The Ethics and Practicality of Compulsory Therapy

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SYNOPSIS

The UK Coalition Government has been discovered considering the compulsory treatment of benefit claimants with mental health related issues, with the punishment of reduced or suspended benefits payments, should they refuse. This has led to discussion and outrage about the ethics, practicalities and sourcing of such therapy. Currently the matter remains in the concept stage to be looked at in future benefit policy changes under a potential future Conservative Government. This article discusses a range of related issues, including ethics, who could provide such a service, whether such a service could work, and the underpinning ideological arguments.

Since the Coalition government came to power, there have been various attempts to reduce the cost to the taxpayer of the welfare state. There has already been great controversy over the nature of health assessments from companies like ATOS for benefits, including ESA (Employment Support Allowance – for those unable to work) and DLA (Disability Living Allowance) or the replacement PIP (Personal Independence Payment – for those suffering from the additional costs of disability). Previous controversies have included assessment interviews where the assessor clearly has little or no medical or mental health knowledge, pressure to attend work or training schemes despite obvious and diagnosed barriers to being able to do so, and the possible readjustment of criteria in the change from DLA to PIP, with the suspicion that behind the smiling platitudes, this will be an attempt to save money.

In July of 2014, a further story broke in the press, notably in the *Daily Telegraph* (12 July 2014), and later repeated in a variety of media formats. To the horror of many, discussions are under way within the DWP to consider requiring persons with mental health issues to receive treatment for their conditions, or risk sanctions, including the loss of benefits. When ‘sanctions’ such as loss of benefits are threatened for failure to comply, the claimant is left with no real choice, and therefore is effectively forced to comply or starve. There is no real choice, therefore, and ‘sanction’ is a polite expression for coercion. It is not clear exactly what treatment would be imposed on claimants, but one can easily deduce that these will be in line with those promoted by NICE (the National Institute for Clinical Excellence) and existing mental health strategies. One could expect cognitive-behavioural based psychological treatments, and of course drugs treatments. There is no indication at this stage as to whether attendance at any alternative provider would be acceptable, nor is there an indication of what might be considered proof of co-operation.

One immediate reaction to this bombshell came from Conservative MP for Totnes, Sarah Wollaston (cited the *Herald Express*, 14 July 2014), who made a number of comments on social media. She asked whether anyone believed such treatment would either be ethical to administer, or successful in practice. She went on to call the idea ‘unethical, unworkable nonsense’, and predicted a rise in prescriptions simply to show compliance. Considering that in the *Herald Express* where the MP is quoted, the figure of some 260,000 people is mentioned (46 per cent of ESA recipients having mental health issues), her comments seem rather understated. One wonders whether the long-term plan, if implemented, would remain just ESA, or whether it might be adopted for PIP claims as well, further inflating the number of people subjected to the new rule. In the same month, headlines in the media have complained about the severe under-funding of mental health services in the UK, as well as financial black holes for the NHS

in general. What effect might a quarter of a million people have clamouring for prescriptions, medical notes and referrals to mental health or 'well being' services on the already-strained budget?

One possible, and typical, reaction that one might expect from the current coalition government could be to encourage private sector companies to tender for the contract to provide 'therapy', just as back-to-work training has been contracted out. Of course, statistics have famously shown that the back-to-work training provision has spectacularly failed. However, if one imagines companies, perhaps G4S, being contracted to provide 'back to work therapy schemes', who would they employ? There appear to be only two options: either completely under-qualified personnel, perhaps students or specially trained drones using computer software; or actual therapists. Many of us in the therapy community already know all too well the limitations of under-trained personnel with computer programmes based around Cognitive Behavioural Therapy (CBT). Were this to be used, one could expect it to be another white elephant, making the government look tough on malingerers, but achieving absolutely nothing. It is all too easy to imagine stressed and anxious persons suffering from mental health conditions having to go through the process of online CBT, which can seem insultingly basic for many, and then have to go back to the GP for prescriptions or other evidence, and then present that, perhaps at an assessment interview. Meanwhile, a new level of 'non-therapists' would be created, with some new title similar to 'wellbeing practitioners', perhaps 'well-work practitioners', which would potentially turn another generation of people off the whole idea of therapy. I fear that forcible pseudo therapy may lead people to question the whole industry, undermining the value that engaging voluntarily with therapy can offer.

If contracted companies like G4S or ATOS are not going to be used, then presumably private therapists would be offered the 'opportunity' to apply for this work. But would anyone be either willing or able to accept such working arrangements? Setting aside the problem of probably awful pay, and forgetting for a moment the fact that there would probably be mountains of statistical client assessment forms to track 'progress' in order to get paid, and simply ask – is it ethical?

It seems to me that the ethical problem exists on a number of levels. Let's start with the concept of an agency or government forcing a person to have treatment. I am no international law expert, but surely this would be in conflict with more than one article of the UN Declaration of Human Rights. Article 3 speaks of the right to life, liberty and security of the person. I would argue that my liberty and security would be affected by being required to have such treatment. Article 12 refers to interference with privacy. What could be a greater infringement of privacy than to be required to discuss private issues with someone appointed to 'treat you'.

A second ethical level here is the pathologization of the condition of the person. I must admit myself to having perhaps become lazy in that I, too, refer to 'mental health conditions' and 'diagnosis', when actually as an analytically trained therapist I dislike the idea of every aspect of the human condition being portrayed as illness. Is it acceptable to force a person whose life experiences have led to distress to have treatment because they are 'ill'? What about abuse survivors, PTSD (Post-Traumatic Stress Disorder) survivors and those others who have survived a variety of developmental, relationship or other crisis or traumata, many of which disempowered them, impacted on their liberty and impacted on their physicality and emotions? Do we now wish to compound the insult by disempowering them, and bullying them into therapy 'because it's good for them and good for the tax payer?'.

When philosophers like Michel Foucault refer to the 'mental health career' of the person post diagnosis, he might have been referring to this current situation. If the government is allowed to pursue this agenda, a diagnosis will not just be a reflection of the collection of symptoms the person has, and perhaps a model to be used for understanding, but it will also become the start of a process that the person is required to follow. To add insult to injury, with the growing realization that the precision of modern diagnosis is debatable, and with psychologists critiquing the latest measurement criteria, do we even have faith in the labels that will potentially trigger compulsory interventions?

And then of course to the micro level, the conversation between the therapist and the coerced client. How can this be consensual when it is *required*? How can the power dynamic be healthy? How can the process be open, free flowing and free of bias? Not only is the client coerced, but they are sitting there in the chair being told that the reason for needing to 'get better' is to 'go back to work'. Not to have more self-understanding, greater self-authenticity, to improve their relationships and dynamics, not to move past personal demons, but to get back to work! Whether the therapist is analytical and wants the process to flow freely, or whether the therapist is humanistic and wishes to express unconditional positive regard, the definition pre therapy that the person is ill and needs to go back to work seems to me to prohibit true therapy. Even the more solution-focused therapist, perhaps a CBT practitioner, is having their goal setting defined not by patient needs, but by social expectation.

Underpinning all this, it seems to me, is a social construction of the client as an ill malingerer who simply needs to be treated to become a good little worker bee again,

because that's what the tax payer wants. This ideological concept of producing workers and maximizing production is a capitalist construct, and would be rightly criticized from a Marxist perspective as a typical emphasis on the means of production. It certainly seems to devalue other potential human values in favour of the person's ability to contribute to production, as if that is the undisputed social value of a human being. This focus on production is, after all, summed up in the coalition government war cry of rewarding those who strive by working, and penalizing those who are perceived as lazy. Indeed the idea that benefits like the new universal credit will ensure that people will always be better off if they work actually has the hidden implication of only recognizing the human value of people through production.

Ironically, the disability premium in tax credits, an additional modest payment for working disabled people to help them remain in work, is being dropped in the universal credit system, further implying that the coalition government feels that ill-health of any kind is a poor excuse for not being productive. The language of the coalition mirrors its ideology, and we are in danger of sleepwalking into a socially constructed world-view where sick people merely need therapy imposed on them to prevent laziness, and where the lack of social housing combined with the so-called 'bedroom tax' means that when benefit payments are reduced, the claimant is in real danger of homelessness. At least in some ruthless Tory administrations, there were 'work houses' to go to!

As someone associated with the Alliance against the Statutory Regulation of Psychotherapy and Counselling, I am also fearful of the kind of 'mission creep' that can occur once government starts redefining how therapy works. If we allow the government to make psychological therapy something that can be imposed, then how might the nature of our profession be changed in the long term? I cannot help but be reminded of the change over time that occurred within Social Services, originally largely church funded 'officers' working in various areas of children's and mental health work, and then being captured as a statutory body. Without getting into a debate over the benefits or losses associated with those changes, it is fair to say that Social Work was changed as a profession. It has become far more homogeneous and standardized, indeed by design; its practitioners enjoy a less than positive overall public perception, and they are blamed for government social failures.

The therapy profession is to be celebrated because of its differences, variety, choices and lack of sameness. Clients can find a model and a therapist that works for them, and if they wish, they can change to something or someone else. The client has free will, choice, diversity and takes personal responsibility when engaging in a process. I fear any coercion will take away personal responsibility and choice, and standardization would lead to a lack of variety, choice and development within the field. The therapy profession to me seems reflective of the complexity and variety of the human condition itself, something the Government does not understand, probably fears, and almost certainly seeks to control through turning experience into diagnosis, and social complexity into malingering.

In conclusion I find myself in the unusual position of agreeing enthusiastically with a Conservative MP. Sarah Wollaston is spot on when she points out that it is unethical, it will not work, and it is a scheme that has not been thought through. It is ideological and not practical, controlling not ethical. As things sit, the scheme is not currently up for implementation, but is on the table for further discussion. What this probably means in practice is that it will be avoided as a hot potato this side of the May 2015 General Election, and then revisited by the Conservatives should they win a mandate at that election. For some time this may remain something that our professional bodies, and ourselves as individuals, need to watch very carefully. S

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