

# Penn ethicist proposes new category for psychiatric patients to justify instances of compulsory treatment

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The "involuntary treatment" of unwilling psychiatric patients has long been accepted as necessary in some cases, for the sake of patients and society, though it can raise serious ethical concerns as well as legal barriers. In a Viewpoint essay published online today in *JAMA*, Dominic Sisti, PhD, an assistant professor of Medical Ethics & Health Policy at the Perelman School of Medicine at the University of Pennsylvania, argues that some of the concerns about treating patients without their consent would be alleviated if the mental health profession recognized an important distinction among these cases.

"The current strict limitations on involuntary [treatment](#) risk allowing people with psychiatric illness to go untreated and experience worsening symptoms despite compelling evidence that they would want to be well," said Sisti, who is also the director of Penn's Scattergood Program for Applied Ethics in Behavioral Health Care, and an assistant professor of Psychiatry at Penn. "A patient may have previously expressed a wish to be treated while in crisis—in which case, a treatment framed as involuntary is actually something else. The proposed concept of nonvoluntary treatment provides a more precise categorization of such cases."

Sisti suggests using the term, and treating accordingly, in situations where there is compelling evidence that patients would approve treatment if their judgment were not impaired by their illness.

Patients covered by this concept would include those who have expressly indicated a desire to be treated when needed, those who have been living successfully in recovery from mental illness and clearly wish to continue doing so, and those who have difficulty escaping severe drug addiction despite an evident wish to become addiction-free.

The "nonvoluntary" category could also cover patients presenting with their first psychotic episode—due to undiagnosed schizophrenia or bipolar disorder, for example—who essentially have no idea what is happening to them.

"With no prior experience of psychosis, these patients have not been able to develop informed preferences about treatment," Sisti said.

The evidence to justify nonvoluntary treatment could include advance directives already provided by the patient to caregivers, as well as testimony from family members, case managers, and primary caregivers—and even the patient's own social media posts.

The nonvoluntary treatment concept would still involve a degree of ethical risk, as the evidence of a patient's authentic wishes might be ambiguous. But, Sisti said, this challenge is not much different than those found in other areas of medicine where a patient seems incapacitated and caregivers and [family members](#) must use their own judgment concerning patient care. Moreover, there is potentially much greater harm in not treating these very sick [patients](#) compared to providing nonvoluntary treatment.

The burden of [psychiatric illness](#), including disorders that could trigger hospitalization, remains very high in the United States. Psychosis-causing disorders alone afflict several percent of the population—more than ten million people. The National Institute of Mental Health also has [estimated](#) that about 100,000 people every year in the United States have

a first episode of psychosis.

**More information:** Nonvoluntary Psychiatric Treatment Is Distinct From Involuntary Psychiatric Treatment, *JAMA*. Published online August 24, 2017. [DOI: 10.1001/jama.2017.10318](https://doi.org/10.1001/jama.2017.10318) , [jamanetwork.com/journals/jama/fullarticle/2652427](http://jamanetwork.com/journals/jama/fullarticle/2652427)

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