

# 2018 PIF Essay Competition 3<sup>rd</sup> Place

Samuel Tan

3<sup>rd</sup> Year Medical Student, University of Queensland



The Royal  
Australian &  
New Zealand  
College of  
Psychiatrists



## Because You Must: Looking at Compulsory Treatment in Psychiatry

Samuel Tan

### Introduction

In a specialty that so acutely wrestles with perception and identity, compulsory treatment is often regarded as an unfortunate necessity. Ethically, modern medicine revolves around the principle of informed consent – the idea that patients have the right to understand and either agree or disagree with their proposed treatment. While this process is suitable for most conventional specialties, the boundaries are less clear in psychiatry. Mental illnesses commonly present with impairment of what Markova and Berrios (1992) term ‘insight’: the ability to recognize one’s condition and the need to treat it. For example, diagnosed asthmatics generally understand the triggers that precipitate their shortness of breath, and carry puffers to manage their symptoms. In contrast, patients experiencing psychosis may reject their prescribed medication, or deny that they are sick at all. Compulsory treatment aims to address this lack of insight by intervening when patients are at their most vulnerable, and is now employed in hundreds of health jurisdictions worldwide (Light et al., 2012). However, the practice remains highly contentious, with detractors often criticizing it as paternalistic, misguided and impersonal. This essay aims to examine the strengths and weaknesses of compulsory treatment in psychiatry, as well as strategies to reduce harm and promote ethical medicine.

### The Benefits of Compulsory Treatment

The primary benefit of compulsory treatment is to protect patients and the people surrounding them. Mood disorders are associated with increased levels of self-harm and suicidality, which can be acutely dangerous to patients’ physical safety. Similarly, conditions such as bipolar I disorder are characterized by periods of impaired and altered inhibition, occasionally with disastrous consequences. In one case report, Grall-Bronnec et al. (2017) recount the tragic tale of a 48-year-old patient who grew obsessed with the stock market and lost 270 000 euros – his life’s savings – in a single week. Compulsory hospitalization can therefore help to constrain irresponsible and harmful behaviour until patients’ situations can be properly assessed. Corroborating this, Agerbo (2007) and Hunt et al. (2013) present epidemiological evidence that involuntary admission is effective at reducing rates of attempted suicide and self-harm.

Moreover, untreated psychiatric conditions are prone to rapid and eventually irreversible deterioration. In a longitudinal study on patients with schizophrenia, Bottlender et al. (2003) demonstrate that a treatment delay of greater than six months from symptom onset is associated with significantly poorer long-term outcomes, including decreased function and greater risk of unemployment and relapse. Similarly, Mieczekalski et al. (2013) outlines the prognosis of untreated anorexia nervosa, including comorbid depression and anxiety as well as physiological complications such as osteoporosis, arrhythmias, and infertility. Therefore, in addition to treating patients’ current conditions, early compulsory intervention also acts to preserve long-term function and wellbeing.

While certainly not its main goal, compulsory treatment offers an opportunity to develop therapeutic relationships with patients who might otherwise slip through the healthcare system. Mental illness continues to be stigmatized on a global scale, resulting in very low rates of healthcare access; Thornicroft

(2007) estimates that up to 70% of individuals with mental illness do not receive treatment for their condition. This is particularly alarming given that regular healthcare access and continuity of care are known to promote better outcomes across a range of psychiatric conditions, including major depressive disorder (Solberg et al., 2006) and bulimia nervosa (Rushing et al., 2003). In a study on patients with schizophrenia, McCabe et al. (2012) further identify the benefits of cultivating a strong patient-provider relationship, including improved medication adherence and reduced symptom levels. When applied cautiously and considerately, compulsory treatment thus has the potential to greatly expand the reach and efficacy of mental health services.

## **Where Compulsory Treatment Falls Short**

Compulsory treatment inherently subverts the ethical guidelines of informed consent and autonomy, and is consequently criticized as being paternalistic and authoritative. It is usually associated with abysmal rates of patient satisfaction (Holikatti et al., 2012). In one study on involuntary hospitalization, over 60% of patients at 1-year follow-up felt that their initial admission was unjustified (Priebe et al., 2009). Sheehan (2009) argues that the coercive nature of compulsory treatment may damage therapeutic relationships, leading disgruntled patients to disengage from their services and providers. While some level of intervention is clearly supported, poorly executed programs may compromise patient outcomes by reducing treatment adherence and healthcare access over the long term.

Similarly, compulsory treatment has been accused of promoting stigma against mental illness. Involuntarily admitted patients commonly report strong feelings of exclusion and devaluation in their personal relationships, as well as self-directed shame at their perceived lack of autonomy and input (Livingston and Rossiter, 2011). Furthermore, there is some evidence that a history of compulsory treatment is associated with future unemployment (Schaub et al., 2010) and reduced satisfaction from private relationships (Hughes et al., 2009). As above, fear of continued stigmatization often causes discharged patients to detach from mental health services entirely. Psychosocial stability is a key factor in mental illness recovery, and compulsory treatment runs the risk of perpetuating a vicious cycle of decreased function and eventual readmission.

Another concerning aspect of compulsory treatment is the role of forced detainment in facilitating social and medical abuse, especially given many patients' psychiatric vulnerability. In a systematic review of involuntary drug rehabilitation, Werb et al. (2016) reports on cases of physical and sexual abuse at drug detention centres, as well as patients being held for up to five years past their authorized treatment period. This issue is further compounded by social and health-related discrimination. Although eligibility for compulsory treatment is generally highly regulated, checklists and criteria all too commonly fail to exclude human subjectivity. For example, Vinkers et al. (2010) found that ethnic minority patients were involuntarily admitted to Dutch hospitals at a proportionally higher rate than Caucasian patients, with the discrepancy being attributed to higher perceived danger. Taken together, these findings paint a bleak picture, and stress the need for accountability and oversight in implementing compulsory treatment initiatives.

## **Moving Forward**

While involuntary treatment is occasionally necessary, it is clear that harm reduction requires health providers to respect patients' rights and involve them in the treatment process. Promisingly, and perhaps surprisingly, psychiatric inpatients initially tend to report neutral-to-positive attitudes towards compulsory treatment (Wallsten et al., 2008). Gilbert et al. (2008) corroborate this, but comment that patients often become disillusioned by poor communication, unnecessary physical restraints, or perceived threats to their safety. Strategies to improve this include maintaining open lines of communication; actively listening for and applying patient input, allowing as much freedom as is safe; and promoting an atmosphere of trust and safety. Another crucial aspect of effective compulsory treatment is maintaining confidentiality, particularly given the impact of stigmatization on patients' social and occupational wellbeing (Schaub et

al., 2010). Compulsory intervention can very readily facilitate strong and sustainable therapeutic relationships, especially if patients are consistently treated as the human beings they are.

On a broader scale, preventative awareness and diagnostic initiatives have the potential to greatly reduce the burden of compulsory treatment. Jarrett et al. (2008) identifies that candidates for compulsory treatment disproportionately belong to poorer socio-economic classes, and thus have correspondingly limited access to mental health services. Targeted surveillance in this demographic could allow for early intervention in at-risk patients, decreasing the number of cases that go on to require compulsory treatment. Even in cases where mandatory treatment is indicated, Nakhost et al. (2012) and Noordraven et al. (2016) demonstrate strong support for starting with less invasive measures, such as depot medications or community treatment orders. These programs promote greater patient autonomy and independence than involuntary hospitalization, and therefore achieve higher levels of patient satisfaction and follow-up adherence (Nakhost et al., 2012).

Research and primary studies are necessary to inform all of medicine, and psychiatry is no exception. However, there is a paucity of evidence on the outcomes of compulsory treatment, especially given the heterogeneity in different health jurisdictions' implementations (Sheehan, 2009). A significant gap in the current literature involves the optimal duration of involuntary hospitalization, and whether it varies across different psychiatric conditions. Furthermore, patients belonging to an ethnic minority (Vinkers et al., 2010) or lower socio-economic class (Jarrett et al., 2008) are over-represented in compulsory treatment. Additional investigation in this niche would be important to determine the exact cause of this phenomenon, as well as identify specific considerations for compulsory treatment in these patient groups.

## Conclusion

Compulsory treatment is a band-aid solution to a much deeper problem: under-recognition and under-management of mental illness in the community. From this perspective, what it manages to achieve is legitimately admirable. Compulsory treatment protects vulnerable patients from physical, psychological, and financial harm; precludes the development of psychiatric sequelae; and provides a foundation to establish long-term therapeutic relationships. Encouragingly, many involuntarily admitted patients report positive outcomes at follow-up, and go on to access treatment services voluntarily. However, compulsory treatment also has the potential to alienate and stigmatize patients, dissuading them from accessing further mental health services. Overall, a holistic approach to improvement would involve identifying at-risk patients and intervening before they require compulsory treatment, as well as using alternatives to full-scale hospitalization where possible.

## References

Agerbo, E. 2007. High income, employment, postgraduate education, and marriage: a suicidal cocktail among psychiatric patients. *Arch Gen Psychiatry*, 64, 1377-84.

Bottlender, R., Sato, T., Jager, M., Wegener, U., Wittmann, J., Strauss, A. & Moller, H. J. 2003. The impact of the duration of untreated psychosis prior to first psychiatric admission on the 15-year outcome in schizophrenia. *Schizophr Res*, 62, 37-44.

Gilbert, H., Rose, D. & Slade, M. 2008. The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC health services research*, 8, 92-92.

Grall-Bronnec, M., Sauvaget, A., Boutin, C., Bulteau, S., Jiménez-Murcia, S., Fernández-Aranda, F., Challet-Bouju, G. & Caillon, J. 2017. Excessive trading, a gambling disorder in its own right? A case study on a French disordered gamblers cohort. *Addictive Behaviors*, 64, 340-348.

- Holikatti, P. C., Kar, N., Mishra, A., Shukla, R., Swain, S. P. & Kar, S. 2012. A study on patient satisfaction with psychiatric services. *Indian journal of psychiatry*, 54, 327-332.
- Hughes, R., Hayward, M. & Finlay, W. M. L. 2009. Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of Mental Health*, 18, 152-160.
- Hunt, I. M., Bickley, H., Windfuhr, K., Shaw, J., Appleby, L. & Kapur, N. 2013. Suicide in recently admitted psychiatric in-patients: a case-control study. *J Affect Disord*, 144, 123-8.
- Jarrett, M., Bowers, L. & Simpson, A. 2008. Coerced medication in psychiatric inpatient care: literature review. *J Adv Nurs*, 64, 538-48.
- Light, E. M., Kerridge, I. H., Ryan, C. J. & Robertson, M. D. 2012. Out of sight, out of mind: making involuntary community treatment visible in the mental health system. *Med J Aust*, 196, 591-3.
- Livingston, J. D. & Rossiter, K. R. 2011. Stigma as Perceived and Experienced by People with Mental Illness who receive Compulsory Community Treatment. *Stigma Research and Action; Vol 1, No 2 (2011): Summer*.
- Markova, I. S. & Berrios, G. E. 1992. The meaning of insight in clinical psychiatry. *Br J Psychiatry*, 160, 850-60.
- Mccabe, R., Bullenkamp, J., Hansson, L., Lauber, C., Martinez-Leal, R., Rossler, W., Salize, H. J., Svensson, B., Torres-Gonzalez, F., Van Den Brink, R., Wiersma, D. & Priebe, S. 2012. The therapeutic relationship and adherence to antipsychotic medication in schizophrenia. *PLoS One*, 7, e36080.
- Meczekalski, B., Podfigurna-Stopa, A. & Katulski, K. 2013. Long-term consequences of anorexia nervosa. *Maturitas*, 75, 215-20.
- Nakhost, A., Perry, J. C. & Frank, D. 2012. Assessing the outcome of compulsory treatment orders on management of psychiatric patients at 2 McGill University-associated hospitals. *Can J Psychiatry*, 57, 359-65.
- Noordraven, E. L., Wierdsma, A. I., Blanken, P., Bloemendaal, A. F. & Mulder, C. L. 2016. Depot-medication compliance for patients with psychotic disorders: the importance of illness insight and treatment motivation. *Neuropsychiatric disease and treatment*, 12, 269-274.
- Priebe, S., Katsakou, C., Amos, T., Leese, M., Morriss, R., Rose, D., Wykes, T. & Yeeles, K. 2009. Patients' views and readmissions 1 year after involuntary hospitalisation. *Br J Psychiatry*, 194, 49-54.
- Rushing, J. M., Jones, L. E. & Carney, C. P. 2003. Bulimia Nervosa: A Primary Care Review. *Prim Care Companion J Clin Psychiatry*, 5, 217-224.
- Schaub, M., Stevens, A., Berto, D., Hunt, N., Kerschl, V., Mcsweeney, T., Oeuvray, K., Puppo, I., Santa Maria, A., Trinkl, B., Werdenich, W. & Uchtenhagen, A. 2010. Comparing outcomes of 'voluntary' and 'quasi-compulsory' treatment of substance dependence in Europe. *Eur Addict Res*, 16, 53-60.
- Sheehan, K. A. 2009. Compulsory treatment in psychiatry. *Curr Opin Psychiatry*, 22, 582-6.
- Solberg, L. I., Crain, A. L., Sperl-Hillen, J. M., Hroschikoski, M. C., Engebretson, K. I. & O'connor, P. J. 2006. Effect of improved primary care access on quality of depression care. *Annals of family medicine*, 4, 69-74.
- Thornicroft, G. 2007. Most people with mental illness are not treated. *Lancet*, 370, 807-8.
- Vinkers, D. J., De Vries, S. C., Van Baars, A. W. & Mulder, C. L. 2010. Ethnicity and dangerousness criteria for court ordered admission to a psychiatric hospital. *Soc Psychiatry Psychiatr Epidemiol*, 45, 221-4.

Wallsten, T., Ostman, M., Sjoberg, R. L. & Kjellin, L. 2008. Patients' and next-of-kins' attitudes towards compulsory psychiatric care. *Nord J Psychiatry*, 62, 444-9.

Werb, D., Kamarulzaman, A., Meacham, M. C., Rafful, C., Fischer, B., Strathdee, S. A. & Wood, E. 2016. The effectiveness of compulsory drug treatment: A systematic review. *The International journal on drug policy*, 28, 1-9.