REVIEW

REVISED Reconsidering the ethics of compulsive treatment in light of clinical psychiatry: A selective review of literature

[version 3; peer review: 2 approved]

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Abstract

The ethics of compulsive treatment (CT) is a medical, social and legal discussion that reemerged after the ratification by 181 countries of the 2007 United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD). The optional protocol of the UN-CRPD was ratified by 86 countries aiming to promote, protect and ensure the full and equal enjoyment of all human rights. It also determined the need to review mental health laws as under this light treatment of persons with disabilities, particularly those with mental disorders, cannot accept the use of CT. This selective review of literature aims to clarify inputs from clinical psychiatry adding evidence to the multi-disciplinary discussion. It provides contradictory evidence on how patients experience CT and its impact on their mental health and treatment programs, also which are main reasons for the use of CT and what efforts in psychiatry have been made to reduce, replace and refine it.

Keywords

involuntary treatment, ethics, persons with disabilities, human rights

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REVISED **Amendments from Version 2**

- Methodology was clarified.
- We removed loaded concepts and replaced them by simpler words.
- Wording was improved to greatly improve clarity of parts of the discussion and conclusion.

Any further responses from the reviewers can be found at the end of the article

Introduction

Compulsive treatment[1] of people with psychosocial disabilities, particularly when these disabilities result from mental disorders, is a problem of a medical, social, and legal nature. Under the umbrella of Public Health and Health Policies there has been intensive research for legal solutions aiming to settle on the one hand, the need for coercive treatment of people with disabilities who, for various reasons, do not recognize the disorder that affects them (or refuse therapeutic interventions) with the protection of their rights, freedoms and guarantees. Table 1 clarifies some of the historical developments on paternalism and autonomy in the last 50 years.

The Council of Europe (CE) and its Bioethics Committee, the European Court of Human Rights (ECHR) promoted several reviews of the mental health legislations. First, the European Convention on Human Rights and Biomedicine (ECHRB), also known as the Oviedo Convention, in 1997 aimed to protect persons that failed to show capacity for consent to treatment (including minors and adults with diminished capacity without representatives) particularly those with mental disorders (article 8) by considering that all medical interventions that could benefit health could be performed under legal provisions in emergency situations (article 8). Second, a new international human rights treaty was drafted in December 2006 and opened for signatures in March 2007 (Nations 2007) the *United Nations Convention on the rights of Persons with Disabilities*, UN-CRPD. It represents the first comprehensive human rights treaty of the twenty-first century, in force since 2008, and is ratified by 181 countries. Subsequently, several other documents were developed focused on the protection of autonomy, agency and dignity of persons with psychosocial disabilities of which Annual report of the United Nations High Commissioner on Human Rights A/HRC/34/32 is recent example.

The UN-CRPD aims to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities" (Nations 2007, p. 4) and therefore provides an opportunity to discuss and review the ethical foundations of the treatment of persons with mental disorders. Table 2 highlights significant articles from the UN-CRPD.

All these provisions are especially important as they imply that disabilities *shall in no case justify the deprivation of liberty* and that competence should be considered at all times – third parties only supporting organization and communication of their will. A literal interpretation of these ideals would determine the immediate interruption of the use of coercive measures in the field of psychiatry, particularly compulsive treatment (CT), for they would consist in a

Table 1. Ethical approaches to patients with mental disorders.

Approaches	Description
Medicalization	Before the 1980's: a paternalistic, authoritarian approach in which the physician was free to decide on behalf of the patient "in her/his best interest"
Legalism (Jones 1980)	The existence of legal provisions of external control, particularly of judicial nature, to regulate and safeguard the rights of persons with mental illness
New legalism (Brown 2016)	Aimed to harmonize the procedural safeguards for the provision of adequate health care and treatment of people with psychosocial disabilities in less restrictive conditions

[1]Scientific literature uses the words "involuntary" (more frequently) or "compulsory" to qualify for hospitalization and/or psychiatric treatment (s) without the informed consent of the mentally ill patient. S/He is considered unable to express autonomously either because s/he refuses to adopt such measures restricting her/his freedom of action, or because s/he does not recognize the disease by which s/he is affected and, consequently, the need for treatment. In this review we chose to favor the term "compulsive", not only because this is what appears in the relevant legal texts, but also because it is the one that facilitates the communication between the various actors in the process (jurists, doctors, law enforcement and family members). (translated from Lei n.° 36/98, de 24 de Julho (Lei de Saúde Mental), accessible in https://www.pgdlisboa.pt/leis/lei_mostra_articulado.php?nid=276&tabela=leis&so_miolo= **ou** em CEJ: *Internamento Compulsivo.* Lisboa, Coleção Formação Inicial, 2016, acessível em http://www.cej.mj.pt/cej/recursos/ebooks/civil/eb_Internamento_Compulsivo.pdf.

Table 2. Significant article ideas from the United Nations Convention on the rights of Persons with Disabilities.

CRPD articles	Description
Article 5	equality and no discrimination
Article 12 n° 3	take appropriate measures to support patients with disabilities' needs to legally exercise their capacity
Article 12 n° 4	provide the appropriate and effective safeguards to prevent their abuse, guaranteeing and respecting the rights, will and preference of the person
Article 14 n° 1b	ensure that persons with disabilities are not unlawfully or arbitrarily deprived of their liberty, that any deprivation of liberty is in accordance with the law and that the existence of a disability shall in no case justify the deprivation of liberty
Article 14 n° 2	warrant that if they are deprived of their liberty, they are entitled to guarantees in accordance with international human rights law and are treated in accordance with objectives and principles contained therein
Article 15	Freedom from torture or cruel, inhuman or degrading treatment or punishment
Article 17	right to physical and mental integrity

violation of the rights of patients (forcing treatment, discriminating, and marginalizing them). Yet there are several clinical situations that show that providing full autonomy to patients with mental disorders would be devastating – e.g., patients with dementia (unable to manage themselves or their property), with depressive episodes (with suicidal ideation and risk) and psychotic episodes (refusing to feed themselves because they believe they are being poisoned). Indeed, the coercion of persons who can choose (disrespecting autonomy) should be measured against the obligation to make a choice when unable to do so (disrespecting vulnerability). Arguments are raised considering the necessary changes in the restrictions of rights of patients with mental disorders and when it would be ethically and clinically reasonable to objectively limit their autonomy. A powerful/convincing argument against the CRPD effectiveness refers to the fact that its predictions focus on autonomy and are silent on how to effectively determine the duty to protect persons with disabilities and on how to provide adequate health care for those with a severe mental disorder. The general worries about the CRPD are included in Table 3.

The use of the CRPD should avoid two extreme positions on CT for mental disorders: (1) continuing with the coercive measures acting while considering the "best interest of the patient" and sustaining the proportionality due to "adverse consequences" or the risk of "serious and imminent damage" or (2) determining the immediate abolition of all forms of coercive treatment as its radical reduction is insufficient.

This is a review of literature which provides inputs from psychiatric practice that could clarify how CT is used and felt in the life of patients and health professionals. Particularly, empirical evidence on the uses (and eventual abuses) of CT, of the negative (and possible positive) experience of coercion and of the present ways to reduce and refine CT.

Table 3. The limitations of the CRPD.

Limitations	Examples
The misinterpretation of concepts	e.g. concept of disability can include or not mental disorders whether they are considered extensively or restrictively
The literal interpretation of measures	e.g., a simplistic reading of the CRPD determines that "everyone has the right to all the rights and freedom without distinction of any kind" (Nations 2007, p. 1) jeopardizing the principles of beneficence and of justice when danger is considered to his life or the life of others (Steinert 2017)
The risk of acting blindly without considering the complexity	ethical debate must consider the actual implications in each setting at each stage of its implementation (Mahomed *et al.* 2018) with scenarios adapted to regional and countrywide circumstances (Dawson 2015). A protection of the rights of persons (McSherry and Wilson 2015) leads to a slow and progressive transformation of the healthcare policies and systems

Methodology

The most relevant journals in the fields of psychiatry (World Psychiatry, The Lancet Psychiatry, Annual Review of Clinical Psychology, JAMA Psychiatry and American Journal of Psychiatry) and medical ethics (BMC Medical Ethics, BMJ Journal of Medical Ethics, Bioethics, American Journal of Bioethics and Journal of Bioethical Inquiry) were searched aiming to achieve full coverage of the topic: "how involuntary commitment is considered in clinical psychiatry?". The search strategy also included the electronic databases: PubMed, SCOPUS, CINAHL, Web of Science. In PubMed included the use of MESH terms "coercion", "involuntary commitment" and "Psychiatry" citation tracking and checking of identified eligible articles reference lists were checked for additional articles, and those that are eligible will be included. As inclusion criteria we considered original papers that answered to the use of Involuntary commitment in Clinical Psychiatry. Our search found a total of 893 papers which were examined by two experts (L.M. and J.C.S.) and, after joint discussion, we included 75 papers for review. Search was performed until December 2018. The references identified were merged and managed with Mendeley. Grey literature was not included.

The use of CT in daily practice

Decisions on coercive measures and on compulsive treatment (CT) appear in the reviewed literature supported by four main reasons: risk, diagnosis, lack of capacity and the effectiveness of the measures. Risk reduction is such a critical factor in the context of compulsive treatment (both in the beginning and interruption) that the measure is perceived as a risk control mechanism (Hsieh *et al.* 2017). Risk in psychiatry has several dimensions and is subject to qualitative and quantitative assessment – risk of harm to oneself, harm to other persons, of greater social adversity, of suffering more or of compromising a treatment plan (Light *et al.* 2015).

Risk and diagnosis are fundamental in the decision of CT, as evidence suggests that persons with severe mental disorder can attack and harm others, including health professionals (Steinert and Traub 2016). Even after CT 25% of patients admitted to an adult psychiatry unit could be at risk of committing an act of violence during their stay at the hospital (Iozzino *et al.* 2015). Yet the use of "risk of violence" to justify CT is not only the most liable to abuse but also no predictive value of any of the usual individual risk factors for violent behavior – male, diagnosis of schizophrenia, substance abuse and previous history of violence – was found (Menculini *et al.* 2018). Due to the subjective nature of risk in psychiatry CT must not become a control mechanism for social risk situations and clinicians should bear in mind that it serves to offer treatment to persons with mental disorders (Rotvold and Wynn 2015a, 2015b, 2016).

Psychotic episodes and behavioral disturbances in patients under previous psychiatric care are most often associated with CT and the symptom profile includes activation, resistance to treatment and "positive" symptoms (Mosele *et al.* 2018), risk of suicide and low *insight* (Braitman *et al.* 2014, Masood *et al.* 2017). Evidence for the clinical rational for CT is detailed in Table 4.

For each country there are precise legal requirements which might not be under use as an analysis of clinical documentation of patients under CT showed that more than 40% clinical records were void of the necessary requirements (Godet and Niveau 2018). These clinical findings are worrying from an ethical and legal point of view where risk/hazard criteria could lead to dismissal of the need for a diagnosis or for treatment (Carabellese *et al.* 2017) and also increase prejudice and negative social representations of CT (Curley *et al.* 2016). The excess of coercive measures in non-Caucasian patients (Henderson *et al.* 2015) or gender disparities (Curley *et al.* 2016) furthers the need to explore the motivations for CT. Particularly the risk of coercion (Rotvold and Wynn 2015b) from other health professionals, from family or the police (Sjostrand *et al.* 2015) and organizational (Sjostrand *et al.* 2015) and financial issues (Green-Hennessy and Hennessy 2015). We must bear in mind that culture and other social factors are also determinants in the application of CT and countries legislations frequently express the cultural milieu and possible constitutional rights (which differ significantly from western to eastern countries as well as from southern to northern Europe).

Table 4. Most frequent reason for compulsive treatment (CT) in clinical practice (Pignon *et al.* 2014).

Depressive & mixed Episode	risk of suicide
Manic episode	lack of insight
Substance abuse	risky behavior
Eating disorders	refuse of support and risk of death
Personality disorder	severity of symptoms
Dementia	behavioral disturbances

The role of decision making for CT is challenging, as psychiatrists must distinguish between signs and symptoms of psychiatric disorders (which would determine the use of CT) and those representing behavioral disturbances resulting from a medical condition (no ground for CT). Disregarding such differences might increase the stigma of mental disorders and awareness of them improves the moral weight and reduces random interpretations of clinical practice (Fistein *et al.* 2016). If CT is to be considered for both then perhaps segregating their legal features is valuable (1) *Medical Incapacity Hold* (MIH) to those who are considered unable to decide and have a psychiatric illness, and (2) *Involuntary Psychiatry Hold (IPH)* for patients with psychiatric disease without *insight* and in need of treatment (Heldt *et al.* 2018). This separation might allow health professionals to better understand the nature of CT in Psychiatry and distinguish it from the lack of competence in many medical illnesses that confusional states bring about. Drug and addiction disorders have other ethical challenges and while they are clear disturbances of behavior they do not fit into key features of mental disorders and also don't apply to "medical" incapacities (Williams 2015).

CT for public health issues, such as tuberculosis, is of particular complexity and represents perhaps the clearest violation of the rights to liberty and privacy in persons whose competence might be unspoiled. Arguments which forward it stand upon both the inviolability of human life (e.g., supporting the coercive use of helmets or forced recycling) and the *principle of reciprocity* – the social obligation as an individual if a group is exposed to detrimental effects on their health resulting from spreading of diseases. This has also supported complex moral decision making under Sars-COV-2 (COVID 19) – e.g. mandatory vaccination. Yet CT for public health reasons has had several censures (McLaren *et al.* 2016) and other strategies have been proposed (Karumbi and Garner 2015). First, promotion of health education, increased access to services and settling socioeconomic and organizational determinants are effective for these situations (Mburu *et al.* 2016). Second, there is contradicting evidence of its effectiveness (Nagata *et al.* 2014) and it is rarely used even when there is legislation toward it (Villalbi *et al.* 2016).

The impact of CT in the treatment process should also be measured. Eating disorders (ED) are a good example of the complexity of CT considering clinical severity, capacity to decide, overall risk and effectiveness of the measure. First ED patients don't seem to have lost the capacity to decide and decision stands upon risk of death (Westmoreland *et al.* 2017), severity, comorbidities, previous admissions, the incidence of self- injurious behavior (Clausen and Jones 2014) and yet it might damage therapeutic alliance (Douzenis and Michopoulos 2015) and lead to early drop-out from other programs (Schreyer *et al.* 2016). It is possible that forms of power and control (and the need to regulate them) are not only external to the subject but can rise from within. In such case, the patient would need external help in managing, building, and applying decision making or else suffer internal coercion. Internal forms of coercion would then be mediated in the clinical relation in which directivity and surrogate decision making might be helpful. Table 5 shows other contradicting evidence on the effects of CT.

Experiences of coercion and CT are not one and the same – the first occur in 15% of patients under CT but 20% of patients under voluntary treatment also report coercion (Edlinger *et al.* 2018). Emotional and cognitive features of the coercive events rather than the number of events appear responsible for its negative impact (Rusch *et al.* 2014). Such reactions are reduced when patients are allowed to exercise their autonomy, when they experience pleasure in activities/interactions and in the context of a good therapeutic alliance and increased if they endure trauma and humiliation (Danzer and Wilkus-Stone 2015). Forms of physical coercion appear linked with greater dissatisfaction (Smith *et al.* 2014, Mielau *et al.* 2016) and therefore medication should be preferred to physical restraint (Guzman-Parra *et al.* 2018). Yet the evidence isn't definitive as one study points to involuntary drug administration as the most censored measure (McLaughlin *et al.* 2016). Moreover, the coercive experience of being under CT might even be linked with dynamic process of recovery – several patients consider that CT was a necessary measure in the end of the treatment (Gowda *et al.* 2017). Table 6 presents evidence of the negative impact of CT, Table 7 shows evidence on how to reduce these effects (Opsal *et al.* 2016).

A range of measures have aimed to reduce the use of coercion and CT (Kelly *et al.* 2018) either by quantitatively reducing it, by replacing harsher measures or by modifying the experience of coercion. Table 8 indicates these three sorts of changes.

Table 5. Contradicting evidence of compulsive treatment (CT).

CT leading to physical and emotional losses in the patient and health team (Gerace *et al.* 2015)
CT positively impacts on hostility and suicide attempts in psychosis (Nitschke *et al.* 2018)
CT improves prognosis if there is a high risk of recurrence (Lera-Calatayud *et al.* 2014)
CT has scarce long-term benefits (Giacco *et al.* 2018)
CT increases the risk of social adversities and suicide (Giacco and Priebe 2016)

Table 6. Evidence on the negative impact of compulsive treatment.

Inducing internalized stigma and lowering adherence (Kamisli *et al.* 2016)
Prompting experiences of humiliation, oppression and imprisonment (Nyttingnes *et al.* 2016)
Increasing the length of hospitalization irrespective of severity (McLaughlin *et al.* 2016)
Damaging the therapeutic alliance increasing the risk of future coercion (Danzer and Wilkus-Stone 2015)

Table 7. Ways to reduce the negative impact of compulsive treatment.

Increasing freedom in all choices still available (e.g., choosing food) (Danzer and Wilkus-Stone 2015)
Promoting the feeling of physical security (designing and organizing wards for the purpose) (Lamanna *et al.* 2016)
Training of health professionals towards using non-invasive measures (Krieger *et al.* 2018)
Considering advanced directives in early stages of the disease (Mitrossili 2014)
Promoting employment or early return to work (Pridham *et al.* 2018)
Stimulating empowerment of patients and developing autonomy (Danzer and Wilkus-Stone 2015)

Table 8. Measures to reduce, replace and refine compulsive treatment (CT).

Directly reducing CT
Crisis centered psychoeducation and crisis cards and 24-month monitoring after inpatient discharge in situations with social difficulties or history of previous hospitalizations (Lay *et al.* 2018)
Intervention in high-risk states including screening and early intervention (Santillanes *et al.* 2017)
Multidisciplinary care networks, and community support (including home treatment) all shown to reduce CT and favor early discharge from CT (Otsuka 2014, Hoffmann *et al.* 2017)
Replacing CT
Community treatment orders (CTO) and other outpatient settings (Hansen *et al.* 2018)
Care in other forms and *Compulsory community care* (Reitan 2016)
Short hospital unattended leaves (Kisely *et al.* 2017)
Assisted Ambulatory Treatment (AAT) *and Assertive Community Treatment* (ACT) (Wullschleger *et al.* 2018)
Crisis teams with training in psychiatry that could carry out/accompany emergency care (Aagaard *et al.* 2017)
Refining the use of CT
Developing non-clinical skills to allow a satisfactory therapeutic alliance (Jaeger *et al.* 2014)
The use of specific treatment settings, methods and strategies (Ose *et al.* 2018)
Improving family interventions and social support (Jong *et al.* 2014, 2016)
Increasing compassion across interventions (Lamanna *et al.* 2018)
Advance directives (AD) might help ethical challenges in crisis (Jong *et al.* 2016, Henderson *et al.* 2017)

All these interventions have not received full empirical support due to several contradictory studies. There is paradoxical evidence, such as negative effect of social support (Hengartner *et al.* 2016) or positive impact of assertive treatments (Schottle *et al.* 2014, 2018). Moreover, Community Treatment Orders have shown to reduce mortality (9%) and the risk of self-inflicted damage (32%) and provide a modest improvement in the quality of life (Segal *et al.* 2017) while also requiring large and continued engagement to avoid worse consequences (Kisely and Campbell 2014, Riley *et al.* 2014). Another paradox is the fact that CT in inpatient settings appears to be better regulated as other team members and patients can supervise what is happening to the patient in comparison with outpatients settings such as Community Treatment Orders (Riley *et al.* 2014).

Conclusion

The CRPD addressed the issue of autonomy and decision making by patients with mental disorders determining that alternative solutions to CT must be considered when patients can't perform responsible decisions. Yet health is a

fundamental right and CT offers a protection from hazard which dissolution does not seem to solve – affirming autonomy by conventional ethical models or simplistic clinical approaches (Kendall 2014) might damage other rights and dignity of persons with mental disorders (Kelly 2014). Ultimately there is empirical evidence that clinical psychiatry has aimed to clarify the uses and possible abuses of CT, to determine experiences and consequences of its use and developed strategies to reduce, refine and replace it. While there might be the need for interruption of CT in clinical psychiatry, the measures taken cannot risk the misinterpretation of concepts and ignoring the complexity of clinical practice and the systemic changes that should be required. Even if those responsible for CRPD might have already acknowledged these efforts and evidence, while translating these principles into practice stakeholders at nationwide discussions and decisions at a macro level (and possible mental health policies reformations) would benefit from recognizing these inputs from clinical psychiatry where CT takes place.

Data availability

No data are associated with this article.

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Open Peer Review

Current Peer Review Status: ✔ ✔

Version 3

Reviewer Report 28 October 2022

https://doi.org/10.5256/f1000research.138810.r153539

✔ **Sofie Heidenheim Christensen**
Child and Adolescent Mental Health Center, Copenhagen University Hospital – Mental Health Services CPH, Copenhagen, Denmark

no further comments

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Treatment in mental health care, including coercive treatment, specifically focused on users' and next of kin's experiences of treatment

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 2

Reviewer Report 13 September 2022

https://doi.org/10.5256/f1000research.136140.r147228

? **Sofie Heidenheim Christensen**
Child and Adolescent Mental Health Center, Copenhagen University Hospital – Mental Health Services CPH, Copenhagen, Denmark

Summary:

The selective literature review adresses the problem of coercive treatment (CT) in mental health, mainly the juxtaposition of coercion as a violation of rights with the clinical obligation to treat patients with mental disorders.

Firstly, the practice and impact of CT is presented with focus on risk asessment, impact on treatment. Secondly, the experience of coercion and how this may be ameliorated is shortly presented. And lastly, the article touches upon ways to reduce or ameliorate CT.

Critique and suggestions:

The focus on clinical inputs with regards to the ethical dilemma of CT is an important perspective. The very literal interpretation of the articles from the United Nations Convention on the rights of Persons with Disabilities seems not sufficiently nuanced - all articles cited in Table 2 provides caveats. If possible, nuance this point in the conclusion, as I am not, from the material provided, sufficiently convinced that stakeholders do not in fact "acknowledge these efforts and evidence"

"This is a review of literature which provides inputs from psychiatric practice..." – The article does not specify what literature has been reviewed and how the is sample created, and would benefit greatly from this tranparency in terms of validity.

Clear tables, that neatly summarise the points of the article. Very nice.

"Even after CT 25% of patients admitted to an adult psychiatry unit could be at risk of committing an act of violence" – Please clarify, after CT has ended, during CT?

"Yet while individual risk factors appeared for violent behaviors and CT decisions (Menculini *et al.* 2018) – e.g. male, diagnosis of schizophrenia, substance abuse and previous history of violence – their predictive value for violent behavior was not found. Of all the reasons the risk of occurrence or recurrence of violence seems the most liable to abuse (due to the subjective nature of risk in psychiatry) and perhaps the target of the CRPD worries and predicaments – that a measure aimed at the treatment of persons with mental disorders becomes a control mechanism for social risk situations. Indeed, some argue that it overlaid the true reason of CT need for treatment" – This argument is unclear.

"Yet for each country there are legal requirements which might not be under use – more than 40% patients failed to provide them in their records" – Did the patients fail to provide them or did the hospital/administration? Please clarify.

"This would allow health professionals to" – The rest of the sentence seems to be missing.

"CT for public health issues, such as tuberculosis, is of particular complexity and represents perhaps the clearest violation of the rights to liberty and privacy in persons whose competence might be unspoiled." – It seems strange to bring up CT for public health issues in an article focused on mental health, and, if this is a deliberate choice, without a mention of COVID and the moral dilemmas posed by the pandemic.

"Postmodern ethics suggest that forms of power and control (and the need to regulate them) are

not only external to the subject but can rise from within." – Citation missing?

"When they experience satisfaction" – With what?

"Several patients admit" – Admit is a loaded concept (linked to admission of guilt), consider a more neutral “report“ or “consider”.

"Another paradox is the fact that CT in inpatient settings appears to be better regulated as other team members and patients can supervise what is happening to the patient" – To clarify, add “in comparison with Community Treatment Order”.

"interruption of forms of CT" – of certain forms? Be specific as to which forms.

Conclusion:

An interesting perspective, with relevant insights from clinical practice, that would benefit from a section on methodology.

Is the topic of the review discussed comprehensively in the context of the current literature?
Yes

Are all factual statements correct and adequately supported by citations?
Yes

Is the review written in accessible language?
Yes

Are the conclusions drawn appropriate in the context of the current research literature?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Treatment in mental health care, including coercive treatment, specifically focused on users' and next of kin's experiences of treatment

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 18 Sep 2022

Luis Madeira

Answers to the reviewer

The selective literature review adresses the problem of coercive treatment (CT) in

mental health, mainly the juxtaposition of coercion as a violation of rights with the clinical obligation to treat patients with mental disorders.

Firstly, the practice and impact of CT is presented with focus on risk asessment, impact on treatment. Secondly, the experience of coercion and how this may be ameliorated is shortly presented. And lastly, the article touches upon ways to reduce or ameliorate CT.

Critique and suggestions:

The focus on clinical inputs with regards to the ethical dilemma of CT is an important perspective. The very literal interpretation of the articles from the United Nations Convention on the rights of Persons with Disabilities seems not sufficiently nuanced - all articles cited in Table 2 provides caveats. If possible, nuance this point in the conclusion, as I am not, from the material provided, sufficiently convinced that stakeholders do not in fact "acknowledge these efforts and evidence"

ANSWER: We thank the reviewer for pinpointing this possibility and although the CRPD commission to draft the final document did not include any doctors (who could attest for the difficulties of dealing with a simple legislation that does not encompass the nuances of clinical practice) we've now changed the last sentence of the paper which now reads "*Even if those responsible for CRPD might have already acknowledged these efforts and evidence, while translating these principles into practice stakeholders at nationwide discussions and decisions at a macro level (and possible mental health policies reformations) would benefit from recognizing these inputs from clinical psychiatry where CT takes actually takes place.*"

"This is a review of literature which provides inputs from psychiatric practice..." – The article does not specify what literature has been reviewed and how the is sample created, and would benefit greatly from this tranparency in terms of validity.

ANSWER: We agree with the reviewer that this is a major flaw of our paper. This paper is a review of the papers used to produce the national assembly document for Compulsive Treatment in Portugal as we were the most active participants to develop a new mental health law. So, for the first task we both used research methodology and while reviewing the document we did not considered the methodology – we have now salvaged the methodology so that it strengthen the quality of our manuscript. The methodology now reads: The most relevant journals in the fields of psychiatry (World Psychiatry, The Lancet Psychiatry, Annual Review of Clinical Psychology, JAMA Psychiatry and American Journal of Psychiatry) and medical ethics (BMC Medical Ethics, BMJ Journal of Medical Ethics, Bioethics, American Journal of Bioethics and Journal of Bioethical Inquiry) were searched aiming to achieve full coverage of the topic: "how involuntary commitment is considered in clinical psychiatry?". The search strategy also included the electronic databases: PubMed, SCOPUS, CINAHL, Web of Science. In PubMed included the use of MESH terms "coercion", "involuntary commitment" and "Psychiatry" citation tracking and checking of identified eligible articles reference lists were checked for additional articles, and those that are eligible will be included. As inclusion criteria we considered original papers that answered to the use of Involuntary commitment in Clinical Psychiatry. Our search found a total of 893

papers which were examined by two experts (L.M. and J.C.S.) and, after joint discussion, we included 75 papers for review. Search was performed until December 2018. The references identified were merged and managed with Mendeley. Grey literature was not included.

Clear tables, that neatly summarise the points of the article. Very nice.

ANSWER: We thank the reviewer for the positive remark about the paper.

"Even after CT 25% of patients admitted to an adult psychiatry unit could be at risk of committing an act of violence" – Please clarify, after CT has ended, during CT?

ANSWER: We thank the reviewer to identify the lack of clarification of this sentence – this is an important clarification. The sentence now reads "after CT 25% of patients admitted to an adult psychiatry unit could be at risk of committing an act of violence during their stay at the hospital"

"Yet while individual risk factors appeared for violent behaviors and CT decisions (Menculini *et al.* 2018) – e.g. male, diagnosis of schizophrenia, substance abuse and previous history of violence – their predictive value for violent behavior was not found. Of all the reasons the risk of occurrence or recurrence of violence seems the most liable to abuse (due to the subjective nature of risk in psychiatry) and perhaps the target of the CRPD worries and predicaments – that a measure aimed at the treatment of persons with mental disorders becomes a control mechanism for social risk situations. Indeed, some argue that it overlaid the true reason of CT need for treatment" – This argument is unclear.

ANSWER: We thank the reviewer for identifying how difficult it is to retrieve the main argument of this paragraph. It was extensively edited, and we hope it is now clearer. It now reads: "Yet the use of "risk of violence" to justify CT is not only the most liable to abuse but also no predictive value of any of the usual individual risk factors for violent behavior - male, diagnosis of schizophrenia, substance abuse and previous history of violence - was found (Menculini *et al.* 2018). Due to the subjective nature of risk in psychiatry CT must not become a control mechanism for social risk situations and clinicians should bear in mind that it serves to offer treatment to persons with mental disorders"

"Yet for each country there are legal requirements which might not be under use – more than 40% patients failed to provide them in their records" – Did the patients fail to provide them or did the hospital/administration? Please clarify.
ANSWER: We thank the reviewer for identifying a necessary change to better present the data involved. It now reads "For each country there are precise legal requirements which might not be under use as an analysis of clinical documentation of patients under CT showed that more than 40% clinical records were void of the necessary requirements"

"This would allow health professionals to" – The rest of the sentence seems to be missing.

ANSWER: We're very sorry that this has happened – this sentence was edited during the first

reviewer comments and became incomplete – “This separation might allow health professionals to betterunderstand the nature of CT in Psychiatry and distinguish it from the lack of competence in many medical illnesses that confusional states bring about.”

"CT for public health issues, such as tuberculosis, is of particular complexity and represents perhaps the clearest violation of the rights to liberty and privacy in persons whose competence might be unspoiled." – It seems strange to bring up CT for public health issues in an article focused on mental health, and, if this is a deliberate choice, without a mention of COVID and the moral dilemmas posed by the pandemic.

ANSWER: We thank the reviewer for finding this incongruence. Yet this follows from the reviewed literature and seemed to be along with the possibility of (mal)using CT in psychiatry as a social risk measure. We didn’t include the situation with Sars-COV-2 (COVID 19 pandemic) as the reviewed papers were published until 2019 and made no reference to it. Yet we agree that the paper, being published in 2022, should include them so we now edited the paragraph to read: “Arguments which forward it stand upon both the inviolability of human life (e.g., supporting the coercive use of helmets or forced recycling) and the principle of reciprocity – the social obligation as an individual if a group is exposed to detrimental effects on their health resulting from spreading of diseases. This has also supported complex moral decision making under Sars-COV-2 (COVID 19) – e.g. mandatory vaccination.”

"Postmodern ethics suggest that forms of power and control (and the need to regulate them) are not only external to the subject but can rise from within." – Citation missing?

ANSWER: We thank the reviewer for finding this typo. This was also an edited sentence during the first review of the manuscript that was copied with the citation marks but is a sentence of the authors. It is now corrected “It is possible that forms of power and control (and the need to regulate them) are not only external to the subject but can rise from within.”

"When they experience satisfaction" – With what?

ANSWER: We thank the reviewer for identifying the need of further clarification. We went through the original paper and found that the correct word is pleasure – when they are pleased with activities / interactions during the CT. It now reads “Such reactions are reduced when patients are allowed to exercise their autonomy, when they experience pleasure in activities/interactions”

"Several patients admit" – Admit is a loaded concept (linked to admission of guilt), consider a more neutral “report“ or “consider”.

ANSWER: We completely agree with the reviewer that admit is not the accurate word for this sentence – we’ve replaced with consider as suggested.

"Another paradox is the fact that CT in inpatient settings appears to be better

regulated as other team members and patients can supervise what is happening to the patient" – To clarify, add "in comparison with Community Treatment Order".

ANSWER: We agree with the reviewer that the sentence is unclear. It now reads "*Another paradox is the fact that CT in inpatient settings appears to be better regulated as other team members and patients can supervise what is happening to the patient in comparison with outpatients' settings such as Community Treatment Orders*"

"interruption of forms of CT" – of certain forms? Be specific as to which forms.

ANSWER: we agree with the reviewer that the word "forms" should not be part of the wording of this sentence or else it would require us to be specific which would extend the conclusion and not add to the overall idea. The sentence now reads: "While there might be the need for interruption of CT in clinical psychiatry, measures taken cannot risk the misinterpretation of concepts and ignoring the complexity of clinical practice and the systemic changes that should be required."

Competing Interests: No competing interests were disclosed.

Reviewer Report 27 July 2022

https://doi.org/10.5256/f1000research.136140.r144636

Mohammadreza Shalbafan
Iran University of Medical Sciences, Tehran, Iran

Thank you. No additional comment.

Is the topic of the review discussed comprehensively in the context of the current literature?
Yes

Are all factual statements correct and adequately supported by citations?
Yes

Is the review written in accessible language?
Yes

Are the conclusions drawn appropriate in the context of the current research literature?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Psychiatry, Mental Health, Stigma, COVID-19, OCD, Psychopharmacology, Depression

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 1

Reviewer Report 11 July 2022

https://doi.org/10.5256/f1000research.121068.r142241

?

Mohammadreza Shalbafan
Iran University of Medical Sciences, Tehran, Iran

The manuscript discusses an important topic and it`s well-written, by and large. I have some additional comments in order to improve the manuscript:

1. Type of the paper should be added to the title.

2. Main findings of the paper should be emphasized in the abstract.

3. 'CRPD' should be replaced with an appropriate key-word from MeSH.

4. '(article 6)' and some others are not clear enough and should be mentioned more clearly.

5. Description of the columns should be added to the tables.

6. The manuscript needs proof-reading, particularly for capitals.

7. What`s 'CTO'?

8. Cultural and trans-cultural aspects of the topic should be discussed briefly.

Is the topic of the review discussed comprehensively in the context of the current literature?
Partly

Are all factual statements correct and adequately supported by citations?

Yes

Is the review written in accessible language?
Partly

Are the conclusions drawn appropriate in the context of the current research literature?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Psychiatry, Mental Health, Stigma, COVID-19, OCD, Psychopharmacology, Depression

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 12 Jul 2022

Luis Madeira

Answer to the reviewer,

We thank the reviewer for going through our paper and provide a critical appraisal of its content which we believe greatly improve its quality. We answer below individually to the changes requested.
The manuscript discusses an important topic and it`s well-written, by and large. I have some additional comments to improve the manuscript:

1. Type of the paper should be added to the title.

Answer: We thank the reviewer for considering this add on to the paper. It now reads " *Reconsidering the ethics of compulsive treatment in light of clinical psychiatry:* ***A selective review of literature"***. We also agree that it clarifies the purpose of the paper.

1. Main findings of the paper should be emphasized in the abstract.

Answer: We agree with the suggestion of the reviewer. We've now edited the abstract though due to limitations in the number of words we've greatly abbreviated the main findings of the paper. It now reads "*The ethics of compulsive treatment (CT) is a medical, social and legal discussion that reemerged after the ratification by 181 countries of the 2007 United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD). The optional protocol of the UN-CRPD was ratified by 86 countries aiming to promote, protect and ensure the full and equal enjoyment of all human rights. It also determined the need to review mental health laws as under this light treatment of persons with disabilities, particularly those with mental disorders, cannot accept the use of CT. This selective review of literature aims to clarify inputs from clinical psychiatry adding evidence to the multi-disciplinary discussion. It provides contradictory evidence*

on how patients experience CT and its impact on their mental health and treatment programs, also which are main reasons for the use of CT and what efforts in psychiatry have been made to reduce, replace and refine it."

1. 'CRPD' should be replaced with an appropriate key-word from MeSH.

Answer: We agree with the reviewer that the word should be replaced, and we suggest that it Persons with Mental **Disabilities** which is the closest mesh term.

1. '(article 6)' and some others are not clear enough and should be mentioned more clearly.

Answer: We've now added extra density to the article 6 which reads "aimed to protect persons that failed to show capacity for consent to *treatment (including minors and adults with diminished capacity without representatives)* (article 6)"

1. Description of the columns should be added to the tables.

Answer: We thank the reviewer for pointing this idea as we have now edited the tables and added the description of columns to all tables with 2 or more columns. We believe that single column tables are described by the descriptor above them.

1. The manuscript needs proof-reading, particularly for capitals.

Answer: Our manuscript was proof-readed by a paid English-speaking professional translator. Yet we've now asked two native English speakers to go through the manuscript again.

1. What`s 'CTO'?

Answer: We replaced CTO for Community Treatment Orders – a specific form of compulsive ambulatory treatment. The explanation was in the table but fits better in the text itself as the reader might be unable to reach understand CTO abbreviation.

1. Cultural and trans-cultural aspects of the topic should be discussed briefly.

Answer: This is a very interesting and relevant topic in the field of compulsive treatment. Considering the limitations in the number of words we have included the following paragraph "We must bear in mind that culture and other social factors are also determinants in the application of CT and countries legislations frequently express the cultural milieu and possible constitutional rights (which differ significantly from western to eastern countries as well as from southern to northern Europe)."

Competing Interests: there are no competing interests