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Abstract

This paper describes Community Treatment and Counselling Orders (CTO's) and objections by mental health nurses to enforcing 'treatment' without the client's consent and subsequently taking away civil liberties on the grounds that the client may become a danger to themselves or others. It believes the 1990 NSW Mental Health Act went a long way to giving clients fairer treatment but with CTO provisions we have stepped back to 1959 where clients' homes have become extensions of hospitals. It argues that as the Act stands it leaves too many avenues for abuse by punitive and anxious staff and should be amended.

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COMMUNITY TREATMENT ORDERS,

COMMUNITY COUNSELLING ORDERS AND

MODECATE POLICE

by Anthony York*

In line with the NSW Nurses Registration Board's 'Code of Professional Conduct'[1] , it should be known that conscientious objections are held by mental health nurses in regard to professional practice under the 1990 NSW Mental Health Act related to Community Treatment and Counselling Orders. (CTO's)

The objections relate specifically to the enforcement of 'treatment' without the client's consent, and subsequently the taking away of civil liberties on the grounds that the client may become a danger to themselves or others without treatment. This leaves open the likely possibility that defiant clients will be arrested by police and forcibly returned to hospital even though they do not fit the criterion of a mentally ill person under the Mental Health Act.

Psychiatrists have argued that only clients with a history of relapse will be placed on CTO's in an effort to save them from the harmful consequences of non-compliance. This paternalism is considered beneficial for the client and community. Yet this would appear to be counter productive to the concept of normalisation, something we have been trying to implement for a long time, and the new Act was hoped to have gone a long way in achieving this. That is, to give the mentally ill the same rights and standard of treatment as everyone else.

The 1983 Act went a long way to giving clients fairer treatment and was a great departure from 1959. However, with the CTO provisions we have stepped back to 1959, where clients' homes have become an extension of the hospital where psychiatric workers will become unwelcomed visitors enforcing unwanted treatment.

Behind this legislation is the old fear of madness, that mentally ill people may become uncontrollable crazed killers who lurk in shadows. The stuff Hollywood movies have turned into an art form. The truth is far different. The greatest harm done to self and others is perpetrated by drug and alcohol abusers. The damage to spouses and children by domestic violence, incest and sexual assault is enormous (Gorney B. 1989). Therefore if the object of CTO's is the prevention of violence our efforts should be focused upon those with drug and alcohol problems. Should they be placed on CTO's and made to take drugs like Antabuse because they are likely to be dangerous to themselves and others? The idea would be unworkable, laughed at, and strongly resisted by those clients. The seriously mentally ill have been described as being no more

[1] Code of Professional Conduct. Information Booklet, NSW Nurses Registration Board.

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violent than the average population of healthy individuals living in nursing homes and boarding schools. (Graham et al 1990). So why have they been targeted for control?

The legislation singles out mentally ill people for enforced treatment in the community on the grounds that relapse may be prevented in non-compliant individuals, that non-compliant people who relapse may cause harm to themselves or be harmful to others; and on indications that young schizophrenic people who are assertively treated have a better prognosis than those who do not receive assertive intervention. The objection raised about this reasoning is that it has been applied only to the seriously mentally ill, that is, those people suffering schizophrenia and manic depressive illness, and not to people with other illnesses where the same arguments can be applied.

Non-compliance as a nursing diagnostic category has a number of causative elements requiring various interventions. The most common cause of non-compliance with medication is side effects (Van Putten 1974), requiring the administration of more drugs to give relief. Akathesia (continuous restlessness and fidgeting) has been implicated in causing violent behaviour in schizophrenic patients (Van Putten 1975), and the administration of haloperidol has been shown to increase violent behaviour (Herrera et al 1988). But other problems exist which have not yet been addressed adequately with nursing strategies. These include giving clients information about drugs. This would require educating them properly about medication and its effects. This could lead to increased non-compliance when clients discover that some of the side effects of neuroleptics cause permanent damage, like tardive dyskinesia and other tardive syndromes (Kane J.M. 1989) (Remmington G.), but isn't that what making informed decisions is all about? Isn't it better to live in a community where we can have choices, even life and death ones, and not have those decisions made for us by others who think they know better? (Mill J.S.)

Medication holidays are ways clients cope with unwanted side effects and nurses often find clients are no better on medication than off it after periods of abstinence. Research clearly shows that medication simply does not work for many (Brown & Herz 1989), and for others there is an enormous range of therapeutic dosage. Research also indicates that maintenance medication has little prophylactic effect. A survey of the literature indicates that 5-25 per cent are partially or totally unresponsive to anti psychotic drug therapy (Brenner H.D. 1990), and it is estimated by others that 30-40 per cent of clients on medication relapse over a period of one or two years anyway.

Another problem has been the paternalistic attitude taken by psychiatric workers towards clients by disallowing their participation in decision-making about medication and other aspects of treatment. Clients are still placed in the child role and the sick role, generally not given responsibility for their own care. The assumption here is that once a person is ill they are not responsible for their behaviour. With a diagnosis of mental illness this assumption underlies the paternalism - the client is not responsible and never will be.

There is a further difficulty of mistakes being made in diagnosis. Many clients have histories showing several psychiatric diagnoses made by different doctors and requiring different treatment. Diagnosis is difficult and sometimes seems

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to rely as much on opinion as scientific measurement. After all the cause of schizophrenia is unknown and a cure is unknown. Different doctors prescribe different drugs for the same patient and the therapeutic range of dosage with neuroleptics is enormous yet it is not understood how these drugs work (King J. 1990). So what will occur when a client is wrongly diagnosed and forcibly medicated? Will they later be able to sue for wrongful treatment, and who will they sue? The doctor who prescribed the drug or the nurse who gave it? And how will they be compensated?

The role of the Police has been changed by the new law. Until now the Police acted to ensure the safety of the mentally ill, the staff and the community when ordering a Police schedule and when enacting the schedule of a doctor. With CTO's the Police have been drawn into becoming part of the treatment tool, and nurses aligned with Police as agents of social control whose roles are to coerce clients to have an injection or risk incarceration.

Concern exists that community mental health nurses will start to be seen only as enforcers of medication and as a result lose their therapeutic credibility with clients. This may then lead to defiant behaviour in that clients will deliberately sabotage their treatment as a hostile gesture leading to more clients needing CTO's. How clients will react to this pressure is yet to be seen, but it is not a big stretch of the imagination to think some will run away. Clients known to some nurses have already threatened suicide, and in a climate of mistrust and coercion the general effectiveness of mental health services may be undermined. So what measures have been taken to monitor and evaluate these risks?

For the community health nurse to be effective there must be psychotherapeutic relationship. On the one hand accepting the need for biological controls, ie neuroleptics, but also recognising and delivering the other essential ingredients, developing a trusting relationship to provide education, support, crisis intervention, counselling, and normalisation. (Coursey D. 1989). CTO's may destroy this relationship.

Concern also exists about the narrowing of the community mental health nurse's role in the NSW Department of Health which will lead to loss of skills. Until recently community nurses had to perform a wide range of activities, leading to the acquisition of skills in many areas of expertise.

With the lack of a career structure in community nursing this enabled nurses to work in a variety of fields and in a variety of roles leading to clinical excellence and for some - job satisfaction. Community mental health nurses staff drug & alcohol programmes, women's refuges, sexual assault programmes, domestic violence programmes, developmental disability programmes, health education including AIDS services. Many nurses have become expert counsellors in their own fields using their skills in ways which cannot be measured. Staff are able to respond to any problem a person may present with within the general area of mental health, and have a knowledge of community resources to aid these varied problems and be able to assess individuals' needs. With the narrowing of the nurses' role it is feared that community nurses of the future will lose out on experience and opportunities to learn new skills. It is feared the clock will be turned back and once again

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nurses will become subservient tools of psychiatrists and health administrators.

A sceptical but probably true analysis of the provisions of the new Act is the political agenda to save money. It is cheaper to treat people in the community especially in the present circumstances where services are under-resourced with staff and facilities. The promised transfer of funding from hospitals to community as proposed in the Richmond era has never taken place, and the number of homeless mentally ill appear to be growing. Traditionally mentally ill offenders were sent to hospital rather than to jail, where, it was hoped, controls on behaviour would be applied. Yet the policy of de-institutionalisation has put the mentally ill on the streets. No longer protected by asylum those who have behaviour unacceptable to the community would in the usual course of events, be charged by police and given fines and jail terms. However, in order to prevent re-admission to hospital CTO's would appear to be a convenient way of using chemical restraint, resulting in huge cost savings by keeping potential mentally ill offenders out of hospital and out of the jails.

How a CTO is to be placed on a homeless client is yet to be seen. Perhaps homelessness will be a way of escaping a CTO, but recent experience of community nurses following up clients in agencies for the homeless, and on the streets, putting more effort into medicating than finding accommodation for clients, is a disturbing trend in the changing priorities in community nursing. Adequate accommodation does not exist for many of these clients and without Housing Department support to house the mentally ill, nurses are powerless to help, so clients are being referred from hospitals to refuges for the homeless, but this is another story.

It is not good enough to implement CTO's on the grounds that harm may occur. It equally may not.

Most of us have encountered individuals we have felt controls should be applied to, but our anxiety is often not translated into reality. As the Act stands it leaves too many avenues for abuse by punitive and anxious staff. The Act should be amended.

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