UEMS Working Group – Compulsory treatment in the community

The UEMS-Section of Psychiatry is sensitive to the very diverse legal structures in the EU and of the need to restrict itself to general issue. It recognises that detail is the responsibility of individual legislatures and that to try to cover every circumstance would be impossible. Initially, the Section considered attempting to produce a position statement on arrangements for detention under legal measure in EU Psychiatric practice. Following discussions, this became restricted to a consideration of Compulsory Care and Treatment in the Community. This, narrower focus has already been the subject of legislation in some countries [e.g. Mental Health (Care and Treatment), (Scotland) Act 2003] and is being actively considered in others. This paper also has that focus, so that issues relating to hospital care and detention fall out-with the review.

Kilsey et al (2005) in a Cochrane review have shown how few are the randomised controlled trials on involuntary out- patient commitment. The two trials they cite reflect the mental health care systems in specific mates of the TJSA. Here, legal measures were introduced in response to highly publicised acts of violence by persons with mental disorder. The resultant benefits in the management of dangerous individuals are held to be limited. There is evidence of greater benefit for those with schizophrenia, bipolar disorder and other serious illnesses where unrelated to the prevention of acts of violence though this is only providing that there is an appropriate plan of care (Applebaum 2001). It also seems evident chat any legislation, requires both realistic levels of investment in active outreach and intensive multi-agency care coordination in the community. Given the availability of care in the community, however, compulsory care and treatment in that community offers a less restrictive alternative to compulsory in-patient hospital detention.

Principles

The, expert committee charged with making recommendations in rexpect of mental health law reform in Scotland (Millan 2001) commented that such legislation spans a range of boundaries and interests. Most notably, the sensitivities of the patient and his/her carers, as well as of the legal and medical professionals and statutory care providers must all be considered. For these reasons, the committee recommended the adoption of a series of principles to guide those involved in the interpretation and implementation of the legislation. UEMS-Section of Psychiatry has reviewed these principles and believes they provide a sound basis on which to structure discussion.

They reflect the four key underlying principles of medical ethics, namely Justice, autonomy, beneficence (seeking to do good) and non-malificence (avoiding doing harm). Each of the points outlined below can be seen to reflect one or more of these key points.

Justice

Non discrimination

People with mental disorder should wherever possible retain the same rights and entitlements as those with other health needs.

Equality

There should be no direct or indirect discrimination on grounds of physical disability, age, gender, sexual orientation, language, religion, national, ethnic or social origin.

Respect for diversity

Service users should receive care, treatment and support in a manner that accords respect for their individual qualities , abilities and diverse backgrounds. Their age, gender, sexual orientation, ethnic group cultural and religious background should be properly taken into account.

Reciprocity

Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, inducing ongoing care following discharge from compulsion.

Autonomy

Informal care

Wherever possible, care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

Participation

To the extent permitted by their individual capacity, service users should be fully involved, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as these can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it likely to be understood.

Respect for carers

Those who provide care to service users on an informal basis should receive respect for their role and experience. They should have their views and needs taken into account and receive appropriate information and advice.

Beneficence and non-malificence

Least restrictive alternative

Any necessary care, treatment and support for service users should be provided in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

Benefit

Any legislative intervention on behalf of the service user should be likely to produce benefit which cannot reasonably be achieved by other means.

Child welfare

The welfare of a child with mental disorder should be paramount in any intervention imposed on the child under the law.

Target Group

UEMS-Section of Psychiatry believes that resort to compulsory treatment in the community should be restricted to those who have a repealed history of deteriorations through non-compliance, severe enough in the past to have required involuntary in-patient care. Compulsory community intervention should reduce the likelihood that the service user will again deteriorate to a degree that in-patient commitment will again be necessary. There should also be evidence that a treatment plan, with the potential for appropriate care and support, can be delivered in the community. We believe it would be preferable to deliver treatment with medication in a medical setting, such as a local health centre rather than in the service user's home. The intention should be to prevent a "revolving door" situation. Community commitment should not be seen as an emergency, first line legislative intervention or financially cheaper alternative to in-patient hospital care if that is necessary.

Applicants

We believe it would be appropriate for there to be more than one applicant involved in legal submissions. A fully trained psychiatrist must be involved. Additional consideration should be given to requir-

ing a medical second opinion and the involvement of community care professionals, such as any social work and community psychiatric nursing staff, taxed with the implementation of the proposed care plan. We would advise against the direct involvement of carers in the application. Clearly they should be consulted but there is routine experience that their involvement in the legislative application itself may lead to subsequent recrimination from the service user and damage to their longer term relationship.

Appeal

Service users and their carers should have rights of appeal both in respect of the compulsory order itself and of the treatment measures allowed under it. There should be defined time limits for the duration of legally enforced measures although reapplication should be possible, if required. Service users and carers should be aware of these time constraints and reminded of their riphts of appeal at times of review. It is our view that, in the interests of justice, they should not have personally to finance legal representation in respect of appeals against orders or medical second opinions with respect to treatment.

Patient non-compliance

Where identical in-patient and out -patient commitment criteria exist, readmission to hospital care should be possible, providing that subsequent legal review to confirm this is appropriate. Where outpatient criteria differ from in-patient, this may not prove possible and alternative strategies will need to be developed. In practice a degree of service user compliance is essential for the effective functioning of a community order. This needs to be a necessary consideration when an application is initiated.

Conclusion

It would be fallacious to believe that the introduction of legal measures for compulsory intervention in the community will prove successful in isolation. There must also be an associated investment in community services, especially in the training and recruitment of professionals able to deliver the treatment and the supports necessary for service users and carers .

UEMS-Section of Psychiatry is aware that in many EU countries delivery of community care is still at a rudimentary stage. We would advise against the introduction of compulsory community care measures until a robust system of care delivery in the community has already been established and tested for the wider compliant service user population .

References

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