is interested.

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