

Doing what's best, but best for whom? Ethics and the mental health social worker

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Introduction

Of all areas of social work, it is perhaps that of mental health that poses more ethical questions than any other. For the Approved Mental Health Practitioner (AMHP) (a role still held predominantly by social workers although it can also be undertaken by other specified professional groups such as Community Psychiatric Nurses), there is the considerable issue of the powers given to them by the Mental Health Act (MHA) 1983/2007. The MHA allows the AMHP, subject to having the required medical recommendations, to make an application for the detention in hospital (for assessment or assessment followed by treatment) of someone deemed to have a mental disorder, irrespective of the person's wishes. In other words, the person can be legally detained and medically treated against their will, not necessarily because of what they have done but on the basis of what professionals think they may do in future. And whilst the decision to invoke these powers will be based on an assessment as to the risk that the person (possibly soon to be patient) poses to either themselves or others, it is important to note that detention and treatment under the Mental Health Act can also be solely on the basis that it is, again in the opinion of professionals, deemed to be in the interests of the patient's health.

The ethical issues that arise from this professional role mainly concern such things as, on one hand, the personal autonomy and rights of mental health clients, and, on the other, the professional, state sanctioned, surveillance and constraint to which they may be subject. Such intrusive measures are justified on the basis that it is necessary for the benefit of the individual and/or wider society; we are, in some way, doing what's best, we are doing good. The most basic ethical questions for the reflective and conscientious social worker to consider, then, are what this 'good' is and the way in

which it is supposedly being achieved. That is, the particular considerations facing a mental health social worker, when making a decision about how to act well or 'best' in her professional role, are 'what or whose good am I trying to promote or protect'; 'why'; and 'who decides?'

These questions are of course illustrative of wider problems in moral and political philosophy. For example, whether or how we can justifiably constrain or coerce people for the sake of some outcome or 'greater good' (such as consequences for carers or relations; wider public security; social capital; law and order; or even economic efficiency); or for 'their own good' (which raises the problem of paternalism). And aside from these particular issues around intervention in individuals' lives and the use of compulsion, a second, and more general way in which the role of mental health social workers can be seen as ethically important concerns their involvement in facilitating the well-being, or 'happiness' of clients. For there is also a more fundamental sense in which 'Ethics', broadly construed, concerns what it means for us to live good human lives (Aristotle, 2009; Williams 1985). So, insofar as 'mental health' relates in some way to human well being or happiness, the mental health of individuals or the well-being of society can be said to be the business of Ethics. In this respect there are critical questions for the mental health social worker regarding what 'sound mental health' (or similar) is; and the extent, if any, to which it can or should be promoted in clients' lives.

If mental health social work is fundamentally concerned with these two broad and overlapping areas of ethical concern— the legitimacy of intervention itself and the nature and promotion of 'mental health' (or happiness or well being), then the social worker working within the field of mental health, which arguably covers each and every social worker to a greater or lesser extent, is embroiled in the business of Ethics. Therefore, both the professional role and the institutions that confer the duties and responsibilities of said role warrant critical ethical justification (Cordell, 2011). This chapter highlights some of these intertwining ethical difficulties in mental health social work using the example of Community Treatment Orders (CTO), which were introduced in England and Wales in the

Mental Health Act 2007, but also by considering the government's wider in scope 'happiness agenda' (BBC News, 2010), as it also raises questions over the meaning of mental health, happiness and the role of the state in their pursuit.¹

In terms of intervention, one major ethical problem that arises from the introduction of CTOs is that of justifying intervention, constraint or coercion in clients' lives after they have been discharged from hospital; another, in relation to 'happiness', is interpreting the nature and scope of 'mental health' as that which supposedly justifies intervention in the life of both clients and the wider public. A further important issue, which relates to both these aspects of mental health policy, is the need to understand the way in which institutions (through government policy or state legislation) shape the conception of mental health. Through a critical discussion of the arguments supporting the introduction of the CTO and of the ways in which their implementation has been defended, not only do we raise doubts over some of the theoretical and ethical justifications for the use of CTOs, we also raise questions about what we mean when we say we are endeavouring to improve the mental health or happiness of the subjects of social work. Our intention is not to provide a blueprint for practice but to create a critical space for social workers to think about how, why and on what basis they are pursuing certain aspects of their professional role.

From Community Care to Community Treatment

Mental health legislation has long provided for the detention and treatment of the 'mentally ill' subject to certain criteria being met. The Mental Health Act (MHA) 1983, enacted prior to the widespread move to care in the community, was held by some to be inadequate for the contemporary period when most mental health care was located within the community rather than in the old long stay psychiatric institutions. High profile tragedies where ex-patients had killed were used to argue that community care had failed and that it had put the public at risk from psychiatric

patients, and the patients at risk from themselves due to violence, self-harm and/or neglect. Such concerns were hugely influential in the drawing up of the Mental Health Act (MHA) 2007 which amended the 1983 Act (McLaughlin, 2008).

The MHA 2007 provided powers by which patients detained in hospital for treatment, could, upon discharge, be made subject to a Community Treatment Order.ⁱⁱ The CTO can compel the patient to abide by certain specified conditions, most notably, though not exclusively, that they continue to take any prescribed psychiatric medication. Failure to comply could lead to the patient being recalled to hospital, where the drug could be forcibly administered.

The introduction of CTOs was controversial in a number of ways, but mainly because it changed the citizenship rights of psychiatric patients post-discharge from hospital. Whereas previously, under the MHA 1983, patients lost the legal right to refuse medical treatment whilst subject to hospital detention, once discharged from the section and returned to the community they regained the same rights of citizenship as everyone else,ⁱⁱⁱ such as the right to refuse medical treatment, even if this goes against professional medical opinion and is likely to be detrimental to our health.

Given the adverse effects that psychiatric medication can cause,^{iv} it is perhaps no surprise that many ex-patients exercised this right and stopped taking their medication and/or otherwise disengaged from their clinical team. Such non-compliance was implicated in the so called 'revolving door' patient phenomenon, whereby someone was admitted to hospital, got better with medication, was discharged, stopped taking the medication, relapsed, was readmitted to hospital and so on. Non-compliance with medication was also implicated in several homicide Inquiries into cases where ex-patients had killed (Howlett, 1997). Irrespective of this, a history of non-compliance is not necessary for a CTO to be imposed; it can be applied to a patient after his first compulsory admission for treatment provided the criteria below are met.

A CTO may be made under section 17A(5) of the Mental Health Act 2007 if

- (a) the patient is suffering from a mental disorder of a nature or degree that makes it appropriate for him or her to receive medical treatment;
- (b) it is necessary for his or her health or safety or for the protection of other persons that he or she should receive such treatment;
- (c) subject to his or her being liable to be recalled, such treatment can be provided without his or her continuing to be detained in a hospital;
- (d) it is necessary that the responsible clinician should be able to exercise his or her power under section 17E(1) to recall the patient to hospital;
- (e) appropriate medical treatment is available for him or her.

Given the significant change in status and power dynamics between professionals and patients brought about by the introduction of CTOs it is worth considering both the basis for their enactment and the evidence as to their effectiveness. In the next section we will first consider the issue of individual autonomy and state intervention in the life of the individual. Second, we look at some ethical arguments for the use of CTOs and whether they are mostly used for the benefit of the patient, society or professionals.

The Autonomous Subject and State Intervention

There are some basic ethical worries about CTOs that are separate from concerns about whether they actually achieve their aims. Perhaps most pertinent are concerns about certain inviolable moral rights which recognise the autonomy of the individual subject; rights that one has not by convention or legal decree but simply by virtue of one's status as a human being or a person. Many think that such rights cannot be violated or ignored for the sake of society or for what others see as that individual's good.^v

The ethical question of intervention in individuals' lives, and whether or not this constitutes a violation of rights or autonomy, is especially pertinent to social work because, in some form or another, intervention in other people's lives is exactly what much of that work is characteristically *about*. Importantly, intervention is often justified in mental health patients' lives in a way in which it would not be justified in the lives of others, where a widely held anti-paternalist principle is taken to respect the value of personal autonomy (literally 'a law unto oneself'); of self governance.

The source of this ethical view – on which the autonomy of the rational agent as a moral being is basic and primary – is most often attributed to the eighteenth-century German philosopher Immanuel Kant. From a Kantian perspective people should be seen as ends in themselves, never merely as a means to some end. This posits persons with an inviolable right to be accorded human dignity which should not be compromised in order to secure some other goal.

Much of the language of individual rights and respect for persons is rooted in a broadly Kantian view, and much of the discourse of the ethics and values of social work reflects this approach. According to Bogg,

the professional needs to ensure that their actions are undertaken in an appropriate, proportionate and informed manner. The ability to exercise coercion should never be downplayed: the aim of a transparent application of power requires the worker to identify the power dynamics and to ensure that the individual's rights are observed at all times. Coercion is neither a threat nor an incentive: it should only be used if it becomes necessary according to the criteria set down in law, and disagreement between worker and user is never sufficient justification.

(2010, p.57)

This view is reflected in many of the explicitly stated aims and ethical guidelines of social work. For example, Banks (2006) examined a selection of codes of ethics for social workers from thirty-one

different countries. She found that most codes start with a list of professional values and/or principles which include variations on such themes as 'respect for the unique value of the individual person; service user self-determination; social justice and professional integrity' (p.83). In practice then, the mental health social work role entails mediating between different sets of obligations and interests (Yianni, 2009).

Of course, respect for service user self-determination may well be a guiding principle, but in the case of statutory powers this is often overridden, with those subject to them, temporarily at least, not accorded the status of autonomous subject. This can be justified in several ways, perhaps most notably with respect to the prevention of harm to others.

The Harm Principle

The eighteenth-century utilitarian philosopher John Stuart Mill famously railed against interference in people's lives for any other reason but the protection of others. In *On Liberty*, Mill stated his famous 'harm principle' thus:

That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.

(2008 [1859], p.14)

Whilst the harm principle is robustly anti-paternalistic, it might be seen to permit intervention in individuals' lives under certain conditions that are typical of mental health social work. Hence it is worth considering two such Millian defences of such intervention.

Firstly, the harm principle does not necessarily preclude preventive detention or treatment of the kind allowed under the Mental Health Act. If there is a 'foreseeable risk' of future harm then Mill concedes that the government (for our purposes in the guise of designated mental health professionals) may be within its rights to intervene before the event in order to prevent its occurrence at some future point.

As in other areas of legality and ethics, intervening in someone's life against his will in order to prevent serious harm to them or to others may provide a stronger justification than would (supposedly) intervening to improve his personal welfare. This would appear to be Bogg's (2010) position when she states that 'In circumstances that may result in restrictions being applied, the question must always be asked, is it necessary for the individual's health *and* safety or to protect others?' (p.79, our emphasis). However, the wording of the MHA is slightly different, and this difference has major implications. Detention can be justified if it is deemed necessary for the patient's 'health *or* safety or for the protection of others' (S.3, our emphasis). Thus, compulsory admission and treatment can be justified solely on the basis that professionals deem it to be beneficial to the patient's health; he does not also have to be a danger to himself or anyone else. Of course, the reality is that with pressure on psychiatric bed space only those deemed a risk to self or others are likely to be admitted, nevertheless, legislative powers can be used legitimately whether risk is present or not.

Secondly, Mill states that his doctrine 'is meant to apply only to human beings in the maturity of their faculties' (p.14), which precludes children and others unable to take care of themselves, or more precisely for our purpose, those to whom we have a duty of care. It is recognised that in order to apply the duty of care it is occasionally necessary to restrict someone's freedom and autonomy,

to exercise control over them, which can directly impinge on other basic rights. Thus, perhaps it could be argued that in such cases coercion, constraint and intervention in mental health work is no such violation of autonomy when the subject is not autonomous in the relevant sense. That is, following Mill, a line of justification for CTOs could be quite non-paternalistic and even consistent with anti-paternalism and the value of personal autonomy (Dale, 2011; Munetz et al. 2003). For, it might be said that CTOs are by definition correctly applied only to subjects who, episodically or in the longer term, do not possess the kind or level of autonomy that would include them in the scope of the harm principle; that they are no such 'law unto themselves' is precisely the reason they are subject to constraint, for example by the terms of the Mental Health Act.

However, a problem with this view is that there is a crucial contrast between the initial detention under the Mental Health Act and the imposition of a CTO. At the point of admission to hospital under the MHA it is generally agreed, by professionals if not the patient, that the patient is so 'mentally ill' that they can no longer be left in the community, at which point his individual rights are overridden. However, at the point of discharge the patient, whilst technically still deemed to be 'suffering from a mental disorder of a nature or degree that makes it appropriate for him or her to receive medical treatment', can be otherwise mentally well, have full mental capacity and deemed able to be returned to the community.

This is due to the MHA being risk based, not capacity based, and means that, as most patients, at the point of discharge if not admission, will have the capacity to make treatment decisions, 'community treatment orders will commonly be imposed on people who have capacity ... [And] we should also not forget that community treatment orders will compel patients to take medication that will be effective to differing degrees and could have seriously debilitating side-effects' (Lawton-Smith, 2008, online).

As mentioned above, prior to the MHA 2007, a discharged patient regained the rights of citizenship that most of us take for granted, in particular with regard to this example, the right to refuse medical

treatment, even if to do so would place his health at serious risk. This is no longer the case and marks a major shift in the citizenship status of discharged patients subject to a CTO. The concepts of personal freedom and autonomy entailed the right to make the wrong choices. Here then is a case in which a patient is deemed 'well' enough to be discharged into the community but not enough to enjoy the freedom and autonomous status shared by others within that community. Hence it is not so clear that Millian type exemptions from the 'harm principle' apply in this case. In addition, far from being free to refuse medication that would benefit them, they can be compelled to take medication that can give them adverse medical conditions.

The subject of a CTO may be mentally healthy, in relative terms at least, and have full mental capacity but he does not return to full citizenship status but to a reduced social standing, neither full citizen nor patient but a diminished hybrid of the two - the 'community patient'.

For the good of society?

In the introduction we referred to one way of justifying intervention in a person's life by reference to the promotion of some 'greater good', a good which benefits society more widely and for the sake of which that individual's interests might be subordinated. This reflects a utilitarian view, on which the right thing to do is always that which will maximise the 'utility', the happiness or welfare, of society overall. Notwithstanding many of the problems with and objections to utilitarianism as a moral or political doctrine (Kymlicka, 2001; Rawls, 1972; Smart and Williams, 1973; Scarre, 1996), there is a clear and plausible line of justification for CTOs which has a distinctly utilitarian form.

According to Maden (2005), a consultant psychiatrist and vociferous proponent of the need for CTOs, the principle at stake 'is not whether we, as a profession or as a society, value dignity, autonomy and choice. The tough choice is whose dignity, autonomy or choice takes precedence? That of the cyclist in Richmond Park, or that of the restricted patient?' (online). Maden is referring to

the case of John Barrett, a psychiatric patient, who stabbed a cyclist to death in Richmond Park, London in 2004. The same case was also frequently highlighted by government ministers as they justified the need for CTOs.^{vi} Maden (2004) argues that mental health professionals 'need to keep in mind the importance of public relations'. This is because 'the people who pay for services have identified safety and public protection from violence as their priorities, and clinicians need to respond to those concerns' (p.4). Losing this 'public relations battle', will, in his view be to the detriment of psychiatric patients (Maden, 2005). Here, Maden appears to be using a utilitarian argument, in that restrictions on the few will be to the benefit of the many, either in terms of protecting them from possible attack and/or the alleviation of anxiety. Following this logic, Maden also argues that there need be no therapeutic benefit for the patient in order to justify compulsory detention.

On a utilitarian view then, the decision to place someone on a CTO could be seen as promoting the greater good of society, where in this case the good can be specified in terms of public safety via the prevention of criminal and violent acts. From such a teleological (goal-led) perspective, if the ends justify the means, if a safer society for the majority is achieved then the loss of citizenship rights for an individual or a minority can be justified. Given that a major factor in their introduction was a response to some high profile tragedies in which ex-patients had killed others, and, albeit to a lesser extent, cases where they had killed themselves or otherwise exposed themselves to danger and neglect, issues of public safety and patient quality of life tend to be the areas given most attention in research into the effectiveness of CTOs.

In terms of social and mental health practices, then, it should be borne in mind that utilitarianism *per se* is at odds with the principle of personal autonomy and the inviolability of certain rights. The utilitarian may, in some circumstances, be in favour of upholding some rights or promoting individual autonomy, but only and always when doing so would promote utility (Kymlicka, 2001). Rights or individuals' autonomy could in principle be violated if this could be justified by the actual or

expected outcome of greater utility overall.^{vii} Thus, utilitarian justifications of CTOs should warrant caution from those who see such principles and values as rock solid guides for mental health social work.

But as well as raising theoretical doubts about the inappropriateness of a utilitarian rationale in mental health social work, it is also worth considering whether, in fact, the actual use of CTOs achieves the end of public safety; in other words, whether this justification for CTOs succeeds in its own utilitarian terms. As we shall see, this is far from conclusively supported by evidence.

For example, Parker and McCulloch (1999) found that non-compliance with medication is over-emphasised in relation to homicides by ex-patients. A National Confidential Inquiry into Homicides and Suicides by People with Mental Illness took place in both 2001 and 2006 (DH, 2001; DH, 2006). The earlier report surmised that compulsory CTOs *may* prevent just two homicides per year, whilst the later one admits that 'We have no reliable way of calculating how many homicides [or suicides] would be prevented by a community treatment order' (DH, 2006, pp.93 and 139). This raises the question of *which* two homicides would be prevented.^{viii} Given the unreliability of risk assessments how many false positives would be needed to ensure the two true positives were medicated? Very many, according to some reports. The Cochrane review (Kisely et al. 2005) looked at 'compulsory community and involuntary outpatient treatment for people with severe mental disorders'. It found only two relevant trials and concluded that they 'provided little evidence of the efficacy on any outcomes such as health service use, social functioning, mental state, quality of life or satisfaction with care.... In terms of numbers needed to treat, it would take 85 outpatient commitment orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest' (online). In addition, an international review that considered studies over a thirty year period concluded that there was little evidence that CTOs were effective in such things as reducing hospital readmission rates or compliance with medication (Churchill, 2007).

So, the justification for CTOs in utilitarian terms of promoting greater societal goods, such as public safety, is questionable in the very terms favoured by utilitarian reasoning. Aside from important concerns about patients' rights or autonomy and their centrality in mental health practice, there is a legitimate scepticism about whether CTOs 'work' in quite the way that some proponents of the measures claim.

For the good of the client?

So much for justifying the constraint of individual patients in terms of the good of others. What about the promotion of the good of the patient themselves? It could be argued that if the CTO effectively promotes the well-being or mental health of the individual subject to it, that this could provide justification for its use separate from whether, or the extent to which, it promotes the wider public good. So, whether or not CTOs make for a safer society, they could be effective in facilitating a better life for the 'community patient'. However, similar doubts may also be raised about the practical efficacy of CTOs as a paternalistic measure, i.e. as a means to promote the 'good' of the client.

First, we need to know to what extent if any does the CTO actually benefit clients themselves. Of those studies that do show benefits they tend to be that some patients found that they gave some structure to their lives, that families found them useful when their relative 'lacked insight' and, perhaps unsurprisingly, that clinicians were the group most consistently positive about the efficacy of CTOs (O'Reilly et al. 2006). The patients' views of CTOs also need to be placed in context. For example, Gibbs et al. (2005) found that many preferred to receive involuntary treatment at home rather than as an in-patient. However, in itself this is just to establish a preference of one option out of the only two available, not that the chosen option is desired or considered beneficial by the

patient. To infer the latter would be like saying that because in-patients prefer to be detained for six rather than twelve months that they are in favour of their detention for the lower period.

A second doubt about CTOs in relation to the paternalistic justification is whether their actual use is typically solely directed at the good or well-being of the client in question or, in fact, whether the tendency is towards using them as a means to professional protection, with risk-averse practice being a factor in the imposition of a CTO. It is worth remembering that the use of CTOs was initially said to be necessary for a relatively small number of 'revolving door' patients. Maden argued that they were necessary 'to allow compulsory treatment in the community of patients with a serious mental illness and a history of violence and non-compliance' (quoted in James, 2006, online). In similar vein, Dawson and Burns (2008) argued that the powers 'should give clinicians the confidence to make *selective* use of the new regime' (online, our emphasis). Despite such claims, the early signs are that the use of CTOs far exceeds initial estimates and, rather than being imposed selectively are being used on a wider and less specific group of patients than envisaged by these commentators.

As McLaughlin (2010) points out,

The government envisaged that between 350-450 CTOs would be issued in England and Wales in the first year. However, the number issued has far exceeded the government's and its advisers' expectations. In the first five months in which professionals were able to issue them, November 2008 to March 2009, there were 2,134 issued in England alone. It may be the case, as some argue, that the initial surge is due to those on a sort of 'waiting list' being put on CTOs as soon as possible once it became an option, and that the rates will stabilise after this initial surge, although you would have thought that the great and the good who worked to bring this legislation through would have accounted for this in their initial estimates.

(p.145)

Again, even leaving aside for the moment the debate about ethics, autonomy and citizenship rights, in today's climate there was always the risk that professionals would err on the side of caution and use CTOs as an instrument of managing the risk to themselves of anything going wrong rather than as an option of last resort. There is also the suspicion that due to pressure on psychiatric hospital beds (too few beds, too many patients), many are being discharged early on CTOs rather than having longer hospital treatment.

So the paternalistic justification for CTOs can be questioned on grounds of efficiency (are CTOs effective at promoting the good of clients?) and the way on which they are employed (are they used primarily in the interests of professionals rather than those of their patients?).

The pursuit (or imposition) of happiness

If there are many ethical issues for the social worker to consider when it comes to the use, non-use, or indeed misuse of statutory powers in relation to the detention and treatment of mental health service users, the social worker's task may seem far less controversial when it comes to improving the mental health of her clientele. After all, it is often when people are suffering mental distress that they come into contact, either voluntarily or not, with mental health services. In working with people who are unhappy, the pursuit of happiness would appear to be a reasonable strategy.

Yet consider that the very concept of 'happiness' has exercised the minds of some of the greatest thinkers within Western philosophy, as well as politicians, statesmen, social policy devisors and those professionals, including social workers, responsible for their implementation.^{ix} For example, Aristotle saw *eudaimonia* (sometimes translated as 'happiness' or perhaps more instructively as 'flourishing') as the condition of living well over the course of a characteristically human life. So being *eudaimon*, living the good human life, is neither reducible to pleasant sensations nor to 'feeling happy' from time to time, and is much more in keeping with what we might think of as good psychic health. By contrast, the 'hedonistic' utilitarian Jeremy Bentham saw happiness purely as the

presence of pleasure and the absence of pain, whilst the eighteenth-century economist Adam Smith believed that wealth could produce happiness but also that there was more to well-being than material possessions.

This philosophical controversy over happiness and mental health provides practical problems for social workers at the coal-face of mental health work, for if the concept of happiness itself is unclear and contested, so is its relation to 'mental health'. It is important in terms of coercion, constraint and patient autonomy, and it is worth noting that coercion can be of a more subtle variety than the use of statute (Campbell and Davidson, 2009). Understanding 'mental health' broadly as a spectrum of human well-being or happiness raises an interpretive problem with justifying a mental health policy or particular act of intervention on the basis of the client's mental health; for example what is measured, who measures it and how is it to be measured? We can even legitimately ask ourselves if it is possible to measure it.

In response, one could insist that 'mental health' is what mental health social work should be concerned with, and that this requires no direct concern with 'happiness'. Perhaps, on this view, mental health is a precondition of happiness; a *capability* one needs for happiness, but that may be all.^x Indeed, it is possible to argue that implicit in the introduction of CTOs is that for those subject to them, if they cannot achieve happiness they *will* achieve mental health, at least as defined and measured by professionals. However, where delineating 'mental health' and 'happiness' was never conceptually easy, it is also currently practically conflated by policy, where governmental concern with poor mental health goes wider than the measures discussed above in relation to patients subject to mental health legislation. In the contemporary period actual judgments about individual cases are made in a context in which furthering 'mental health' together with 'happiness' are among the stated aims of the government.

The previous New Labour government was so concerned with the rates of unhappiness in the country that it appointed an advisor, Lord Richard Layard, to identify ways to improve the nation's

mental health. In 2006 Layard proposed the training of an additional 10,000 Cognitive Behavioural Therapists who were to be based in 250 centres across the country. The current coalition government is also concerned about the mental health of the nation, Prime Minister David Cameron commenting that ‘there’s more to life than money and it’s time we focused not just on GDP [Gross Domestic Product] but on GWB – general well-being’ (quoted in Stratton, 2010).

The mental health and happiness agenda should give the mental health social worker pause for thought. Social work professionals and their organizations are agents and agencies which operate simultaneously under the auspices of public legislation and regulatory frameworks, and also in the private lives of individuals. That is, they work at the interface of the state and its institutions on one hand, and clients – or groups of clients such as families – on the other. In such a position, social work in mental health is perhaps especially susceptible to becoming one of the vehicles through which ‘the mental health of the nation’ (however that is conceived by governments or their advisors) might be effected, the use of CTO’s being a particular case in point.

Importantly, the idea that we can use technical measures to calculate ‘happiness’ itself seems to reveal a particularly simplified understanding of the concept which may, arguably, be used to justify practices which are detrimental to ‘happiness’ proper. For Aristotle, as we have seen, happiness is a way of being and acting over the course of one’s life, not merely a state of feeling happy, and it is through our actions in the pursuit of the good and virtuous life that happiness in this sense could be achieved. We need not be Ancient Greeks or confirmed Aristotelians to agree that there is more to human happiness than feeling cheerful; that such things as projects, relationships, achievements, and exercising and developing our intellectual and emotional capacities are a crucial part of what we think of as a worthwhile – ‘happy’ – life (Nozick, 1974). Similarly, the pursuit of knowledge and awareness of our inability to fully account for the human condition, of facing up to the realities of some of the horrors of the world, can leave us saddened and dissatisfied. From this perspective, it is possible to claim that artificial happiness, or more precisely, drug induced euphoria or contentment,

whether by the voluntary use of illicit drugs or their legal administration under a CTO, is an abdication of the pursuit of happiness and also of responsibility for facing up to both our own and society's problems.

This does not mean, from an individual case by case perspective that the use of prescribed medication is never warranted or beneficial, or that psychosocial interventions such as Cognitive Behaviour Therapy cannot help some individuals, it is merely to illustrate that such chemical or technical approaches to the achievement of 'happiness' suggest a view of happiness that is a far cry from the concept's classical philosophical meaning. The practical danger here is that when such approaches also form governmental thinking – CTOs for the few, CBT for the many – it could be argued that to a greater or lesser degree, social policy not only views an ever-increasing number of us as unhappy but also as less than autonomous subjects.

Conclusion

In this chapter we have sought to detail some of the ethical problems that arise in relation to the introduction of Community Treatment Orders for psychiatric patients from teleological (utilitarian) and deontological (Kantian) perspectives and also to highlight the way in which such orders are justified and subsequently used. We also noted that the government's focus on mental health and happiness risks simplifying both concepts and reducing our status as autonomous subjects. Space precludes a detailed discussion of the role of power in shaping the moral and ethical agenda (Webb and McBeath, 1989), but we hope that the power differentials between mental health professionals and their patients have been made clear, especially in the power of the former to categorise the latter as mentally ill which can then make them subject to mental health legislation with all that can entail.

In questioning the evidential base and ethical perspectives in favour of CTOs we have sought to highlight the danger of hiding behind simple ethical assertions such as 'I'm doing what's right'. Unpicking such an assertion necessarily leads to a need to elaborate on what is meant by 'right' and precisely for whose benefit is this 'right' action being implemented. As we have discussed, it is potentially possible to justify the CTO and indeed other aspects within mental health social work by recourse to ethical arguments, so in this respect the CTO or any other measure is not inherently 'unethical' *per se*, so we are not arguing that the conscientious mental health practitioner should categorically refuse to be involved with them. On the contrary, this chapter has to a large extent been motivated precisely by the fact that these practitioners now have a duty to decide upon and justify the use of CTOs in a range of circumstances, and we have sought to show that much greater consideration to the ethical dilemmas of mental health policy in theory and practice is needed at both the level of direct practice and wider political discourse.

In this respect, we hope to have suggested that 'doing what is right' in the professional capacity of the mental health social work role cannot simply amount to the correct application of rules or procedures. Most obviously such rules, or measures including CTOs, require interpretation at the ground level of practice, case by case. But the ethical professional may also think about their specified duties and what their role demands of them at a much more fundamental level.

The radical contribution to social work, at its best, endeavoured to make social workers think critically about what they were doing, why they were doing it and on what basis. In short, it endeavoured to stop social workers from being complacent in their role, to make them feel uncomfortable at some or other aspect of their social role and professional practice. This is important not only in and of itself, but also to aid critical evaluation of professional role obligations and the institutions that define those obligations with the aim of improving practice. In questioning the justification for CTOs and the drive for 'mental health', well-being' and 'happiness from utilitarian, Kantian and Aristotelian^{xi} perspectives, we have sought to carry on that radical tradition.

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ⁱ There are several useful critiques of the drive towards empowerment, well-being and therapy. For example, Cruikshank (1999), influenced by Foucault's work on governmentality and bio-power, argues that the rise in such measures represents an aspect of neo-liberal welfare policies, and that our 'empowerment' in reality represents our subjection and loss of autonomy. Furedi (2004) similarly sees the management of people's emotions as being representative of a new conformity, although he implicates both the political right and left in the cultivation of such a scenario.

ⁱⁱ There has been discussion over the pros and cons of introducing compulsory community treatment orders many times during the latter decades of the twentieth-century; although the early years of the new millennium saw a renewed and sustained focus on them which culminated in their incorporation into the MHA2007.

ⁱⁱⁱ There were some exceptions, for example those subject to court orders.

^{iv} We deliberately did not use the term 'side-effects' as this can trivialise the symptoms. If they are happening to you they are *effects* of the drug. They may be unintended consequences but the symptoms are real.

^v For further philosophical analysis and discussion of rights and their justification see e.g. Wenar (online) and Waldron (ed.), 1984.

^{vi} The highlighting of this case shows either a careless disregard for the facts or a manipulative use of the media, as linking the John Barrett case to a need for community treatment orders conveniently overlooks the fact that he was actually an in-patient at the time of the killing. He had been given one hour's unescorted leave from the ward but absconded from the hospital grounds. Whilst noting many professional failures in his care, the chair of the inquiry team stated that, 'the remedy for what went wrong in this case lies not in new laws or policy changes' (Barrett Report, 2006, p.9).

^{vii} For a stark illustration of the implications of hard utilitarianism from social-science fiction, see Stanley Kubrick's film of Anthony Burgess's novel *A Clockwork Orange* (Warner Bros. 1971). Embroiled in controversy for implementing the 'Ludovico' method of forcibly brainwashing violent offenders to expunge any of their criminal inclinations and make them 'good' (sweet and mechanical, like 'a clockwork orange'), the home secretary declares loudly to Ludovico's opponents in its defence "the point is that it *works!*"

^{viii} The problem of assessing the consequences of one's actions or inactions is especially pressing for utilitarians and any kind of 'pure consequentialist' theory which assesses the moral worth of any action or policy on its actual or expected outcomes (See Lenman, 2000).

^{ix} Some conception of what it means for humans to live well and the conditions for such – and so to some extent a view of what human well being or happiness consists in – implicitly underpin many political philosophies. For example the early Marx, with Engels (1999), argued that the exploitative relationship of the capitalist class over the working class, and the estrangement of the worker from their own productive labour – from which the capitalist now makes a profit by extracting 'surplus value' – was the root of man's 'alienation': i.e. a disconnection from the capitalist, from his own work, and from other workers in the same situation. For Marx and Engels, man's 'true' self as a freely co-operative, productive and social 'species-being' is stunted by the historical and political conditions of capitalism, and can only be realised with the overthrow of capitalism (and eventual replacement by genuine communism).

^x For the 'capability' approach to welfare see Sen (1985).

^{xi} For a more detailed defence of a neo-Aristotelian virtue ethical approach to social work see McBeath and Webb (2002).