Coercion and compulsion in community mental health care

Andrew Molodynski*, Jorun Rugkåsa, and Tom Burns
Oxford University Department of Psychiatry, Social Psychiatry Group, Oxford, UK

There is ongoing debate in the UK as to the place of coercion and compulsion in community mental health care. Recent changes in service provision and amendments to the Mental Health Act in England and Wales have increased the scope for compulsion in the community. This has intensified the debate revealing fault lines in the psychiatric and legal professions. Despite powerful arguments from all sides there is little empirical evidence to inform this debate at a clinical or a theoretical level. This review utilizes evidence from articles in peer reviewed journals. Papers were identified from electronic databases, the authors’ databases of relevant literature and personal correspondence with experts in the field. The evidence base is relatively small but is expanding. It has been demonstrated that informal coercion is common in USA mental health services and can be experienced negatively by patients. There is evidence that powers of compulsion in community mental health care are used frequently when available and their availability is generally seen as positive by clinicians when practice becomes embedded. The evidence for the effectiveness of compulsion in community mental health care is patchy and conflicting, with randomized or other trials failing to show significant benefits overall even if secondary analyses may suggest positive outcomes in some subgroups. There are widespread regional and international differences in the use of community compulsion. Research examining treatment pressures (or ‘leverage’) and the subjective patient experience of them appears to be expanding and is increasing our awareness and understanding of these complex issues. There is an urgent need for evidence regarding the usefulness and acceptability of compulsion in the community now that powers have been made available. Trials of the effectiveness of compulsion are needed as is qualitative work examining the experiences of those involved in the use of such orders. These are needed to help clinicians utilize the powers available to them in an informed and judicious fashion and to ensure adequate training.

Keywords: coercion/compulsion/community mental health care/community treatment orders/informal coercion/treatment pressure/leverage/community psychiatry/outpatient commitment

Accepted: April 28, 2010
Introduction

Issues of coercion and compulsion in the community care of people with severe mental illnesses are among the most hotly debated in psychiatry. This debate has been ongoing since the first attempts to support and/or control those with severe mental illnesses and over the years has evolved in parallel with the evolution of psychiatric and social care. Until recently this debate generally focused on treatment in hospitals, initially large institutions and then smaller more local psychiatric units. With the move towards providing ‘care in the community’ the locus of treatment in most developed mental health care systems has changed substantially.

The introduction of the functional mental health teams in the UK, prescribed in the National Service Framework for Mental Health, has further enabled the intensive community treatment of those with severe mental illnesses. Substantial amendments to the Mental Health Act (MHA) in England and Wales in 2008 have for the first time explicitly provided for compulsory supervised community treatment. The aim of these changes was to provide care and support for patients outside hospital to enable them to achieve the highest level of functioning possible while reducing frequent readmissions in the so-called ‘revolving door’. In the controversy surrounding these changes, increasing emphasis has been placed upon the need to establish the extent and impact of informal coercion (often referred to as ‘leverage’ or ‘treatment pressure’) in community mental health services, capturing the subjective experience of those receiving care.

This review article will first outline some of the historical and recent changes in the UK mental health services and mental health legislation. It will then explore practical and ethical issues of both informal and formal coercion, focusing particularly on recently introduced powers of compulsion in the community in England and Wales.

The move into the community

Throughout the 19th and the early part of the 20th century, large asylums were built across Europe and the USA to treat, confine and exclude from society those with mental illnesses. This in part reflected a societal fear of ‘madness’ and the stigmatization of the mentally ill, both still major concerns over 100 years later. In 1954, there were 150,000 psychiatric hospital beds in the UK and little in the way of community care. This meant that most people with severe mental
illnesses were treated in hospitals and that compulsory (or coercive) treatment occurred almost solely in these settings.

In the last half century there have been major changes in the provision of psychiatric services, with a progressive reduction in psychiatric beds. The latest census of psychiatric beds in England and Wales reported that there were 30,533 in all, 16% of these in the private sector.4 There has been a parallel expansion in community services to provide treatment and support for those no longer in hospital. A number of factors came together to begin the process of deinstitutionalization and the move into the community. Increasing concerns about the quality of care in large institutions and the effects this could have upon patients5 were reinforced by a number of scandals regarding abuses by staff and patients upon the most vulnerable. Effective treatments for severe mental illnesses such as chlorpromazine became widely used in clinical settings in the latter half of the 1950s.6 This caused a change in professional attitudes to the outcome of psychotic illnesses and real optimism for the potential cure or containment of symptoms. At the same time, the 1959 MHA was introduced requiring psychiatrists and social care agencies to provide aftercare in the community following hospitalization. Despite these important changes within mental health care services themselves, the most powerful drivers of change were probably external. The introduction of the welfare state meant people no longer needed to be in an institution to be provided with material support. This in turn created a potential opportunity for significant financial savings as large asylums were expensive to run. It was in this climate that Health Secretary Enoch Powell made his now famous ‘water tower speech’ in 1961, urging the halving of psychiatric bed provision in 15 years.7

In the decades that followed large hospitals were progressively closed in many countries. There was considerable variation in the rate of closure and the provision of community services. In the USA, the process of deinstitutionalization was particularly rapid and community provision was initially (and in some respects still is) patchy.8 Changes were more systematic in the UK and through the 1970s and 1980s community mental health teams were introduced that covered all geographical areas and were characterized by a multidisciplinary approach and high regard for continuity of care. These changes have generally been perceived as positive, despite a number of high-profile failures of community care.

The last decade has seen significant changes in the UK mental health services, with large increases in funding to provide more intensive community services. The National Service Framework for Mental Health1 specified detailed service configurations and led to the widespread establishment of Assertive Outreach, Early Intervention and Crisis
Resolution Teams; the ‘functional mental health teams’. These teams differ in a number of respects, but all allow for high levels of contact and support for those with severe mental health problems. Specialized services such as Assertive Outreach are generally welcomed by patients and families and have led to improved levels of satisfaction. By their very ‘assertive’ nature however, they may be perceived as coercive or pressurizing. This increases the need to improve our understanding of such pressures and how they affect the relationships between patients and services.

Informal coercion in community mental health care

Debates about the use of pressure in psychiatry have traditionally focused on the formal mechanisms for compulsion, which until recently would involve compulsory admission to hospital. However, this represents only part of the overall picture. A number of different strategies (often called ‘leverage tools’) are routinely used to encourage or even pressurize patients to accept treatment. Such pressures can usefully be thought of as constituting a hierarchy, ranging from ‘persuasion’ at the least coercive end to ‘compulsion’, which is often used as last resort when relationships have broken down: Figure 1 (from Szmukler and Appelbaum).

These different levels of pressure can be understood in routine clinical practice in the following case.

Debbie is a 30-year-old woman with bipolar disorder who has had a number of admissions to hospital over the years, often detained under the MHA. Between admissions she keeps well and functions as long as she accepts medication and support. Without these she quickly becomes unwell. Her illness has been damaging to her life situation and as a result she has only limited contact with her two daughters, aged 6 and 4. Debbie has just stopped taking her medication. Her community nurse, Tom, is increasingly concerned about the situation and keen to try and avert another damaging relapse. He is aware that while medication does not guarantee stability it appears to have worked well for Debbie over the years.

Tom talks to Debbie and explains the evidence for medication in bipolar disorder and the fact that her pattern of relapse indicates that this applies to her. This is ‘persuasion’.

Persuasion fails, and Tom tries to appeal to Debbie on the basis that they have known each other for a long time; he has always been there to help and would not advise her to do something that was not in her best interests. He has moved from a simple explanation to a more
personal approach using their relationship to try to achieve his goal. This is ‘interpersonal leverage’.

Tom’s appeals did not work and Debbie is starting to show early signs of deterioration. There is a sale of children’s clothes coming up and Debbie wants to buy something to give to the girls when she next sees them. Tom offers to give her a lift but says he can only do so if she is reasonably well. Whether or not Tom means to imply she needs to take treatment in order to gain his assistance is left unclear, but that is Debbie’s assumption. This sort of offer contingent upon accepting treatment is known as ‘inducement’ in Szmukler and Appelbaum’s hierarchy.

The following week Debbie is due to see her daughters. She is still refusing treatment and now shows signs of irritability, which for her is an early sign of relapse. Tom explains that the access visit might have

---

**Fig. 1** Hierarchy of treatment pressures.

- **Persuasion**
  - Clinician sets out benefits of a particular course of treatment
  - Provides information and answers concerns and questions
  - Patient is free to either accept or reject the advice about the treatment

- **Leverage**
  - Clinician can use personal relationship with patient to influence decision-making process
  - Additional pressure can be placed on patient by expressing approval of one course of action and disapproval of another

- **Inducement**
  - Clinician may suggest that patient will receive additional support or services if they agree to participate in the suggested course of treatment

- **Threat**
  - Clinician may suggest that services and support will be withdrawn if patient does not comply with treatment
  - Clinician may also mentioned that use of the MHA will be considered if the patient does not comply with treatment

- **Compulsion**
  - Clinician will compel the patient to take treatment against their will by legally requiring them to adhere to treatment, either in the community or hospital, by using provisions of the MHA
to be cancelled if she gets any more irritable or is still refusing treatment, and that he has a duty to let social services know about the situation. Given the link between declining support and/or treatment and Debbie’s ability to see her children, this may be classified as a ‘threat’. Another form of threat might be Tom explaining to Debbie that she may need to be taken in to hospital soon unless she starts to take treatment voluntarily.

Debbie deteriorates further and becomes chaotic and angry. She is now at risk and is still refusing treatment and Tom reluctantly arranges an MHA assessment. Debbie is detained under the act and taken to psychiatric hospital. This is ‘compulsion’, the use of legal powers. Debbie will be deprived of her liberty but will have right of appeal to an independent tribunal.

Interactions such as those between Tom and Debbie occur every day in clinical practice. The lower levels of pressure may be helpful and appropriate in our relationships with patients. After all, pressure is ubiquitous in human relationships and likely to be particularly pertinent in challenging and difficult ones. Given this, it is important that we acknowledge these issues and attempt to understand as much about them as possible. The current evidence base is small. The most substantial work on such informal coercion is from North America, conducted by Monahan et al. Their study explored self-reported coercion (which they call ‘leverage’) among a large sample of psychiatric clinic attendees in five different areas of the USA. The study aimed to determine the prevalence of subjective experiences of the use of leverage, and their association with patient characteristics and treatment patterns. The term leverage is more commonly used in the North American literature. Similar to Szmukler and Applebaum’s concept of treatment pressures, ‘leverage’ refers to the perception that the provision of some form of support is contingent upon the acceptance of treatment (often medication). The researchers asked interviewees about their experiences of leverage in four domains of life and the results are shown in Figure 2.

The levels of experienced coercion were reported as a range because the study was conducted across five sites and rates of individual leverages differed considerably. Overall rates of self-reported leverage were between 44 and 59% at all sites leading the researchers to conclude that the use of leverage was ubiquitous in routine mental health services. While overall rates of leverage were similar in different areas the actual form it took varied significantly across the sites. The researchers believed this may be because clinicians used what was locally available.

Monahan et al. also found that approximately 11% of mothers and 6% of fathers with mental illnesses reported they were required to take
medication or attend treatment sessions in order to maintain custody of their children. Other studies have suggested that such experiences can delay or prevent help seeking and be a cause of stigma. Monahan et al. demonstrated significant positive associations between overall reported leverage and a number of factors, including:

- younger age (44 or below);
- lower level of functioning, as defined by global assessment of functioning score;
- multiple previous hospital admissions;
- higher intensity outpatient use;
- longer overall time in treatment.

Such characteristics are also common in those under the care of community mental health services in the UK, suggesting that there are similar issues for our services. It has been put forward by some that the majority of psychiatric patients in the UK experience their care as coercive, as they know of the existence of powers to compel. Some authors argue that no one is entirely free in a system that contains compulsion.

### Compulsion in community mental health care

As described above, deinstitutionalization has gradually moved psychiatric services into the community. The necessity of providing formal coercive treatment outside hospitals is now commonly accepted and is reflected in the recent changes to the 1983 MHA. Extended leave of absence (section 17 leave) for those detained in hospital has been used for many years and has been shaped by several legal challenges. It is generally agreed that such leave continues to have a place in mental...
health services and can constitute an important part of a patient’s treatment plan.

In 1996, aftercare under supervision (also known as supervised discharge or section 25) was introduced. This could be used to require patients to attend for treatment, live where directed and make themselves available for assessments but did not require them to accept treatment. Guardianship (section 7) can require a patient to attend for assessment or treatment and direct where he or she should reside. Guardianship is commonly used for those with cognitive impairment but relatively little used in community psychiatry.

The next step in the evolution of formal coercion in the community in England and Wales was the introduction of supervised community treatment in 2008, as part of the substantial amendments to the 1983 MHA. Under this regime, an individual can be made subject to a community treatment order (CTO) if they are deemed to need ongoing compulsion following a hospital admission under sections 3 or 37 of the Act (treatment orders). The order contains two mandatory conditions: that the patient must make him or her self-available for examination by a second opinion doctor and again for the purposes of possible renewal. Further conditions are usually imposed by the initiating clinician to ensure the patient receives treatment and to protect the patient and/or others from harm. Breaching of conditions, such as non-adherence to medication, may lead to recall to hospital in the absence of signs of relapse. It is far from clear how often the powers of recall will be used. The international experience shows variation from frequent use in several US states to relatively low rates in some New Zealand services.

It is too early to precisely determine patterns of CTO utilization in England and Wales. The most common conditions so far seem to include a requirement to accept medication, agreement to see mental health workers and sometimes residence in a specified location. Conditions must only be made if necessary for the health and safety of the patient or others and excessive restrictions may breach human rights legislation. Section 17 leave remains available (and is still accepted practice). However, clinicians are now directed to consider using a CTO instead if granting leave for 7 consecutive days or more. This change, along with the removal of supervised discharge, signals that government views CTOs as the primary method of providing involuntary supervision in the community. The CTO is the only legal regime, which can insist on adherence with medication (although medication cannot be forcefully administered unless the patient has been recalled to a ‘safe place’).
The debate surrounding CTOs

The introduction of supervised community treatment has been highly controversial and was preceded by a heated debate lasting more than a decade. In other countries there have been similar levels of debate and controversy but when made available, orders were incorporated into practice swiftly. Initial proposals in England and Wales were met with broad opposition from service users, psychiatrists and mental health charities. The amended proposals, now enshrined in law, continue to provoke vigorous debate and the psychiatric profession remains divided. Some view CTOs as ethically unacceptable because of the infringement of rights and freedoms. Others believe they are potentially beneficial to patients and their families, or argue that they constitute only a minor amendment to current law or practice.

The arguments on individual human rights, and people’s rights to make lawful decisions about their own lives have been particularly forceful. This position provides powerful arguments against coercive treatment but may be vulnerable to the criticism that such a purely rights-based approach could leave ‘revolving door’ patients in unacceptable circumstances, preventing them from improving their lives. Not to pursue compulsory interventions could be seen as conflicting with mental health practitioners’ primary obligation to help.

Much of the debate has centred on issues of an individual’s capacity to make decisions about his or her treatment. Such competence may, of course, be compromised or even absent in those with severe mental illness. Others may have to make decisions on their behalf. This requires good knowledge about the person’s values and opinions based on when he or she was capacitous. It is commonly viewed as appropriate that when the patient’s views are not available ‘best-interest’ standards should be applied.

It has been argued that while politicians sought to introduce CTOs in order to address the public’s fear of crimes committed by people with mental health problems, the protection of society is an insufficient reason to justify detention. This is particularly the case given the difficulty in predicting serious violence by those with mental health problems. The ‘principle of reciprocity’ requires that restrictions of civil liberties must be matched by the provision of adequate and high-quality services. This was one of the underpinning principles of the amended MHA in Scotland, which introduced compulsory powers in the community in 2005. Some have suggested that the use of compulsion may be enabling and consistent with ‘the recovery model’ if adequately resourced and accompanied by clear goals for treatment and progress.
Despite the fact that CTOs have now been introduced in England and Wales and are being extensively used (over 4000 where applied for in the first year following their introduction in November 2008), the debate continues with intensity. Unresolved issues include:

- whether capacity should have been a fundamental principle of the new Act;
- whether having CTOs will increase the overall level of coercion;
- whether CTOs can contribute to better outcomes;
- which patient groups may benefit from CTOs, and in what way;
- whether a ‘lobster pot effect’ means it is relatively easy to be placed on a CTO but harder to ‘get off’ one, leading to an inexorable rise in numbers over time;
- whether potential benefits justify the restrictions in civil liberties.

The evidence

The debate regarding CTOs is, in part, sustained by a lack of convincing evidence for their effectiveness. There have been a number of studies evaluating CTOs internationally, particularly in Australasia and North America, and this research has been reviewed in detail by Dawson and Churchill et al. The majority of the existing research consists of observational, non-randomized studies, explorative surveys of stakeholder views or service evaluations. It is problematic to generalize from these findings because of differing methodologies, legal systems and healthcare contexts.

In his review, Dawson points out that after an initial ‘bedding in’ period, the use of CTOs often increases. This is particularly so where there is a reduction in hospital beds and a build-up of community teams. Therapeutic benefits for patients are reported, such as greater compliance with outpatient treatment (particularly medication), and reduced rates of hospital admissions. Some studies show better relationships between patients and their families, enhanced social contact, reduced levels of violence and self-harm and the earlier identification of relapse. Dawson identified a strong focus on medication (particularly depot medication) as opposed to other treatment forms and he found that CTOs were often used for the maximum permitted duration.

Churchill et al. reported similar findings. Their systematic review found that, although different stakeholder groups held very different views about CTOs, the top priority for all was the avoidance of involuntary hospitalization. They also found that where CTOs are
implemented, they are used with ‘remarkable consistency’ in terms of patient characteristics:

‘They are typically males, around 40 years of age, with a long history of mental illness, previous admissions, suffering from a schizophrenia-like or serious affective illness, and likely to be displaying psychotic symptoms at the time of the CTO. Criminal offences and violence are not dominant features amongst CTO patients’.

The overwhelming majority was single and lived alone. Churchill’s review concluded that overall there was insufficient evidence to support the introduction of CTOs.

Only two randomized controlled trials (RCTs) have been conducted to test the effectiveness of CTOs. The New York study\textsuperscript{33} has been criticized for a number of methodological problems. It found no significant differences in outcome between those placed under involuntary outpatient treatment orders and those treated informally. The North Carolina study\textsuperscript{34} was more rigorously conducted and has been highly influential. Although this trial also found no difference in readmission rates between the experimental and control groups, secondary analyses suggested some potentially important differences: those who received sustained CTOs (>180 days) and regular clinical contact (>three times each month) had 57\% fewer readmissions and 20 fewer hospital days overall compared with the control group. This increased to 73\% and 28 fewer days for those with a diagnosis of schizophrenia. These findings are post hoc analyses and do not constitute proof of effectiveness. They may reflect selective prolonging of CTOs when it seemed to benefit a patient. Similar findings have, however, been reported in an epidemiological study by Kisely \textit{et al.}\textsuperscript{35} On the basis of the North Carolina RCT, Swartz concluded that CTOs may be of benefit when they represent ‘a reciprocal commitment by community programs to provide sustained and intensive treatment to patients under court orders’.\textsuperscript{34}

A Cochrane review\textsuperscript{36} of the two existing RCTs found that it would require 85 CTOs to prevent one readmission to hospital, 27 to prevent one episode of homelessness and 238 to prevent one arrest. This led the authors to question whether the increase in overall levels of coercion was justified by the potential benefits. This review, like the ones conducted by Dawson and Churchill, acknowledged the limitations of the current evidence base and concluded there was an ‘urgent need’ for good quality RCTs in this field. Such RCTs should aim to establish whether it is the intensity of treatment or the compulsion itself that affects outcomes. Questions have been raised whether it is ethical to introduce or continue community compulsion in the absence of such evidence.\textsuperscript{37}
A small number of qualitative studies have been conducted looking at the views and experiences of community compulsion among patients, families and health professionals. In all groups there appears to be ambivalence about whether potential positive benefits outweigh negative effects. There is significant variation within each group and this is particularly pronounced among patients. CTOs are experienced as a clear threat to personal autonomy, identify and self-presentation, but some patients also point out they allow for more freedom than hospitalization and can act as a form of security. Therefore, while some patients find CTOs unacceptable others wish to remain on the order.

Clinicians in general hold more positive views about CTOs and see them as a helpful means to provide care to a patient group, which can be hard to engage with. Some view CTOs as administratively burdensome and only effective if used as part of a long-term treatment plan. These last two points are also raised by family members. Family members identify benefits (to the patient and themselves) from community coercion more readily than patients but remain concerned with having to still ‘bear the brunt’ of community care. They also voiced concerns about the stigmatizing effects for their relative of being made subject to an order. Recent analysis of the New York ‘assisted outpatient treatment’ scheme suggests that experienced coercion and stigma are no greater amongst those subject to orders than those receiving similar levels of support without compulsion.

Conclusion

Recent changes in service provision and mental health law have intensified the debate regarding coercion (formal or informal) in community mental health care. For the first time in England and Wales there are explicit powers to mandate compliance with treatment in those outside hospital.

There is accumulating evidence that many patients feel pressurized or coerced and that this may increase stigma and lead to delays in help seeking. Research and clinical experience suggest that treatment pressures may help people accept treatment that can improve their social and clinical outcomes. Indeed some studies reflect such positive opinions among a proportion of patients and families, even if others remain unconvinced. Overall, the current body of research into experienced coercion does not support firm conclusions as to whether or not coercion may be justified on the basis of improved patient benefit. It is important that we continue to gather good quality evidence regarding patients’ experiences of coercion and compulsion and their effects on
engagement and outcome. This may enable us to minimize practices that are detrimental to outcome while employing those which may be beneficial.

The recent introduction of CTOs after many years of debate and discussion has proved contentious. Much of this debate has focused on the key issue of balancing an individual’s right to self-determination against their need for treatment while being mindful of wider societal concerns. There are strong opinions on both sides. Despite the doubts, the use of CTOs has substantially outstripped official expectations (www.guardian.co.uk, www.birminghamuserwatch.blogspot.com/2009/05/community-treatment-orders-nos-by-uk.html). All this is in the absence of convincing evidence that they improve clinical or social outcomes or reduce hospital use.

Good quality research in England and Wales to assess the effectiveness and tolerability of CTOs (and other coercive measures) is urgently needed. This may enable us to apply such interventions in a judicious and informed way. Current opinion and practice in the area is very varied. The potential benefits of these measures have to be carefully balanced against the overall increase in length (if not intensity) of coercion involved. Such evidence needs to be incorporated into the training and continued education of those who have the power to compel treatment to consolidate and regularize practice. Only thus can we ensure those who may benefit from such approaches do so, while protecting those who may not from unwarranted coercion.

References

7 Powell E. Speech to the National Association for Mental Health, 1961.


