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Compulsory Treatment: The Point of Tension Between Systems and Individuals in Psychiatry

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I. Introduction

Compulsory treatment remains one of the most controversial areas within psychiatry, yet is also a major feature of the Australian mental health system. In 2016-17, half of all overnight stays for psychiatric patients were involuntary, and use of compulsory community treatment is particularly common, compared with other countries (Light et al., 2012; Australian Institute Health and Welfare, 2018).

The controversies surrounding compulsory treatment in psychiatry relate to a dynamic interplay of ethical frameworks, models of understanding complex behaviour and the limitations of empirical evidence. The effects of the systems of compulsion that emerge from this interplay cannot be reduced to a list of benefits and harms. Indeed, such outcomes are often hard to define, measure and realise in clinical practice. While these difficulties relates to compulsion itself, they also stem from the intrinsic tension in applying systems of care in psychiatry to the nuanced needs of individuals with mental health problems.

II. Ethics and Models of Understanding: Defining the Benefits and Harms in Compulsory Treatment

Individuals with certain characteristics have long been forced to accept interventions from others aiming to modify their behaviour, even when they refuse. Systems for enforcing interventions are built upon ethical frameworks that define potential benefits and harms. Their implementation relies on changing models of understanding behaviours that differ from established norms.

Initial uses of compulsion were justified through the ethics of paternalism, which allow infliction of interventions upon individuals who may cause harm for protection of others. The model of understanding such behaviours was social, and targeted those who did not conform to societal standards. Benefits and harms existed only in relation to the community, not the individual. For instance, Roman governments could involuntarily detain a *furiosus* (a violent individual without control or insight) for the benefit of social protection, if deemed harmful to others and beyond containment by one's family (Watson, 1985; Harris, 2013). Similarly, in the asylum era of the 17th century, as Foucault (1964) recounts, psychiatrists were asked by the State to determine the dangerousness of individuals with certain characteristics, such as political dissidence or irrationality. They also helped decide if involuntary intervention was needed to protect society and mitigate nonconformity (Foucault, 1964).

Modern compulsory treatment combines paternalistic ethics with several other concepts. Mental health legislation features a combination of John Stuart Mill's 'harm principle', where individual liberty can be deprived if there is a risk of harm to others, as well as 'soft paternalism', where liberty is restricted for the protection of self and others when one is unaware of their at-risk behaviour (Mill, 1859; Robertson and Walter, 2014). Such behaviours are understood through the medical model, which views them as resulting from a diagnosable illness (Murphy, 2017). Benefits and harms extend to both communities and individuals. As doctors, psychiatrists must work to facilitate benefit and avoid harm according to the medical principle of beneficence, which refers to acting in the 'best interests' of patients (Childress and Beauchamp, 2001). In addition, doctors, legal representatives and community members must regularly

review the potential benefits and harms of compulsory treatment, as well as provide opportunities for patients and families to express countervailing views (Royal Australian and New Zealand College of Psychiatrists, 2017).

However, the ethics and models of understanding in any these systems of compulsion face challenges when applied to individuals. Psychiatrists are often poor at predicting an individual's risk of harm, whether through decision-making tools or unstructured clinical judgement (Fazel et al., 2012). Perceptions of 'best interest' are likely to be equally dubious and difficult to evaluate. Even if objective standards of best interests existed, it is hard to imagine how they could be applied fairly to *all* individuals who qualify for compulsory treatment. Furthermore, who should be given ultimate authority in determining the benefits and harms of compulsion for individuals when doctors, lawyers and community members disagree?

III. Evidence: The Medical Model and the Individual

The medical model in psychiatry demands the production of empirical evidence to support claims about benefits and harms of interventions. In the case of compulsion, the evidence is sparse, and its key findings are limited by compelling alternative explanations, as well as perverse methodological challenges relating to the study of individuals with severe forms of mental illness.

Supporters of compulsion refer to literature which claims that harms caused by forced therapy are outweighed by the strong therapeutic relationships and improved quality of life that result from strictly monitored treatment adherence amongst those who refuse care (Romans et al., 2004). Other studies indicate compulsion increases engagement with outpatient support services to help address issues exacerbating poor health, such as unemployment (Barnett et al., 2018). Alternatively, opponents of compulsion cite systematic reviews showing contradictory findings about compulsion failing to achieve key benefits, including improved quality of life and medication compliance (Kisely, Campbell and O'Reilly, 2017).

In addition to the inconsistency in findings, the involvement of other variables cannot be excluded. Perhaps the potential benefits of compulsion reflect an increased intensity of treatment or the pressure on community services to obtain positive outcomes, rather instead any effect of compulsion itself (Light et al., 2012b; Kisely, Campbell and O'Reilly, 2017). Such benefits may be achievable in the without forced therapy, and instead through improved early access to care (Lawton-Smith, Dawson and Burns, 2008; Bhugra et al., 2017). Both sides of the debate are also limited by the need for studies to exclude patients with severe illness who lack insight, and cannot consent to participation. Findings may therefore not be applicable to the main population of interest who are most likely to benefit from compulsion (Curtis, 2014; Barnett et al., 2018).

In clinical practice, psychiatrists directly engage with the shortcomings of this evidence, as well as developing understandings of the natural history of psychiatric illnesses. For instance, outcomes for people with early-psychotic conditions seem to improve with intensive treatment in the short-term (Correll *et al.*, 201). Perhaps this may continue in the long-term if compliance is maintained, and this may require compulsion. However, this remains largely unknown. Furthermore, it is unclear if the trajectory of other illnesses can be changed, especially in individuals meeting diagnostic criteria for multiple illnesses. This may reflect a need for more innovative ways of studying the use of compulsion in particular conditions. Some, however, argue clinical experience is all that is required. Perhaps benefits and harms become clear enough when previously well patients deteriorate shortly after their treatment becomes voluntary, and compliance declines (Mustafa, 2014).

III. Evolution: A Hybrid Alternative, and the Challenges of Systems and Individuals

The United Nations' Convention on the Rights of Persons with Disabilities (CRPD), which Australia ratified in 2008, considers disabilities, including mental illnesses, as the result of interactions between impairments

and environmental barriers, rather than correctible functional deficiencies (UN General Assembly, 2007; McSherry, 2014). On this view, those with disabilities cannot have their liberty deprived because of their disability (UN General Assembly, 2007).

The CRPD requires a rejection of paternalism in favour of autonomy-based ethics. Individuals and their personal goals are prioritised, and understood through a hybrid social and medical model. Australian psychiatry has embraced this view through 'recovery orientated practice', which sees patients as experts in their own lives and goals, and doctors as experts in providing treatment for illness to help meet individual needs (RANZCP, 2016).

Australian governments have interpreted the CRPD as indicating that compulsory treatment cannot be delivered on the basis of disability alone, but may still be given when other factors exist alongside disability. Some have argued that in mental health, this must be done through systems similar to other areas of medicine, allowing compulsory treatment only when individuals lack capacity, rather than pose risks of harm. This means compulsory treatment can only be given when a patient cannot make decisions due to their illness. When capacity is restored, treatment cannot be forced. Additionally, consistent with autonomy-based ethics, the benefits and harms of treatment are ultimately defined by the individual. When one lacks capacity, doctors must review an individual's documented goals in advance directives, or consult others appointed to act on their behalf (Rees, 2010; Szmukler, 2015).

While this hybrid alternative seems to avoid problems of the past, and support human rights, it still suffers from challenges associated with applying systems built for populations to diverse individuals. If paternalism is discarded, communities must accept the possible scenario of harm being inflicted upon others by a person who is mentally unwell, but can satisfy a capacity assessment. Such harms may be avoidable if treatment were enforced. In addition, capacity-based approaches may be suitable for degenerative conditions such as dementia. However for individuals with an intermittent, relapsing courses of illness, having to continuously review capacity could be time-consuming and impractical for both patients and psychiatrists.

IV. Conclusion

The controversy surrounding the potential benefits and harms of compulsory treatment is likely to endure, regardless of changes in ethics, models of understanding behaviour and empirical evidence. The tension between systems for populations and the nuanced needs of individuals is key to understanding the persistence of this controversy, and the ability to balance its implications, a central part of clinical practice involving compulsory treatment.

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