Chapter 14

The ethics of coercion in community mental health care

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Introduction

How we reconcile an individual's right to liberty with coercive interventions is a fundamental question in medical ethics and psychiatry, especially given psychiatry's chequered history. Current measures within developed countries are generally quite tightly regulated and there is a relatively strong evidence base to support the use of modern-day psychiatric interventions. Nevertheless, many ethical questions remain, particularly in relation to coercion within community mental healthcare, a growing and relatively underexplored phenomenon (as described in earlier chapters).

The last 70 years have seen major reforms of mental health laws and practices throughout the developed world, motivated by a mixture of risk-based, libertarian, and economic factors. In general, mental health law is now preventative and status-based, allowing forcible detention and treatment where there is perceived risk to individuals themselves or others resulting from a diagnosed mental disorder (Dawson and Szmukler 2006). While the need for legal provision to enforce treatment is widely accepted, its form remains controversial. Strong arguments can be made that status- and risk-based laws are intrinsically discriminatory against those with mental disorder, and that a fairer measure would be based on decision-making capacity, regardless of diagnosis (Dawson and Szmukler 2006; Bach and Kerzner 2010). At present, even in jurisdictions with capacity-based laws applying to non-consensual medical treatment, coercive measures are usually introduced through separate legislation specific to mental disorder, with restrictions that do not apply to the broader population.

Until recently debate centred on the use of enforced treatment and detention within a controlled inpatient environment. Now, however, as psychiatry moves increasingly towards community care, the question is far broader, in terms of both setting and the conditions judged as warranting coercive measures. While community care may have been envisioned as a step towards greater liberty within psychiatry, use of coercion in many countries is currently increasing (Salize and Dressing 2004; Keown et al. 2008; Health and Social Care Information Centre 2013; Robiliard 2013; Zielasek and Gaebel 2015).

Formal coercion within the community typically takes the form of a community treatment order (CTO) mandating enforced recall to hospital for those who are non-compliant with treatment. Many jurisdictions permit the application of an order, even

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for those patients who retain decision-making capacity, and CTOs may function to impose continuing treatment on an individual who, once stabilized, is regarded as sufficiently 'safe' to live within the community (Dawson 2006; Lawton-Smith et al. 2008). In addition, other forms of leverage also occur, such as withdrawal or withholding of particular benefits in order to promote adherence, and the 'coercion context' of mental health care (see Chapter 8) can increase their coercive pressure. Essentially the ongoing justification for CTOs stems from anticipated risk, should an individual, usually with a history of defaulting on prescribed treatment, default again.

Thus community coercion appears to cover a new 'grey area', with an individual being deemed well enough to live within the community but not to make his or her own decisions about matters such as treatment. CTOs could therefore be seen to take the pre-emptive and speculative dimension of anticipated risk one step further (Szmukler 2014). The 'risk' criterion embedded in mental health laws makes mental disorder the only situation in most societies in which involuntary detention (or the threat of involuntary detention) can be invoked, not because a dangerous act constituting a criminal offence has taken place but because it is believed that there is a high probability of a dangerous act occurring. If we extend this to an individual subject to an ongoing CTO, but now sufficiently stable to live outside of a controlled inpatient environment, we are not simply allowing coercion based on risk of some kind of harm in the near future; we are, effectively, extending this to a judgement that, should a stable individual decide to discontinue treatment, the risk from discontinuation is sufficiently high to over-ride their right to make treatment decisions. Given the moral imperative to limit coercion and respect the right to self-determination wherever possible, we need to think very carefully about whether such an extension is justifiable.

In this chapter, we will lay out a framework of ethical assumptions underlying coercion in community psychiatric care and explore the inherent difficulties. We will not focus on individual jurisdictions, but on a range of examples and some general principles applicable to countries with reasonably well-developed legal systems. We will consider the justifications for such measures, the mechanisms through which they are imposed, their potential consequences, and the significance of their effectiveness. We shall not be considering provisions in forensic practice concerning patients who have committed a serious offence.

Overall, we would like to suggest that coercion within a community, as opposed to the inpatient environment, does not raise radically new questions, but can be seen to heighten the complexity of the ethical concerns surrounding coercive treatment, and thereby highlight some major ethical difficulties within existing mental health legislation and practices. To conclude, we will offer some ideas for reforms that could incorporate coercion, where necessary, into a framework more adequately suited to the human rights of patients.

Conventional justifications for involuntary treatment

The need for some provision for compulsory treatment of mental disorders is generally accepted. It is usually justified on the basis that severe episodes of illness may cause

an individual to be unable to understand the need for interventions to help treat a condition that may result in serious harm to themselves or others if untreated. The threat to individual freedom of choice is viewed as outweighed by the risk to oneself or others. A legal framework gives structural validity to such measures and also entails safeguards intended to prevent abuse. In practice, however, appraisal of risk is often disproportionate and inaccurate.

It is also important to acknowledge that formal coercion, even when deemed necessary, still involves an experienced loss of liberty which may be deeply traumatic and can never be a 'perfect' solution. Any provision for coercion must be accompanied by a moral obligation to ensure that it is only carried out in circumstances where it is deemed necessary and with the minimum degree of perceived violation.

Coercion within the community—liberalist justifications

Liberalist motivations played a large role in the move towards community care, with hopes for improved quality of life and human rights. With asylums being viewed as a form of social segregation allowing greater opportunity for unregulated coercion, many hoped that community care could increase integration and social contact and allow greater control and restriction of coercion while encouraging patients to take a more willing and active role in their own care.

If accepted unreservedly such justifications may well appear to suggest that care within the community, when safe, is automatically better for an individual than inpatient treatment. One might draw a further conclusion that a community setting, even when the treatment involves coercion, is preferable to hospitalization. It is also often argued that community coercion can lead to an improved and more stable quality of life amongst vulnerable 'revolving-door patients' if it can induce adherence to treatment and thus decrease admissions.

However, there are various problems with these arguments. First, while the asylum system may have been flawed in many respects, the security and support of an inpatient environment can be a valuable resource during severe episodes, and care in the community should not be seen as a near replacement. Nonetheless, inpatient provision is rapidly diminishing. Inpatient care is extremely costly and, as resources are stretched, increased community care, which allows for shorter admissions, can be seen as one dramatic way to reduce the cost of mental health care by facilitating vast reductions in beds by cutting the duration and number of admissions. In the UK, for example, bed numbers fell by 31% between 2003 and 2013, with extremely deleterious consequences (NHS England 2014). Similar reductions have occurred in other countries, such as the USA (Treatment Advocacy Centre 2014). Those in crisis may be denied inpatient treatment or, with no bed available locally, may be admitted to a hospital far away from home. Patients may not be admitted until symptoms have escalated to crisis point and detention might be necessary. All too often, discharge occurs before it is therapeutically ideal.

Far from decreasing coercion, the reduction in psychiatric beds has been accompanied by increased formal coercion. During the same period UK mental health detentions have increased (Keown et al. 2008; Health and Social Care Information Centre 2013). A recent UK parliamentary report, for example, identified 'an inverse relation

between the number of beds currently available and the number of people being detained' and recommended urgent investigation into the reported phenomenon of clinicians using formal detention to secure a bed (Health Committee 2013).

Coercion within the community—risk-based justifications

The difficulties intensify when we examine the further consequences of this treatment shift. If society relocates mental health care into the community, concerns are raised for public security. High-profile, but extremely isolated, cases of homicides by patients are sensationalized by the media and spark disproportionate public alarm and recrimination against clinicians. Thus, despite hopes that coercive measures in psychiatry should reflect the patient's best interests, all too often it appears that inaccurate and unsubstantiated estimation of risk becomes the over-riding motivation. The procedures for assessing the risk of serious harm to the individual give extremely poor results (Hart et al. 2007; Large et al. 2011a; Wand and Large 2013; Singh et al. 2014). For rare events such as suicide, homicide, or even serious violence to others, even with the very best risk assessment procedures and propitious research conditions, the 'false positives' (i.e. those predicted to be 'high risk' but not committing such an act) hugely outnumber the 'true positives'. For example, in the year following discharge from hospital, only 2% of patients predicted to be at 'high risk' of suicide actually committed suicide (Large et al. 2011b). In the UK around 1% per year of serious violence in the community is committed by patients treated by community mental health teams, and a similar tiny percentage of those rated as 'high risk', using the best available risk assessment instruments, act violently. Predicting a homicide involves a false positive rate in the thousands for each correct prediction. These are the examples of the statistical 'base rate' problem: events that are rare are extremely difficult to predict accurately, even with the best available methods (Szmukler 2003; Large et al. 2011a).

Risk aversion and risk management have become increasing features of decision and policy making within the developed world, and are increasingly influential within psychiatry and public debate on mental illness (Turner 2014), with risk assessment now being a standard part of mental health service provision. For psychiatric patients deemed to be well enough to live long-term within the community, perceived risk provides a major impetus for invoking coercive measures and outweighs consideration of statistical probabilities, best interests, or civil liberties. The increased use of such measures could also be seen to increase stigma by giving structural reinforcement to prejudicial and stereotype-based beliefs about mental illness and dangerousness (Undrill 2007).

Risk-based measures justify coercion by considering the individual, if untreated, to be such a serious risk to themselves or others that treatment, even if involuntary, is in the best interests of themselves and society. In addition to the problems of inaccuracy, such measures also constitute unfair discrimination against those with mental illness. As Kisely et al. (2005) suggest: 'It is, nevertheless, difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest'. Psychiatric patients are the only group within society who can be constrained on a basis of a perceived *risk*

of harmful actions, rather than by committing a violent and illegal act (Dawson and Szmukler 2006). Furthermore, given that community coercion is not constrained by a 'ceiling effect' limiting the numbers of involuntary patients to available hospital beds, it may be opening the floodgates for subjecting increasing numbers to such measures.

Mechanisms for community coercion

The extension of the 'coercive context' and its ethical ramifications

Once a legal system has unique and status-based provision for the formal coercion of those with mental illness, the shared knowledge of such provision amongst both patients and those involved in their care creates a context within which the patient can be pressured in various ways—for example to make treatment decisions—even when formal measures are not actually invoked:

> The very possibility that coercive measures can be used will be part of the situational context in cases in which staff and patients differ in their opinions about what is the best course of treatment to undertake. Hence, there is a subtle interrelationship between coercion and compliance in all realms of psychiatric care.
>
> Sjöström (2006)

This is all the more pertinent within a community setting, where the possibilities for coercive practices can be extended beyond those available within a controlled inpatient environment in a number of related respects: (1) the people who can be involved in implementation; (2) the type of coercive interventions which can be used; (3) the lower level of severity of the condition; and (4) the length of time for which the patient is exposed.

Within mental health law coercive interventions are usually clinically driven. Decisions are based on judgements by mental health professionals, variously approved by a judge or tribunal at the outset, or after a time interval, or following an appeal by the patient (or carers or supporters). In principle, decisions are based upon the expert opinion of more than one mental health professional, involve clinical objectivity, and are formulated within a very distinct legal framework designed to protect the rights of the patient. Once coercion moves into the community, those contributing to the coercive process may well expand beyond the clinical team. With CTOs, for example, depending on jurisdiction, restrictions governing factors such as place of residence or behaviours may be imposed, and carers or other members of the public may be drawn into the monitoring process (Dawson 2006). Non-clinicians (e.g. social services and housing association staff and families) can also use the 'coercion context' to exert pressure upon patients. The involvement of non-professionals raises questions not only about objectivity and the understanding of mental disorders, but also about the patient's relationships with his or her community. Involving members of an individual's social network with the implementation of coercive measures, whether formal or informal, and however indirectly, has the potential to create a power imbalance which may compromise those relationships. However useful the involvement of

the wider community in psychiatric care, it raises clear ethical questions surrounding issues such as trust, equality, and abuse, even if unintentional.

Broadening the 'coercion context' within the community also extends the processes through which coercion is implemented. Formal CTOs have been introduced to impose treatment adherence on those outside an inpatient setting, while leverage through factors such as housing or finance are also increasing. Moreover, such processes can be seen to extend the applicability of coercive measures beyond periods of illness, when safety is severely compromised, to periods when the individual is sufficiently stable to live outside the hospital environment.

A hierarchy of coercive measures

Although ethical debate is dominated by issues surrounding formally sanctioned compulsion or CTOs, the range of ways in which coercive measures can be implemented is far broader and the implementation of coercive pressures involves a range of different mechanisms. 'Treatment pressures' can be seen as a spectrum, involving progressively stronger levels of coercion (Szmukler and Appelbaum 2008). This spectrum can be presented in the following way, going from less to more coercive measures:

(1) persuasion

(2) interpersonal leverage

(3) inducements

(4) threats (including deception)

(5) compulsory treatment (community or inpatient)

For each of these categories it is important to consider the types of processes used and how interventions are classified and evaluated in relation to each other.

Compulsion (formal coercion)

At the most severe end comes compulsion. Not only does this involve the strongest levels of coercion, it also requires formal sanction and is, for both these reasons, the subject of the most sustained discussion. CTOs are the most common form of compulsion ('backed up force supported by legal statute'; Szmukler and Appelbaum 2008) exerted within a community setting. Typically, they mandate that a patient who fails to comply with treatment can be forcibly returned to hospital, sometimes directly to an inpatient environment. In general, statutes vary concerning whether medication can then be automatically administered by force.

As with so many changes in psychiatric practices, CTOs have both liberal and more restrictive motivations. One can differentiate between 'least restrictive types' and the 'preventative' types. In the former the criteria for the CTO are more or less identical to those for inpatient treatment orders and the CTO is imposed when the person's mental state has already deteriorated, as a less restrictive alternative to forced hospitalization. 'Preventative' CTOs, broaden the applicability of the order and are used within psychiatric management with the aim of preventing deterioration. While 'least restrictive types' present no substantial additional ethical challenge to existing statutes, they are less easy to use. In effect, they are little different from existing practices of, for example, 'trial leave' or 'supervised discharge' from hospital (Churchill et al. 2007).

'Preventative' types offer a new range of possible applications, but greater ethical challenges, since they move away from imminent risk or danger to pre-emptive measures to prevent the possibility of such dangers and broaden the stages of illness to which compulsion can apply. The types of CTOs vary between jurisdictions (Dawson 2006). In the USA, statutes are moving increasingly from 'least restrictive' to 'preventative', while in a number of other jurisdictions orders are mixed, boundaries unclear, and the type instituted may depend upon clinical discretion in individual cases.

From an ethical point of view the main concern is with 'preventative' types, although 'mixed' types can also present challenges, since a lack of clarity may well lead a patient to perceive greater levels of compulsion or consequences for failure to follow the conditions of the order than are in fact in place. Even with 'preventative' CTOs, contravention usually has only limited consequences, and further assessment, often accompanied by transfer to an inpatient order, is generally required before compulsory treatment can be given. The major effect of 'preventative' CTOs appears to be to facilitate the swift return of non-compliant patients to a hospital environment, often with police involvement. When orders are 'mixed' and boundaries unclear, leading patients to believe that their choices are more limited than they in fact are, compulsion may effectively happen through deception rather than statute. This is a major point to consider, as CTOs may enable a situation where a lack of clarity enables a greater perception of restriction and lack of choice than are actually instantiated within the law. Not only is the range of those who can be subject to compulsion through an order being broadened, but patients may be experiencing elevated coercion through deception about the actual power of the law. One clinician reports a patient's confusion: 'I don't think it's made any difference to her. I think actually she still thinks that she has to take medication. I'm not sure that she realised the difference between the Section 3, Section 17 leave and the CTO and not being under any restrictions at all' (Stroud et al. 2013). Thus the ethical issues here do not simply concern what is dictated by the law, but the worrying consequences of legal obfuscation.

The use of CTOs might also have a number of other potentially problematic consequences, and considerable opposition and concern has been raised by clinicians (Lawton-Smith et al. 2008; Manning 2013). Firstly, they might affect the quality of treatment. Treatment options may well be limited to those which are enforceable under such schemes, with intramuscular 'depot' injections often the only treatment option that can be confidently monitored, even if it is not necessarily the most desirable (Patel et al. 2011). Over-reliance on the use of CTOs may well mean that care shifts from attention to the quality of available community services and an exploration of alternative options for engagement to enforcement (or threats) (Sinaiko and McGuire 2006). The pressure to enforce orders may also result in resources being diverted to groups subject to such orders and away from others.

Living in the community while subject to such an order might contribute to feelings of social isolation in a number of ways, such as: increased feelings of stigmatization (RA Malatest and Associates 2012); altering dynamics in relationships with non-clinicians, such as carers or hostel workers who play a part in assessing adherence; and increasing fear of further coercion which may discourage an individual from seeking help. CTOs have been unpopular with many patients for increasing coercion and

decreasing legitimate debate about the problems associated with certain medications. One patient, for example, described the change in their relationships with family and carer that occurred after the imposition of a CTO as 'instead of them being concerned out of care and compassion for the problem I was having, there was reason for them to be responsible and have authority over me', and also reported feeling criminalized and stigmatized and with restricted choices (Manning 2013).

Moreover, the issuing of a CTO is not a rare occurrence, as was initially envisaged. Factors such as the absence of a 'ceiling effect', already mentioned, have led to increasing numbers of patients being subject to formal compulsion. The 2012 statistics for Ontario, Canada, for example, show that the 'prevalence of CTOs (issues or renewals) has risen from an estimate of less than five per 100,000 to 36 per 100,000 in 2010/11' (RA Malatest and Associates 2012), while the use of CTOs is high and increasing in Australia (Health and Social Care Information Centre 2012). Similar marked increases can be seen in the UK and elsewhere, where the number of CTOs issued has far exceeded initial estimates (Taylor 2010).

There is also good reason to question the true effectiveness of such interventions. A 2011 Cochrane review states that 'compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care' (Kisely et al. 2011). Similarly Rugkåsa and Dawson (2013) argue that the current evidence from randomized controlled trials suggests that CTOs do not reduce readmission rates over 12 months, even though a decrease in readmission among 'revolving-door patients' is a primary justification given for their use.

Given that coercive interventions compromise the principles of liberty and the right to self-determination in a number of important dimensions, effectiveness could be a factor which might be argued to outweigh some disadvantages and render such interventions more morally justifiable. If it is the case that such interventions are not effective and yet their use is increasing then there are serious ethical ramifications. As Rugkåsa and Dawson (2013) put it: 'when CTOs restrict patients' autonomy, however, and there is a duty to provide the least restrictive form of treatment, the RCTs must give pause for thought'. Likewise, McCutcheon (2013) writes: 'we have to ask ourselves what are the ethics of treating a patient with an intervention that they will often not desire when we have no evidence of its benefit?' (Taylor 2010; McCutcheon 2013).

Informal leverage mechanisms

By leverage we refer to a pressure to accept a course of action—this 'is distinct from persuasion and compulsion'. It is a concept that is increasingly identified with the informal pressures commonly used to influence patients, and involves three key components: 'use of a specific identifiable lever', such as finances, housing, or access to children; attachment of explicit conditions to the acceptance or declining of the proposal; and a proposal made by those 'perceived [by the patient] to have the power to act upon the conditions they impose' (Dunn et al. 2014). Although quantitative data on the use of leverage are harder to gather than for formal measures, patient surveys suggest that leverage is a commonplace experience within community mental health (Monahan et al. 2005; Canvin et al. 2013; Dunn et al. 2014). Despite its prevalence, however, there

are virtually no formal or accepted guidelines, which makes it far harder to deal with ethical concerns and establish consistent practice.

Threats

Threats are commonly viewed as imposing conditions which would leave an individual worse off than their 'pre-proposal baseline' if they fail to comply with the proposal. According to Wertheimer's influential account, this baseline involves a consideration of the broad moral context within which the proposal is made, and whether an individual will be significantly disadvantaged in this respect (Wertheimer 1989). In contrast to compulsion, the use of threats may depend more heavily on an individual's awareness of the possibility that non-compliance may result in compulsion. A typical example might be the patient who is informed that their refusal of voluntarily admission to hospital will result in forced admission.

In ethical discussions, threats are usually placed at the very worst end of the spectrum, and it is generally accepted, on an institutional level, that formally sanctioned compulsion is more ethically acceptable than threats. The UK Mental Health Act (MHA) Code of Practice 2007 (4.12), for example, states: 'the threat of detention must not be used to induce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)'. In practice, however, this is far from the reality of what occurs, a fact which might seem alarming (Health Committee 2013). The threat of involuntary admission, whether explicit or implicit (i.e. believed by the patient), is probably commonly used within psychiatry to convince patients to accept treatment or hospitalization. Even in those instances where a clinician may believe that their words technically constituted 'persuasion' or 'unwelcome prediction' rather than 'threat', the 'coercion context' means that the recipient will very likely understand this as a threat that voluntary status will be removed if they fail to comply. This gap between ethical guidelines and clinical practice poses something of an ethical conundrum, as the prevalence of threats might seem to suggest that theory does not reflect our ethical intuitions about their use. Analysis of what threats involve can show that it might be worth reconsidering the conventional evaluation.

We can divide instances that are usually categorized as threats into three broad categories. First there are threats that involve deception—the patient is threatened with consequences which, unknown to them, cannot in fact be implemented. As we have suggested in the case of CTOs, this type of threat might be better categorized as a type of 'compulsion via deception' with the subjective experience of compulsion, even where compulsion is not formally sanctioned. Second, there are threats which stipulate conditions involving the deprivation of something to which an individual is unconditionally entitled by law or duty of care. Both types of threat are clearly ethically unacceptable (Bonnie and Monahan 2005; Dunn et al. 2012). The third, and probably most common, use of threats is to produce compliance without implementing formal compulsion when the threatened outcome would be both possible and legal. The term 'threat' carries negative associations of intimidation and exploitation, while compulsion is perhaps seen to involve greater transparency. Yet, are we being influenced by this to push aside what could conceivably be judged a preferable course of action, in terms of both subjective experience and consequences? For example, would

it necessarily be worse for a manic patient to accept treatment purely because refusal would result in forced hospitalization, rather than being subject to formal admission and treatment?

Threats are often judged as inferior to inducements on the basis that the threatened party will be worse off if the threat is carried out. However, the same argument might also suggest that a threat can be preferable to compulsion. If the patient resumes medication, recovers, and avoids deterioration and formal hospital admission, this would surely seem preferable to the alternative in terms of outcome. Although the subjective experience of being threatened may be disturbing, it is unlikely that this would be worse for the individual than the subjective experience of forced admission and treatment. A threat, even if complied with, may offer the patient more remaining freedoms than would a compulsory admission.

Another major concern about threats is the lack of established guidelines. However, as long as it is maintained on a structural level that threats must be avoided, a lack of scrutiny or regulation will remain, even if usage is widespread. In particular, if it is truly judged to be preferable for the individual to remain within the community and retain voluntary status, it seems that this distinction should be re-examined and that we need a framework that can properly accept discussions and guidelines surrounding the use of threats.

Inducements

The use of inducements, incentives, or offers varies by region and is currently far more widely used, for example, in the USA than the UK, although the increased shift towards community care does seem to be leading to an increase in the actual or proposed usage of inducements. Within community mental health care, examples of inducements might be offers that could leave the person better off in terms of housing or other benefits in return for adherence to medication or other aspects of their prescribed treatment. In principle, an inducement is an offer of something without which the individual to whom the offer is made will be no worse off than they were prior to the offer; in this respect an inducement is often seen as less problematic than a threat (Wertheimer 1989; Dunn et al. 2012). Their increased use in the USA is perhaps linked to patients being diverted from the criminal justice or social care systems (Sinaiko and McGuire 2006), through, for example, 'mental health courts'. Here a sentence after conviction for an offence is suspended if an offer of psychiatric treatment is accepted (this is an offer, not a threat, since its rejection would leave the person as convicted and sentenced, and thus no worse off, than if the offer had never been made). There have been calls for greater attention to be given to examining the ethical dimensions of such interventions (Monahan et al. 2005; Appelbaum and Redlich 2006).

We will briefly consider the particular ethical challenges presented by inducements and how these compare with those presented by threats and coercion. There are a number of ethical concerns with inducements themselves, while the gap between inducements and interventions perceived to be more coercive may also not be as clear-cut as one might assume.

First, there is the issue of fairness in allocating resources. Why should those patients who are reliably compliant with treatment be denied privileges, and why should

the resources of services or finances be diverted disproportionately to less compliant patients? Those who are not offered incentives may be discouraged from accepting treatment, while a reliance on incentives could foster a culture of dependence by encouraging patients to take a more passive role in their care. If clinicians stand to gain from patients' compliance, there is also a risk of exploitation, insofar as benefits to the clinician, rather than patients' best interests, could become a significant motivation for offering inducements (Dunn et al. 2012).

Inducements involve 'relations of power', although the assumption of an 'economic' rather than a 'power-structure' paradigm means that the associated ethical issues are often overlooked (Grant and Sugarman 2004). This is particularly relevant within mental health care, where the 'authority-relationship' of clinician and service user is already framed within a coercive context that will very likely affect the individual's degree of voluntariness in decision making. Furthermore, in jurisdictions where, for example, the law is ambiguous on the rights of a representative payee to withhold or dispense benefits or where the patients are themselves unsure (Elbogen et al. 2005), the boundaries between offer and threat become blurred (Bonnie and Monahan 2005).

A key element of inducements is also that they offer an 'extrinsic benefit' rather than being 'the natural or automatic consequence of an action or a deserved reward or compensation' (Grant and Sugarman 2004), and we can see this aspect as being problematic in terms of best interests and 'incommensurability of values'. The primary and intrinsic aims of medical interventions are to improve health and human flourishing. Clinicians are expected to offer independent health-related guidance. Offers of secondary material gains from medication, such as money or housing, may come to corrupt or degrade the value of the primary aim, as well affecting the patient's sense of agency by disrespecting what they consider to be in the best interests of their own health. To use material incentives to convince a patient with capacity who has decided not to comply not only undermines their own decision making concerning their best health interests (Szmukler 2009) but also endorses a commodification of medical treatment instead of its value lying in its promotion of wellbeing. We would argue, *contra* Dunn et al. (2012), that this is the case, regardless of the eventual possibility of relapse.

In addition, there is the risk of discrimination against poorer patients, insofar as any resulting decrease in voluntariness will be greatest for those to whom the material benefit on offer would make the greatest degree of difference. Material inducements might even be seen to be exploiting the typically low socio-economic status of those with long-term mental health conditions to influence their decision making. There is also the risk that such transactions alter the nature of the relationship between caregiver and recipient, whether personal or professional (Elbogen et al. 2005). A UK survey of clinicians' attitudes to offering financial incentives for adherence revealed widespread reservations surrounding the use of such measures, in terms of all of these concerns (Claassen 2007).

Finally, if we reconsider the common assumption that inducements are less coercive than threats, problems may emerge in the ethical division usually posited between them. It is undeniable that benefits, as well as penalties, have the potential to influence how individuals make decisions, especially within a 'coercive context'. Yet, inducements might still seem distinct from, and less morally troubling than, threats and penalties,

since the latter appear to leave those who do not accept them in a worse position than they were prior to the proposal being made. The relative ability of threats and inducements to influence decision making would be supported by well-attested theories of 'loss aversion', where threats of deprivation exert more influence than offers of benefits, even where material outcomes are the same (Kahneman et al. 1991).

Nevertheless, just as we have suggested that threats may be morally acceptable if the threatened consequences are legal and acceptance of the proposal could be advantageous, we might also wish to question the idea that inducements, whether declined or accepted, do not leave those to whom they are offered unharmed. First, there are the multiple concerns already detailed, such as the possible disempowerment, dependency, inequality, and perceived coercion due to context, which may result simply from offering inducements, whatever the choice. These concerns are raised in other discussions of the use of incentives, for example in the context of political or medical research (Collier and Collier 1979; Grant and Sugarman 2004; Emanuel et al. 2005).

It is also important to consider the fact that many inducements considered within a psychiatric context are a long-term and iterative intervention, and this in itself complicates the issues involved. For example, in a recent trial of inducements, patients were paid inducements of £15 on either a weekly, fortnightly, or monthly basis when they received anti-psychotic medication (Priebe et al. 2013). Given the low economic status of the majority of those on long-term antipsychotics for the maintenance of a psychotic disorder, this amount may well represent a substantial increase to their monthly income in the long term. Indeed, the most significant result was a perceived improvement in quality of life amongst those who received the intervention, and, given that there was no appreciable difference in health outcomes between the control and intervention group, it seems possible that this change might be attributed to the increased income.

If the individual accepts for a period of time and then wishes to reconsider, they are now making this decision within a framework where receiving payment for medication has become the norm. Any decision to discontinue will be now be perceived as involving a loss of income or benefits, which may well have made a substantive difference to their quality of life. The argument that without the offer having been given they would have received no payment regardless of choice is less compelling once the payment is iterative and remuneration has, for them, become the accepted norm in return for taking medication.

Moreover, this leads to further questions about long-term adherence. Inducements are offered to those who may be reluctant to comply in order to encourage adherence. If compliance is now secured, unless the individual experiences a radical shift in their views about the health benefits of medication, their motivation for adherence very likely stems to a great degree from the financial benefits. If the inducements are then subsequently discontinued, they may well lose their motivation to continue with treatment. The consideration of whether to use inducement schemes must therefore take into account not simply the effects while the scheme is in place but the potential problems it might cause for participants after discontinuation.

Within a psychiatric context, there are some very clear problems, therefore, in the idea that offers leave those who decline them, or even those who accept, them

unharmed in some significant ways. Moreover, the potential disadvantages of inducements are far less transparent than those that accompany a threat; this, in itself, might be seen to render them ethically problematic.

For all the above reasons it appears that, from an ethical standpoint, it becomes hard to justify the use of inducements within psychiatry. Though exposure to financial incentives may be commonplace in many spheres of life in our market-orientated society, the particular context of mental health care requires special recognition. Mental health patients commonly experience a lack of respect from many sources for their preferences and values, and are marginalized as participants in society. There is a clear risk that inducements will serve as a structural reinforcement of this marginalization and disempowerment.

Interpersonal leverage and persuasion

Similar problems occur even at the lowest end of the coercive spectrum if we consider the use of interpersonal leverage and persuasion. With persuasion, an appeal is made to reason to convince an individual that a particular course of action would be in their best interests. Interpersonal leverage might be seen as an emotion-based addition to persuasion, in which an individual uses a well-established and positive relationship with someone to influence their decision, for example by showing signs of distancing or disappointment if the recommended course of action is rejected.

Both are means of influencing decision making. As we have argued, within the 'coercive context' of much mental health-care practice any such influence runs the risk of being perceived by the patient as coercive. Moreover, there may be a 'grey area' where even these modes of persuasion could seem to imply, from the patient's perspective, an element of underlying threat. For example, a clinician in an outpatient clinic might argue that, based on several similar past instances, the likely consequence for the patient of withdrawing from medication would be involuntary admission. One might call this an 'unwelcome prediction', a prediction based on evidence and not intended as a threat. However, there may in practice be a fine line between the reasoned arguments suggesting likely consequences and what might be perceived as a threat, especially when the individual expressing these arguments would be likely to be part of the team that makes the decision to invoke involuntary treatment.

A range of difficulties

There are clear ethical difficulties across the range of coercive and 'leverage-based' interventions employed in mental health care. An examination of these difficulties shows that, within the coercive context of mental health, there is greater overlap between the different categories of intervention than there might first appear, so that their relative classification and evaluation needs careful consideration.

Nevertheless, despite the prevalence of the varying types of leverage within current mental health-care systems, there has been little attention to guidelines or sustained ethical discussion of those interventions that do not involve formal compulsion. If we are seriously to consider the relative ethics of all mechanisms of leverage, we need a structural approach to mental health care which can make space to accommodate guidance for the whole range of treatment pressures employed in practice.

An alternative approach to involuntary treatment

Severe mental disorder can lead to clinical situations where a patient appears to lack true autonomy, so that coercive interventions may well reflect their best interests even if they incur short-term loss of liberty. Despite the numerous ethical difficulties, it seems that we need provision for coercive interventions and that individual types or instances must be examined in terms of what might maximize their ethical coherence. This is all the more pressing within a community context, where the complexity and scope for such interventions has broadened considerably.

Many current difficulties appear to stem from the underlying risk- and status-based structure of mental health legislation. Not only does its dependence on status render it fundamentally discriminatory, but the emphasis on risk leads to overuse of coercive measures based on prejudicial, over-protective, and highly inaccurate justifications (Dawson and Szmukler 2006; Szmukler and Rose 2013). It also leaves gaps surrounding the use of informal coercive interventions, often used as an alternative to formal measures, to obtain compliance. Further problems arise from a lack of clarity and consistency, which increases the likelihood of greater degrees of coercion being experienced by a patient because of confusion about their rights.

A recent development in international law, the 2006 United Nations Convention on the Rights of Persons with Disabilities (CRPD) is highly relevant here. With its move from substitute to supported decision making (see Chapter 13), it is pushing us towards an urgent reconsideration of existing laws regarding coercion. The CRPD rejects substitute decision making, and there is currently extensive debate surrounding the difficulties of applying this principle to a mental health context (Kelly 2014). However, it also stipulates our obligations to respect the 'current will and preferences' of an individual and to support them in reaching a valid expression of these.

A better approach to mental health legislation might therefore be to use a 'decision-making capacity and best interests' approach, where best interests are determined by trying to attain the closest possible understanding of the *authentic will and preferences* of the individual (Dawson and Szmukler 2006; Szmukler et al. 2013). Assessment would take into account a patient's current mental state and abilities but would also involve a fuller picture of their beliefs and values, drawn from their past history—for example, the consistency of the person's decision-influencing beliefs with their broader life choices, the support such beliefs have, whether they are amenable to revision or argument, their stability over time, their evolution, the extent of their self-endorsement, past commitments they have engendered, and their cultural meaningfulness and rationality, to name but a few possible considerations—together with any advance statements they themselves might have written, to assess whether their current preferences are consistent within this broader framework. To a certain extent such ideas are represented within the framework of legislation such as the Mental Capacity Act (MCA) 2005, which stipulates that determination of best interests must take into account, where 'reasonably ascertainable', 'past and present wishes and feelings', likely beliefs, values, or other considerations if the individual had capacity (MCA 2005, 1.4.6). However, the individual's will and preferences are still only used post-assessment to determine their best interests, rather than being integrated into

the capacity assessment, while capacity-based legislation is, in practice, almost always trumped by mental health legislation.

An approach based on an assessment of 'will and preferences' would reflect the language and values of the CRPD more closely than current frameworks. By making 'will and preferences' central to determining capacity, the 'best interests' criterion, used to determine what action should be taken, will be reframed far more in terms of the subjective beliefs and values of the patient. This would force us to interpret the person's own beliefs and values and perhaps help in the move towards a model which can incorporate greater degrees of supported decision making. Ultimately, decisions about whether to bring in substitute decision making might still depend on the likely harm from non-compliance, the 'adverse effects' anticipated, for example, by Bach and Kerzner (2010). However, this understanding of harmful consequences would be determined by the deeply held values of individuals themselves, as opposed to general and unsubstantiated estimates of risk.

This approach is highly suitable to making decisions about 'coercive' interventions in a community mental health-care setting. One would aim for the least coercive option, while the more coercive the intervention the stronger the justification must be. This framework offers a structure for clinical discussion and fosters greater clarity and transparency in decision making.

In theory, the aim of coercive interventions would no longer be the avoidance of putative risk, which is both inaccurate and discriminatory, but the maximization of will and preference-based best interests and, through this, the maximization of self-determination. Some ways to achieve this in practice might be to encourage increased use of advance statements and their incorporation within a legal and clinical framework. Although the aim of advance decision making is often seen as decreased coercion or hospitalization, it could also be used by the patient to determine a means of including coercive measures in their care in a manner acceptable to them, by specifying preferences for treatment or management of their affairs during periods when they might be lacking in capacity. They might even incorporate coercion into their own supported decision-making process. For example, could a person include a request for a set period under a CTO, either to shorten the period of hospitalization or because they know from past experience that they will discontinue treatment even when apparently 'well enough' to be discharged? Similarly, a patient who anticipates future episodes of mania, for example, might use a self-binding advance directive (a Ulysses contract) to ensure that they receive treatment, even if they are unwilling at that time, at the advent of precursor symptoms which they themselves have identified and accepted in agreement with their clinical team. In this way, they could use their experience of past episodes and treatments to dictate a strategy involving coercion, as a form of damage limitation, whether this be compulsion or using the contract as leverage.

These considerations present a major challenge to mental health services. The potential for an expansion of coercive interventions in response to community fears and diminishing resources is substantial. Mental health professionals rightly accept an obligation to act to protect their patients and those around them from serious harm. However, if abuses are to be avoided, they must not allow unrealistic views either of risk or the effectiveness of coercive interventions amongst the wider community or professionals to obstruct any modifications to current law and practice that can enhance their ethical acceptability.

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