EDITORIAL

Guest Editorial

Involuntary Psychiatric Treatment: Ethically Justified?

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Psychiatric hospitals of the twentieth century were designed to provide continuous care to patients with psychiatric disorders who were unable to live independently. While conditions within these institutions were far from ideal, many mental health professionals considered them a safer alternative to leaving patients with no family or social support on their own, with psychosis, mania, disturbed mood or other symptoms potentially leading to self-harm and harm to others. Yet institutionalization meant that patients could be committed and treated with psychotropic drugs, or techniques such as electroconvulsive therapy (ECT), against their will. The antipsychiatry movement of the 1960s and 1970s associated with R.D. Laing, Thomas Szasz and others rejected these practices (Wall, 2018; Burns, 2020). They were also challenged by civil libertarians defending patients' right to refuse commitment and treatment. Misinformation about psychiatric treatment in the media through films such as *One Flew Over the Cuckoo's Nest* generated negative public opinion about psychiatric hospitals and the treatments they administered to patients. All these factors influenced the gradual demise of many of these hospitals.

The main objection to involuntary commitment and treatment was that it was paternalistic and violated patients' liberty. Psychiatrists and other mental health professionals who provided treatment without patient consent were failing to discharge their duty of respect for patient autonomy. They failed to respect them as individuals capable of making their own decisions about what was in their best interests (Beauchamp and Childress, 2019, Ch. 4). Autonomy presupposes the cognitive and emotional capacity to make informed decisions about whether to have or refuse actions that affect the person. Arguments against forced treatment rely on the assumption that patients have this capacity. But moderately severe to severe psychiatric disorders can impair or undermine it. In symptomatic

patients who lack or are impaired in their capacity to reason and make decisions regarding their health, failure to forcibly treat them could be interpreted as a failure to discharge the duty of nonmaleficence in protecting these patients from harm (Beauchamp and Childress, 2019, Ch. 5).

Past and current proponents of the antipsychiatry movement argued that releasing patients from psychiatric hospitals to which they had been involuntarily committed would restore their autonomy and was in their best interests. For many people with untreated mental illness, this clearly has been false. The illness can take away their autonomy and ability to live independently. This is not always the case, but it has occurred to a disturbing extent in many jurisdictions. Closure of psychiatric hospitals and the challenges for patients living with psychiatric disorders who were released from them are one factor in the rise of homelessness. The British Columbia Mental Health Act of 1965 encouraged community psychiatric treatment to replace institutionalized treatment. This led to the phasing out and eventual closure of the Riverview Hospital in Coquitlam, B.C. in 2012. The increase in the number of homeless people with untreated mental illness in greater Vancouver during this period and after indicates that community treatment has not been able to meet patients' needs.

I witnessed a similar phenomenon following the closure of the Northampton State Hospital in Massachusetts when living in Northampton from 1983 to 1995. In 1978, the United States District Court approved the Brewster Consent Decree, which emphasized the psychiatric patient's constitutional right to treatment in the least restrictive environment possible (*Brewster v. Dukakis*, 1981). This led to a reduction in the hospital's patient population and the subsequent closure of the Hospital in 1986. Because patients received treatment in the Hospital, many were left untreated following their release. With only a few group homes, the least restrictive environment for many became the streets. Although the homeless population in Northampton following the closure of the state hospital was much smaller than the population in Vancouver during the phasing out and after the closure of Riverview, the percentage of people with untreated psychiatric disorders living without the support they need in these and other jurisdictions raises serious questions about claims that involuntary treatment is paternalistic.

The Supreme Court of Canada case of *Starson v. Swazey* (2003) is a specific illustration of the conflict between forcing medication on a patient to treat a psychiatric disorder and the patient's presumed

right to refuse it. Scott Starson was an engineer and computer programmer with a gift for doing physics at a relatively high level. Diagnosed with bipolar and schizoaffective disorder with psychotic features, he was found not criminally responsible for making death threats to others on the grounds that his cognitive and affective symptoms indicated impaired capacity to control his thought and behavior. Starson was committed to a psychiatric hospital and treated with psychotropic drugs against his will. He argued that the drugs prevented him from thinking at full capacity and that he had the right to refuse them. The psychiatrist involved in this case (Ian Gary Swazey) argued that Starson was incapable of consenting to the proposed treatment and should be treated involuntarily. The Ontario Consent and Capacity Board agreed with Swazey's assessment of incapacity. But the Ontario Court of Appeal overturned the Board's decision. In considering an appeal from Swazey to uphold the initial legal decision, the Supreme Court of Canada ruled that Starson was not incapacitated and was competent enough to refuse psychotropic medication. Not long after the ruling, Starson was again committed to a psychiatric hospital for his disorders. He was discharged on the condition that he adhere to an antipsychotic drug regimen, which reduced but did not eliminate his delusions. Although he insisted that the drugs interfered with his thinking and that he had a right to refuse them, his persistent delusions suggested that he lacked insight into his impairment and the degree of decisional capacity necessary to retain and exercise such a right.

It is unhelpful to frame and discuss these issues in general binary terms of treatment versus no treatment, or institutionalization versus de-institutionalization. Psychiatric disorders fall along a spectrum involving varying degrees of impairment in reasoning and decision-making. Some patients with the positive symptoms of schizophrenia (hallucinations, delusions) may have lucid moments in which they can make rational decisions. Their symptoms may wax and wane. A person with bipolar disorder may retain decisional capacity when they are not experiencing hypomania or mania. But this depends on whether their symptoms are controlled and whether they can control their thought and behavior. In moderately severe to severe cases, antipsychotics for schizophrenia, antidepressants for major depression, and lithium for bipolar disorder may be necessary for this control. When symptoms are resistant to pharmacological interventions, ECT or other forms of neuromodulation may be appropriate and effective in regulating them, though the degree of their invasiveness requires patient consent. These judgments do not apply to all psychiatric patients but depend on the unique mental states and circumstances of each patient.

Some may argue that cognitive behavioral therapy or other psychosocial interventions can safely and effectively treat psychiatric disorders without psychotropic drugs. They may point to a recent meta-analysis of research questioning the theory that depression is caused by low levels of serotonin (Moncrieff et al., 2022) and use this to question of efficacy of selective serotonin reuptake inhibitors (SSRIs), the most commonly prescribed antidepressants They may also point to the adverse effects from most of these drugs, claiming that they can have as much of a negative impact on a patient's overall health and quality of life as the disease itself. This meta-analysis is not the last word on SSRIs, or indeed on other classes of antidepressants. Studies have indicated that, when combined with psychotherapy or other forms of psychological support, ketamine (Gee et al., 2021) or psilocybin (Doss et al., 2021) can relieve depressive symptoms in patients whose symptoms have not responded to other medications. Still, additional studies are needed to establish their long-term safety and efficacy. Despite differences in how they regulate brain metabolism and a person's mental states, psychotropic medications can control symptoms of major depression and other psychiatric disorders and restore a patient's functional capacities. The adverse physical, psychological and social effects from failing to treat can be much worse for the patient than any adverse effects from treatment.

Even when forced treatment with psychotropic drugs is necessary to protect incapacitated patients from harm and restore their autonomy, it is not sufficient. Rather than thinking of psychotherapy, pharmacotherapy and social support as distinct factors, they should be considered as integrated factors within a holistic biopsychosocial model of psychiatry (Engert et al. 2020). In addition to the three factors just mentioned, this model includes education to promote or improve patients' and families' understanding of psychiatric disorders. The context in which psychiatrists administer treatment is as important as whether it is administered voluntarily or involuntarily. The institutional setting is especially important for patients when family or other forms of social support are absent or inadequate to meet patients' needs. This includes psychiatric hospitals, psychiatric units within hospitals, or group homes that provide care within a safe and supportive environment aimed at enabling patients to recover and reintegrate into the broader social community. Ideally, these settings would involve programs that encouraged patients to engage in meaningful activities, as in the Menninger Clinic in Houston (https://www.menningerclinic.org), and improved architectural design, such as the Taube Pavilion in Mountain View, California (https://www.elcaminohealth.org/health-behavioral-health-services-tube-pavilion). But at least it would require significant improvements in all

aspects of patient care over Riverview, Northampton, and other psychiatric hospitals of the past.

The key issue surrounding involuntary treatment is not cognitive liberty per se. Rather, the issue is whether, or to what extent, a patient's capacity to make decisions regarding their mental health can be impaired by a psychiatric disorder, and whether psychotropic medication is necessary to restore it. If medication is the only or most effective way of preventing psychosis, mania or other mental disturbances and thereby restoring this capacity, if patients cannot understand the reasons for having and adhering to treatment, and if lack of insight increases the risk of self-harm and harm to others, then forced treatment can be medically and ethically justified. Again, though, this judgment must be patient-centered and based on the specific needs and decisional capacity of each patient. It must be based on the degree of cognitive and emotional capacity the patient retains, or loses, in understanding, or failing to understand, the need for treatment and making an informed autonomous decision to accept or refuse it. In some cases, a patient may retain enough of this capacity to make such a decision. In other cases, they may not retain it, and involuntary treatment may be necessary.

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