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Discuss the potential benefits and harms of compulsory treatment in psychiatry

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Introduction and Background

Recent epidemiological data suggests 2–3% of Australians, judged by diagnosis, duration, degree of disability and severity of symptoms, live with severe mental illness (MI) (Department of Health and Ageing 2013). Severe MI may in some instances give rise to involuntary or compulsory treatment. In 2016–17, nearly half (45.4%) of overnight hospital admissions to a mental health (MH) facility involved involuntary psychiatric treatment, as did 13.8% of community healthcare contacts (Australian Institute of Health and Welfare 2018). Complex ethical issues arise as a result of compulsory treatment as patients are prevented from providing consent. Deinstitutionalisation in Australia over the last 70 years has reshaped how mental healthcare is delivered with increasing reliance on delivery of therapies in the community (Mental Health Commission of NSW 2014). Compulsory treatment in community settings (as opposed to as an inpatient) arguably does not raise unique ethical questions but may heighten the complexity of these ethical concerns (Szmukler 2009). Given the increasing emphasis on treatment in the community and complexity of the ethical issues this raises, this essay will predominantly focus on compulsory treatment in community settings, while making some comparisons to inpatient settings.

Compulsory treatment is defined as enforced hospitalization and psychiatric treatment of an individual citizen (Robertson & Walter 2014). Notably, however, enforced psychiatric treatment now also increasingly occurs for extended periods in the community. Psychiatrist and former Deputy Commissioner of the Mental Health Commission of New South Wales, Professor Alan Rosen defines these “Community Treatment Orders” or “CTOs” as “The legal and psychosocial process whereby a person who is likely to cause danger to themselves or others because of untreated or inadequately treated mental disorder, is obliged to undergo mental health treatment or care in an outpatient or community setting” (Rosen 1987 cited in Light 2015, p. 3). Australia has one of the highest rates worldwide of such orders, which continue to evolve in their nature and scope (Dawson 2005; Lawton-Smith 2005).

Similar to most health interventions, compulsory treatment is accompanied by both potential benefits and harms. However, the MH context and the compulsory nature of such treatments introduces the potential for additional benefits and harms, as well as complicating the moral justifications for, and obligations resulting from, such treatments. Furthermore, the nature of compulsory treatment orders is such that harms and benefits may occur at both the individual and community level. Not uncommonly, these may be in tension—where the potential benefits at the community level may give rise to harms at the individual level and vice versa.

Moral Justifications for Compulsory Psychiatric Treatment

The legal basis for coercive psychiatric treatment lies in the doctrine of *parens patriae*, according to which the state has the power (and obligation) to safeguard the interests of the incompetent. This essay will consider the two broad ethical justifications used to invoke this doctrine before later considering their limitations and potential for harm. First, Mill’s harm principle establishes the right of the state to enforce the social contract in order to protect its citizens against harm. On this basis, coercive psychiatric treatment

may be justified in order to prevent the patient harming themselves or others (Robertson & Walter 2014). An alternative justification is the beneficence principle. Based on liberal notions of justice propounded by Rawls, Daniels and Nussbaum, this justification aims to address the diminished autonomy and capacities of an individual affected by MI (Robertson & Walter 2014). Although notions of benefit and harm are fundamentally normative and therefore contestable,¹ for the purposes of this essay the Merriam-Webster definition of benefit will be used as something that “promotes well-being” (Merriam-Webster 2019) and harm as that which promotes the opposite. The potential benefits and harms of compulsory psychiatric treatment will be considered for both the individual subjected to such orders and the broader community also.

Benefits of Compulsory Psychiatric Treatment

Severe MI certainly has deleterious effects on affected individuals, their families and the broader community. Mental illness can significantly interfere with a person’s cognitive, emotional and social capabilities. As a consequence, patients may experience economic disadvantage, under- or unemployment, homelessness and reduced productivity (Australian Institute of Health and Welfare 2014). Compounding these financial hardships is evidence of social isolation, stigma and discrimination (Morgan et al. 2011; Reavley & Jorm 2013). Resultant social exclusion serves to limit an individual’s opportunities and may perpetuate psychological harms through long-term stress and anxiety (Australian Institute of Health and Welfare 2014). Arguably these harms can have consequent effects on communities through the loss of productive individuals, strain on social relationships, risk of violence, and burdens placed on carers (Australian Institute of Family Studies 2008).

Given the harms outlined above, there would seem to be *prima facie* benefits to treating MI. However, the nature of MI is such that it may act as a barrier to the individual seeking out care voluntarily. This may then give rise to the need for compulsory treatment in order to deliver the benefits of mental healthcare. For some forms of severe MI, there is evidence that delays to commencing psychiatric treatment are associated with poorer physical, social and psychiatric prognoses which potentially can be avoided by beginning initial therapy involuntarily (Wang et al. 2004; Perkins et al. 2005; Penttilä et al. 2014; Marshall et al. 2014). There have also been demonstrated benefits to the community, with economic analyses indicating substantial gains to productivity with the treatment of common MH disorders (Chisholm et al. 2016). Additionally, people with MIs are among the most vulnerable in our community. By obligating the state to provide MH services, CTOs may therefore be viewed as a tool to guarantee patients’ fundamental human right to health and adequate healthcare.

However, the application of the beneficence principle requires that the proposed intervention provides suitable therapy and an assurance that the benefits of the therapy outweigh the harms (Kerridge, Lowe, & Stewart 2013). While initial coercive inpatient care may be necessary for severe MI, once stabilised, coercive treatment may need to be continued in the community—facilitated by CTOs. Worryingly, there is a dearth of convincing evidence for substantial benefits for such community orders. The outcomes of randomised or matched-control studies on CTOs have failed to demonstrate reduced hospitalisation rates (Light 2014; Kisley, Campbell, & Preston 2011). Furthermore, some authors have questioned whether any of the demonstrated benefits of CTOs actually result from the compulsory nature of treatment or simply from the increased intensity of treatment such orders facilitate (Kisley et al. 2013; O’Brien, McKenna, & Kydd 2009).

¹ Though epistemically relevant, an adequate overview of the ethical debate of who decides, and what constitutes, a benefit or harm is unfortunately beyond the scope of this essay.

Harms of Compulsory Psychiatric Treatment

In addition to questions as to the benefit arising from compulsory treatment, compulsory treatment is also not without harms. In the past, these harms largely arose from the institutional context in which such treatment took place. Individuals led an enclosed and formally administered life, their identity undermined by total barriers to the outside world, dispossession of the person's roles and privacy, and requirements for physical and verbal deference (Goffman 1961; Karmel 1969). Where possible, modern practice of psychiatry avoids long-term involuntary admissions and adopts the principle of using the least restrictive environments where possible (World Health Organization 2003). Although this avoids many of the harms arising from institutionalisation, new and different harms may also arise in community settings.²

One potential harm relates to the “invisibility” of CTOs in public policy. A recent review of Australian MH policies revealed little in relation to how CTOs operated, their organisation or role in the state or territory's MH system (Light et al. 2012). The authors argue that omitted data pertaining to CTOs makes it difficult to build confidence in the MH system and reforms and marginalises those who are subject to involuntary orders by entrusting their care to a system not publicly acknowledged and which may consequently be less open to assessments of accountability and quality. Policy silence on CTOs risks further inequity and arguably perpetuates a lack of community knowledge regarding the nature of MI and its treatment which in turn contributes to its stigmatisation (Light et al. 2012).

In addition to public policy, Australian law pertaining to compulsory treatment has been identified as a source of potential harms. The focus on risk of dangerousness (risk of harm to themselves or others) as the standard to justify compulsory treatment arguably promotes dangerousness as a core feature of MI, leading to possible misunderstanding which may further perpetuate stigma (Allan 2003). Additionally, some have argued such a test is inadequate as it requires significant deterioration of a person's MH to the point that they represent a substantial risk their own or other's welfare. Arguably, the threshold instead should be based on beneficence and best-interests assessment instead of risk of harm, which would therefore facilitate earlier intervention and avoid substantial deterioration (Callaghan & Ryan 2012).

However, lowering the threshold for intervention would need strong justification given that there is the potential for significant harm to the individual when administering compulsory psychiatric treatment. Compulsory treatment is, to varying degrees, necessarily intrusive and concerns have been raised regarding the impacts of such treatment on fundamental human rights such as privacy, bodily integrity and autonomy and the subsequent deleterious effects this can have on a person's MH (Dawson 2005; Dawson 2008; Gostin & Gable 2004). Whether in the community or as an inpatient, compulsory treatment orders empower MH professionals to detain people in hospital for treatment, monitor a patient's condition and administer coercive treatment (Light et al. 2012). Despite the beneficent intentions of avoiding harm and restoring autonomy, application or threat of coercive treatment may actually undermine the purported benefits of this treatment due to the patient's experience of alienation and feelings of dissatisfaction and may therefore undermine future non-coercive efforts to engage patients (Office of the Chief Psychiatrist 2001; Szmukler 2009). In addition, witnessing coercive treatment may lead other prospective patients to avoid seeking care for fear that their voluntary status may be changed to involuntary (Dennis & Monaghan 2013).

Finally, concerns have been raised about the potential misuse of the CTO framework—using coercive treatment to compensate for an under resourced MH system (Szmukler 2009). As outlined above, CTOs create an obligation on the state to provide access to treatment. And a recent qualitative study of consumers, carers, clinicians and Mental Health Tribunal members in NSW, demonstrated that CTOs were frequently used to increase access to psychiatric treatment in the face of resource deficiencies (Light 2015). However, utilising CTOs for the *primary* purpose of plugging resource gaps and providing access

² It is contested whether deinstitutionalisation can more accurately be described as a process of transinstitutionalisation—where the locus of psychiatric treatment moves from the asylum to nursing homes, emergency departments and prisons (Sisti, Segal, & Emanuel 2015).

to psychiatric treatment, rather than to overcome the barrier to treatment created by the MI itself, relies on unjustified coercion and is inconsistent with the principles of “least restrictive” care.

Conclusion

While compulsory psychiatric treatment has the potential to offer clear benefits to the individual and community, compulsion itself has numerous associated harms which must be considered and minimized where possible. Caution must be exercised to ensure such orders are not misused, and to ensure that compulsion is necessary to achieve the intended benefits.

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