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INTRODUCTION

Involuntary treatment of psychosis is an ethical fault line where impaired decisional capacity, elevated risk, and structural under-resourcing converge. Non-cooperative patients with schizophrenia and related psychoses frequently present with anosognosia; neurobiologically driven lack of insight that undermines informed refusal and raises the question of whether “consent” or “refusal” is meaningful at all. At the same time, coercive measures can undermine dignity, damage trust, and be experienced as punitive rather than therapeutic. Contemporary ethical analysis emphasizes the four principles of beneficence, non-maleficence, autonomy, and justice, but empirical work shows that these are applied inconsistently, within power-imbalanced systems where communication is often poor and coercion is normalized as “last resort” without a clear justificatory process.

AIM

To examine ethical tensions in the involuntary treatment of non-cooperative patients with psychosis (how autonomy, beneficence, non-maleficence, and justice are balanced in practice, which criteria and safeguards ethically justify coercion, and what strategies minimise ethical harm while preserving clinical responsibility).

METHODS

- Ethical-theoretical review:
 - Analysis of principles-based frameworks (beneficence, non-maleficence, autonomy, utility, justice) and duty-based and shared-decision models in psychosis care.
 - Examination of how anosognosia and fluctuating capacity challenge “classic” autonomy.
- Empirical and scoping literature:
 - Synthesis of a recent scoping review of 35 studies from 14 countries on ethical issues in involuntary psychiatric treatment, including criteria, risks, and mitigation strategies.
 - Integration of narrative and cohort data on patients’ retrospective views of coercion, relapse, and help-seeking.
- Legal and human-rights frameworks:
 - Comparison of typical statutory criteria (severe mental disorder, risk to self/others, or grave disability; least-restrictive requirement; time-limited review) with capacity-based and CRPD-inspired human-rights approaches.
- Applied ethical analysis:
 - Critical appraisal of inpatient coercion versus community treatment orders (CTO/AOT) and their impact on autonomy, stigma, and long-term engagement.

RESULTS

Lack of insight in schizophrenia (often neurobiological rather than defensive) means refusal of treatment may not represent a truly autonomous choice. Time-limited involuntary treatment can, in some cases, promote autonomy by restoring reality testing and decisional capacity, but only if followed by genuine shared decision-making once capacity returns.

Patients commonly report feelings of humiliation, fear, and loss of dignity after forced hospitalization, restraint, or medication, with a subset describing experiences as traumatic and deterrent to future help-seeking. Longitudinal data show mixed views: a substantial proportion later judge the admission as necessary or beneficial, but this does not negate the need to minimise coercive practices and their psychological cost.

Across jurisdictions, psychosis is central to eligibility for involuntary treatment, but thresholds differ (diagnosis-based vs broad “mental disorder”; risk-based vs capacity-based standards). Ethical consensus supports: (a) demonstrable impairment of capacity; (b) serious and imminent risk to self/others or severe self-neglect; (c) failure of less-restrictive alternatives; and (d) continuous review, with rapid transition back to voluntary status when possible.

Community treatment orders are framed as less restrictive, maintaining patients in the community while mandating adherence to medication and follow-up. Evidence for reduced relapse or improved quality of life is limited and inconsistent; concerns include chronic surveillance, blurred voluntariness, and extension of coercion into everyday life. Ethically, CTOs are acceptable only if they clearly reduce hospital days and risk, are regularly reviewed, and are embedded in robust community supports (housing, employment, psychosocial care).

Clinicians navigate dual risks: ethical and legal scrutiny if coercion causes adverse drug reactions or trauma, and parallel criticism or liability if failure to intervene leads to suicide, violence, or severe self-neglect. Standard-of-care reasoning therefore requires explicit documentation of risk-benefit analysis, discussion (as far as possible) with patients/families, and ongoing monitoring of adverse effects and outcomes.

Strategies to minimise ethical harm include:

Before coercion: de-escalation, advance directives, crisis planning, family involvement, and assertive outreach as preferred options.

During coercion: clear communication of reasons, time-limits, and rights; attention to privacy, cultural safety, and trauma-informed practice; proportionality in the type and duration of constraints.

After coercion: structured debriefing with patients and staff, opportunity to contest or review decisions, and inclusion of the experience in future care planning to rebuild trust.

Organisational measures (such as ethics consultation, moral deliberation groups, and staff training) help teams recognise power imbalances and refine decision-making in borderline cases.

CONCLUSION

Involuntary treatment of non-cooperative psychotic patients can be ethically defensible only as a last-resort, time-limited, autonomy-restoring intervention under strict criteria of impaired capacity, serious risk, and lack of safer alternatives.

Ethical practice requires proportionality, transparency, meticulous documentation, and systematic efforts to reduce the frequency and intrusiveness of coercion through strong community services and genuine patient participation.

Embedding structured ethical reflection, human-rights awareness, and trauma-informed care into routine practice is essential if involuntary treatment is to alleviate suffering and risk without eroding the dignity and long-term trust of people living with psychosis.

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