

Legal leverage

Tony Zigmond's editorial about 'leverage' in English mental health-care helps to demonstrate the promotion of coercion without appeal (as may be even more common in the USA) resulting from an apparent contradiction in local mental health law:

'Even when taking medication is a condition attached to a conditional discharge (from a restriction order, Mental Health Act 1983) or community treatment order, it would be unlawful to recall the individual solely because the individual decided to refuse the medication.'¹

Presumably at the time of conditional discharge (including the requirement that they continue prescribed medication) the person is well enough to cope with the requirement. They are coerced (by stated conditions), hopefully, because it has been demonstrated that without medication they are highly likely to become unwell again.

So what is different about the situation where the person is out of hospital and stops their medication, that they cannot be legally coerced to take it? Has the person changed in some way when they face a similar clinical risk?

Is it better to have a legal provision for this coercion outside the hospital, with all the necessary legal safeguards and reviews required (as under the Australian New South Wales Mental Health Act 2007) or to await decompensation and have caring people desperately trying to forestall such an event, possibly with illegal (and possibly inappropriate) 'leverage' pressures?

The article does not address the often characteristic accompanying distress to the person and their network when a person decompensates into more disorganised psychosis. Perhaps 'he died with his rights on'.

In the Australian New South Wales Act, intervention requires not only the 'least restrictive' option, but also the 'continuing condition' of a mentally ill person and risk of ANY harm. In other words, if the history indicates a chronic illness and the likelihood of decompensation off medication, this must be considered, even if the person is apparently getting by at the time.

Perhaps failure to initiate sensitive intervention, including coercion as necessary, with legal safeguards and appeal capacity, in such circumstances, is negligence. Such intervention may also be regarded as a 'loving act'.

To say that a person has the capacity to make a decision does not determine the quality or appropriateness of that decision.

To say that a person is 'capacitous' because they are capable of apparently understanding their situation (and so 'having the capability of making decisions about their own treatment') and have 'insight' is to leave open much definitional argument, but it is not appropriate as the sole determinant of non-intervention in a situation of carefully determined clinical risk to the person and the legitimate distress of others.

In asking 'Who should have the final say?', Zigmond seems to assume that this question is resolved by choosing either the patient or the psychiatrist. In matters of coercion it is the law that has the final say and at its best it seeks widely and wisely for an answer – hence tribunals. Hence also the need for good law.

It may be that the (statistical numbers) rise in coercion in psychiatric practice is necessary, but dealing with doubts about its desirability is not best met by placing difficulties in the way of people getting treatment they need to live their lives most fulfilling and with others. Rather, the preferred emphasis may be for more careful review, in particular cases, of the necessity of coercion and of prescribing choices.

1 Zigmond T. Pressures to adhere to treatment: observations on 'leverage' in English mental healthcare. *Br J Psychiatry* 2011; **199**: 90–1.

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Coercion, compulsion, adherence, compliance, persuasion and like terms need to be in our clinical consciousness, as recently articulated in the editorial by Zigmond in relation to an English study on leverage.^{1,2} The suggestion that resolving the practice of leverage/coercion is best left to patient choice assumes that there is a lot of coercion going around, albeit erringly. His assumption that other branches of medicine are devoid of similar practice is flawed and incorrect. Removal of children who are obese from their parents, denial of driving rights to individuals with epilepsy who choose to drive and the mandatory revelation of HIV status to partners by reluctant spouses are but few examples of similar coercion in other branches of medicine. It is worth noting that, in these examples and in the examples of mental illness, focusing only on the patient's choice narrows the implications of those choices as they affect others. It also takes away from physicians the collective role they play to the society at large. The following reasons are why, at the time we are trying to allow voluntary participation in treatment decisions, we must guard against amplifying and magnifying 'choice'.

First, choice is shaped and essentially dependent on insight. Correlates of insight are no longer restricted to anosognosia-like views or neuropsychological dysfunction based on injuries to frontal, parietal or temporal lobes. Volumetric reductions in several cortical regions evinced by neuroimaging studies are well documented in chronic schizophrenia and first-episode psychosis.^{3,4} Consequently, lack of insight, unawareness of illness and the need for treatment can no longer be relegated to the domain of choice. Those involve a network of brain structures affected by the disorder. Even the law recognises this in assigning the 'but for mental disorder' designate in various medico-legal criteria.

Second, medico-legal provisions of treatment are unfortunately driven by public reactions to failures in the mental health system. The law is then made and takes precedence in determining the acceptable level of risk to which the society should be exposed. This is known as 'where the public peril begins'.⁵ In recognition of the implications of the choices made for and against treatment, the tension between autonomy and beneficence has not stopped being the most contentious of ethical quagmires. A broader perspective is in order beyond choice.

Third, the rates of coercion cannot categorically be said to be increasing, as opined by Zigmond. To modify the perceived alarming statistics he referenced, other relevant factors should be recognised alongside the increasing number of formal compulsory hospital admissions (1987–2010). The population of English society has not only increased over the past three decades, it has become more diverse with migrants who affect rates of mental disorder as well as the potential for coercion. The tolerance for mental illness and societal acceptance is changing. Community support for patients, a by-product of economic prosperity, has dwindled,⁶ contributing to coercive approaches from both family and practitioners. Although litigation of practitioners is lower in the UK than in the USA, it is nonetheless relevant in determining physicians' attitudes towards voluntariness.^{7,8}

Finally, when the treatment of our patients considers the past and the future, progress in reducing stigma necessitates the use of leverage in some situations. The high rates of the use of leverage have been suggested as a good thing. The Americans have experienced a 'before and after' paradigm of reducing leverage. 'Rotting with their rights on' was not only a title of scientific publications but was the terminology used to describe the repercussions. The UK should learn from this that there are tragic and costly consequences in focusing only on choice.⁹ Despite decades of that experiment in the USA, the opinion to use leverage as a positive tool still exists.¹⁰