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ARTICLE

Changes to Supervised Community Treatment: Fair or Unfair?

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Abstract

This article examines the changes made to supervised community treatment (SCT) legislation, introduced in June 2012. Capacitous patients no longer require a second opinion approved doctor (SOAD) to approve their treatment. Prior to these changes capacitous, consenting patients required their treatment to be approved by a SOAD. This situation was unique in that no other capacitously consenting patients in any area of mental health practice required this form of approval. Additional concerns had been raised that emergency sections of the Mental Health Act were being used because of problems with availability of SOADs. We analyse SCT and these changes from the perspective of values based practice and in terms of fairness. Fairness is discussed with reference to Rawls' account and William's view of fairness as equality. We argue that recent changes make SCT more fair, in the sense that equality has been established regarding approval of treatment between individuals detained under the Mental Health Act on the wards and community SCT patients. The changes also mean that emergency treatment sections will no longer be used in this situation as capacitously consenting patients will not have to wait for a SOAD visit.

Introduction

Supervised Community Treatment (SCT) was introduced with the 2007 amendments to the Mental Health Act (1983) in England and Wales on 3 November 2008.[1] In England and Wales the overall framework is known as SCT while the order the patient is placed on is referred to as a community treatment order (CTO). The purpose of SCT is to ensure that patients with severe mental illness who have been detained for treatment remain well in the community, and avoid relapse and subsequent readmission to mental health units. SCT requires a given patient to comply with a set of conditions, such as

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1 Mental Health Act 1983 (Amended):, part 2, s.17A', www.legislation.gov.uk/ukpga/1983/20/section/17A, 22 May 2013.

taking medication and attending appointments with mental health professionals, whilst allowing him or her to live at home.[2] When such conditions are not met, if the patient becomes unwell he or she can be quickly recalled to hospital for further assessment. If necessary the CTO can be revoked, leading to further detention for treatment. CTOs are aimed at patients – termed 'revolving door patients' – who have repeated relapse and readmission cycles.[3]

Until recently, all patients subject to SCT have been required to see a second opinion approved doctor (SOAD). The SOAD is provided by the Care Quality Commission (CQC). Prior to the introduction of SCT, SOADs only saw inpatients detained under the Mental Health Act who were either capacitously refusing treatment or were incapacitous. Their role was to review the consultant psychiatrist's treatment plan, approving it or not as appropriate. They were given the additional duty of approving the care of all patients on CTOs following the introduction of SCT.[4] The CQC receives around 12,000 requests for second opinions per year in total,[5] 29.5% of which related to SCT in 2011. As at 31 March 2012 there were 128 active SOADs on the CQC panel.[6]

The concept of fairness is debated in the literature and there is no single universally accepted account. Rawls writes about the principle of fairness and notes that 'fairness has two parts, the first which states that the institutions or practices in question must be just, the second which characterises the requisite voluntary acts'.[7] Williams writes about fairness in terms of equality.[8]

We argue that SCT in its original form was unfair because of the use of the SOAD. There was no other area in mental health or medical practice where patients with the capacity to consent to treatment in the community required

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2 S.A. Lawton-Smith, 'A Question of Numbers. The Potential Impact of Community-Based Treatment Orders in England and Wales' Working paper (Kings Fund, 2005), 8. Available at www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/question-numbers-potential-impact-community-based-treatment-orders-england-wales-simon-lawton-smith-kings-fund-20-september-2005.pdf.

3 S.A. Lawton-Smith, J. Dawson & T. Burns, 'Community Treatment Orders Are Not a Good Thing', *British Journal of Psychiatry* 193 (2008): 96-99.

4 Department of Health 'Supervised Community Treatment' ch. 25 in *Code of Practice, Mental Health Act 1983* (London: TSO, 2008) 220-240.

5 Care Quality Commission, 'Second Opinion Appointed Doctors (SOADs)', www.cqc.org.uk/organisations-we-regulate/mental-health-services/mental-health-act-guidance/second-opinion-appointed, 24 March 2013.

6 Care Quality Commission, personal communication, 2012.

7 J. Rawls, *A Theory of Justice,* rev. ed. (Cambridge, MA: Harvard University Press, 1999).

8 B.A.O. Williams, 'The Idea of Equality', in *Equality: Selected Readings*, ed. L.P. Pojman & R. Westmoreland (Oxford: Oxford University Press, 1997).

someone to approve their treatment.[9] Mental capacity to consent to treatment is defined in the Mental Capacity Act Code of Practice as involving the ability to understand the nature and purpose of the treatment, its likely benefits and adverse effects, and to use and communicate that information in a way which is consistent with a capacitous person. Capacitous individuals are described elsewhere as being able to retain, believe, use, weigh and communicate relevant information.[10]

Changes in the Role of the SOAD

The rules about the treatment of patients subject to SCT and SOAD approval changed on 1 June 2012, through section 299 of the Health and Social Care Act 2012.[11] This introduced a new form allowing the approved clinician (AC) in charge of patients' treatment (and hence a responsible clinician, or RC) to certify that the patient is capacitous with regard to treatment decisions and currently consenting to that treatment. This removes the need for SOAD approval. These changes are ethically sound on the basis of restoring equality in terms of community patients being able to consent to treatment without the need for approval from a SOAD, and also because they remove the administrative burden which previously led to some negative consequences for other parts of the mental health system, described below.

Values-based Practice

It has been suggested elsewhere that traditional principles-based approaches to bioethics[12] can be read as somewhat 'algorithmic', 'robotic' and as requiring 'no element of judgment',[13] despite the argument of Beauchamp and Childress against this common interpretation. It can be argued that use of such a principles-based approach is less likely to be problematic in bodily

9 Mental Health Act Commission, 'Coercion and Consent. Monitoring the Mental Health Act 2007-2009', MHAC 13th Biennial Report (London: HMSO, 2007).

10 Mental Capacity Act 2005: Section 3, www.legislation.gov.uk/ukpga/2005/9/section/3, 22 May 2013.

11 'Health and Social Care Act 2012: Section 299', www.legislation.gov.uk/ukpga/2012/7/section/299/enacted, 24 March 2013.

12 T. Beauchamp & J. Childress, *Principles of Biomedical Ethics*, 3rd ed. (New York: Oxford University Press, 1989), 393.

13 T. Thornton, 'Judgement and the Role of the Metaphysics of Values in Medical Ethics', *Journal of Medical Ethics* 32 (2006): 365-370.

medicine, where values held by those involved in decisions regarding care (i.e. patients, carers, clinical staff) are likely to be shared. By contrast, in mental health the tendency is for significant diversity of values. Values-based practice (VBP) emerged as 'a response to the growing complexity of health-care decision-making'.[14] It is described as a way of acknowledging and working with potentially disparate values in health-care decision-making, in order to supplement existing mechanisms. The central premise is thus a 'respect for diversity'.

The approach is set out as ten principles, summarising good process in healthcare decision-making, relating broadly to the relationships between VBP and evidence-based practice, service delivery, clinical practice skills and the idea of a 'new alliance', placing decision-making with those directly involved. Rather than constituting a separate way of considering the ethical issues of a given situation, VBP is conceived as a way of explicitly recognising that in mental health (as in the wider contexts of medicine and science) a 'fact-only' model is insufficient, and requires a 'sharper set of tools'. As such, VBP can be seen as extending the existing bioethical toolkit, rather than replacing it.

We propose that recent changes in the legislation have had a significant effect on the fundamental fairness of SCT. When SCT originally came into force, unfairness was essentially written into the legal framework, because of the requirement for capacitous, consenting adults to have their treatment approved by another clinician, namely a SOAD. The limited number of SOADs and larger-than-expected numbers of patients who have been made subject to SCT have resulted in an inability to meet the imposed legal requirements. One consequence of this was the widespread use of emergency treatment sections to treat on a non-emergency basis, which could be seen as 'bending the rules' somewhat. Such behaviour may have led to similar rule-bending bending in or disregard for other aspects of mental health law, with a subsequent erosion of patients' rights and a perception of unfairness on the part of mental health services.[15] This could affect the willingness of patients to engage with community mental health services, and in some cases cause disengagement and loss of follow-up.[16]

We intend to describe SCT from a VBP position, before going on to illustrate the problems with the use of SOADs in SCT. We will then discuss the recent

14 K.W. Fulford, T. Thornton & G. Graham, *Oxford Textbook of Philosophy and Psychiatry* (Oxford: Oxford University Press, 2006).

15 BBC Radio 4, *File on Four*, 'Care Concerns', Miriam O'Reilly. Broadcast 29 September 2009.

16 M. Allen & V.F. Smith, 'Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment', *Psychiatric Services* 52 (2001): 342-346.

changes to SCT legislation and argue that these changes have resulted in a process that is inherently fairer.

SCT from a VBP Perspective

Detailed consideration of how VBP could be used to underpin good process in decisions around SCT is beyond the remit of this article, but VBP principles as applied to SCT are outlined below.

The first principle of VBP is that all decisions stand on 'two feet', incorporating values alongside facts. When considering whether SCT constitutes a 'good' treatment plan for a given patient, descriptive criteria alone are insufficient. To say that use of CTO is to 'do good' would be an expression of a value judgment, the criteria for which are the descriptive aspects of the CTO.

The second 'squeaky wheel' principle of VBP is that diversity of values causes conflict, and thus brings them to our attention. This demarcates mental illness from bodily illness, as in the latter case the majority of values are likely to be shared, and hence 'invisible'. A CTO could be said to contain a number of implied value judgments on the part of the clinical team, such as 'it is good to be free from psychotic symptoms, *even if* it means that certain side-effects are experienced'. This is a view that is far from universally shared. Exploration of 'squeaky wheel' conflict allows for different parties to express their values, and hear the values of others.

VBP has as its third principle the idea that it is 'science-driven'. It can be argued that the existence of the CTO as a treatment option means that there is more choice than there used to be for patients with a history of repeated inpatient admission and frequent relapses of illness related to difficulties with treatment adherence. The increase in choice of routes to discharge from hospital has brought with it increased diversity, and hence prominence of values.

The fourth principle of VBP, its 'user-centred' nature, is emphasised in work completed by the National Institute for Mental Health. It advocates a 'National Framework of Values for Mental Health'[17] which explicitly discusses respect for values, with 'the principle of service-user centrality a unifying focus for practice'. The authors draw attention to the way in which '"users" are often

17 K. Woodbridge & K.W. Fulford, 'Centre For Mental Health. Whose Values? A Workbook for Values-Based Practice in Mental Health Care', www.centreformentalhealth.org.uk/pdfs/Whose_Values.pdf, 24 March 2013.

lumped together as though they all had the same values'. Qualitative research has shown that in the case of CTOs this is far from true.[18]

The fifth principle relates to multidisciplinary working. Over and above the more obvious benefits of members of different disciplines bringing their professional expertise to decision-making, a multidisciplinary approach also provides the opportunity for a range of value perspectives. The democratic premise of VBP ensures equality in the weight of values, and hence respect for values has to be a two-way process 'between users, carers and providers, between different health care disciplines' and so on. With consideration of a CTO, as well as placing the values of the individual service user at the centre of decision-making, VBP good practice means identifying the range of values held by the team. Gibbs et al.[19] made reference to an earlier piece of work, which found strong, but not universal, support for CTOs among psychiatrists. Lawton-Smith[20] described a two-thirds majority against the idea of CTOs when they were debated by the Royal College of Psychiatrists and the Institute of Psychiatry in 1994 and 2000 respectively.

The next four principles of VBP relate to skills of clinical practice, namely awareness, knowledge, reasoning and communication. 'Awareness' in this context refers to Austin's 'ordinary' language approach to philosophical method.[21] In consideration of use of a CTO, this would involve review of language used in the guiding principles or the specific conditions proposed. For example, 'Criteria for making a CTO'[22] preclude the use of a CTO for someone whose mental disorder is a learning disability, 'unless the learning disability is associated with *abnormally* aggressive or *seriously* irresponsible conduct' (emphasis added). This approach aims to make those involved in decision-making 'recognise the values – some explicit, others implicit – shaping their practice',[23] and to highlight that such value terms occur in everyday texts as opposed to exceptional cases.

The 'gaining of knowledge' advocated in the seventh principle relates to knowledge in its widest sense. It stems from the assertion that we tend to 'get it wrong' when we make guesses about the values of others. As such, anything

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18 A. Gibbs et al., 'How Patients in New Zealand View Community Treatment Orders', *Journal of Mental Health* 14 (2005): 357-368.

19 *Ibid.*

20 Lawton-Smith, 'Community Treatment Orders' (note 3).

21 J.L. Austin, *Sense and Sensibilia* (Oxford: Clarendon Press, 1964).

22 Department of Health, 'Reference Guide to the Mental Health Act 1983. Department of Health: Publications, Policy and Guidance', www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088163.pdf, 24 March 2013.

23 Fulford, *Oxford Textbook of Philosophy and Psychiatry* (note 14).

that we can do to increase our knowledge of values held, 'qualitative or quantitative, narrative, evidence-based, or whatever, is fundamental'. This echoes the fourth and fifth principles, emphasising the need actively to 'collect' values held by all stakeholders in decisions about CTOs. These can then be explored in a reasoned manner (principle eight). This is where approaches such as that suggested by Beauchamp and Childress can fit. Reasoning in VBP is about just this exploration of value differences, rather than determination of a 'right' outcome. Once values have been identified and shared, we are in a clearer position to be able to balance principles of autonomy and beneficence, shown above to be often in conflict in CTO decisions.

This process can only take place through adherence to the ninth principle, that of communication. As has been demonstrated, communication skills in VBP are substantive rather than executive. A 'good' decision owes as much to the process by which it was arrived at as it does to the eventual outcome. If, after due consideration of all values (and facts) involved, the decision is still that a CTO is the appropriate course of action, then this is inherently a 'better' outcome than if the same decision was reached based on facts (with their attached invisible values), not least because of the respect paid to and the participation of all involved stakeholders. This is encapsulated by the tenth principle, 'who decides?'. Using principles of VBP, the decision about use of a CTO is taken by those directly involved, as opposed to a more removed 'quasi-legal ethics' body. Fulford et al. suggest that this may be a way to address 'the progressive alienation of users from providers of services'.

Problems with the Use of SOADs

In an inpatient setting, if a given patient has capacity to make decisions about treatment and is consenting to that treatment, there is no role for a SOAD. Until very recently, under SCT there has been a requirement for capacitous, consenting patients to have treatment approved in exactly this way. This goes against the idea of service user wishes as a unifying focus for clinical practice, which is the fourth principle of VBP.

Similarly, there has been an undermining of the multidisciplinary approach as detailed in the fifth VBP principle. According to this principle, in the course of making a decision about SCT there should be the opportunity for exploration of the full range of value perspectives held. The SOAD should be in essence a part of the multidisciplinary team, given his or her role in making decisions about patient care, but by the very nature of the work is somewhat removed from the nucleus of the process, functioning instead as an overseer. The SOAD would have access to written records, as well as the opportunity to speak to the

patient concerned, but this would not be the same as being party to full exploration of the diverse range of values likely to be held by clinical staff, family, carers, advocates and the patient themself. This would also be more likely to result in the type of guesswork about values held by others that the seventh VBP principle attempts to eliminate. Once values are identified and shared, members of clinical teams are better placed to balance principles of autonomy and beneficence, so often in conflict when it comes to consideration of SCT.

The Ethics of Recent Changes

As noted above, practice changed in this area from June 2012, with an amendment which removed the need for SOAD approval in the case of capacitous patients. This can be seen to remove the concerns discussed above about the SOAD needing to approve the treatment of SCT patients, thereby making SCT fundamentally fairer, from Williams' perspective of fairness as equality; SCT patients are now on a more equal footing with other community patients in terms of not requiring any sort of external approval of treatment.[24] Also the changes remove concerns about this area of mental health practice being perceived as unfair by service users.

In removing the stipulation that capacitous patients subject to SCT must have their care approved by a SOAD, there is closer adherence to the principles of VBP. The process of deciding that a CTO could be used in a given patient's care, and the conditions that need to be incorporated as part of that CTO, need to be collaborative and multidisciplinary. If patients, carers and members of the multidisciplinary team understand each other's perspectives and the reasoning behind their different viewpoints, concordance and subsequent clinical outcomes are likely to be better. Removal of the need to see a SOAD as part of this process ensures that such discussions retain this spirit of collaboration, and that decisions are made on the basis of a good understanding of the diverse range of values held.

In addition to the tangible benefits that removal of the need to see a SOAD brings to capacitous patients subject to SCT, there are subsequent benefits for those who lack capacity to make decisions about their treatment, whether inpatient or subject to SCT. As indicated above, the demands upon SOADs have been unprecedented, with consequent delays in ability to review patients' care and greater use of 'emergency' treatment sections to justify ongoing treatment.

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24 Williams, 'The Idea of Equality' (note 8).

SOADs are now free to concentrate their efforts on those unable to make decisions about the care that they receive, safeguarding those patients rendered more vulnerable by their illness. VBP emphasises 'the principle of service-user centrality as a unifying focus for practice'.[25] When this is compromised by severe mental illness, there is a clear need for other mechanisms to support decision-making.

Conclusion

SCT has provided a further treatment option for people with mental illnesses who have required detention for inpatient treatment. It involves the setting of a number of conditions agreed by a clinical team as necessary to reduce the likelihood of relapse and subsequent readmission. Until 1 June 2012, patients who had capacity to make decisions about their care and consented to it were required to have that care approved by a SOAD, provided by the CQC. This is markedly different to the situation for detained, capacitous inpatients, whose care is authorised by their RC. We argue that this was inherently unfair, notably on the basis of Williams' notion of equality. Since the removal of the need for SOAD involvement with capacitous patients subject to SCT, there is restoration of this equality, both with inpatients who are capacitous and consenting to treatment, and indeed capacitous outpatients not subject to SCT, who also discuss and agree their care with the appropriate multidisciplinary team.

Removal of the SOAD role with regard to such patients is also more in keeping with the principles of VBP, as the person authorising the treatment plan is now better placed to explore and take account of the diverse range of values held within a clinical team, alongside those held by advocates, carers and patients. Decisions are made by those who are directly involved, as opposed to a separate 'quasi-legal ethical body' as represented by the SOADs, by their very nature at a remove from the situation. This promotes the VBP notion of a 'new alliance' between patients and clinicians. Where SOADs are needed is in the care of those who are unable to take the central role in decisions about care; those who lack the requisite capacity. Diversion of the SOADs' energies in this direction directs the safeguards where they are needed, removing them from where they are potentially harmful.

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25 K. Woodbridge & K.W. Fulford, 'Centre For Mental Health. Whose Values? A Workbook for Values-Based Practice in Mental Health Care', www.centreformentalhealth.org.uk/pdfs/Whose_Values.pdf, 24 March 2013.