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Balancing Public Health and Personal Rights: An Ethical Framework for Mandatory Outpatient Psychiatric Treatment

Nisha Gurung[1]*, Prakash Rai[1]

[1]Department of Ethics in Health Care, Faculty of Health Sciences, Pokhara University, Pokhara, Nepal.

***E-mail** ✉ nisha.gurung@gmail.com

Abstract

Compulsory treatments legally mandate care for individuals—typically those with mental disorders—who refuse therapeutic interventions and pose a danger to themselves or others. Compulsory outpatient treatment (COT), also called a community treatment order, extends this involuntary care from hospital settings into the community. Although implemented in over 75 jurisdictions globally, COT remains one of the most debated practices in psychiatry and raises significant ethical concerns. Despite extensive discussion, ethical considerations often remain theoretical, focusing on arguments for or against compulsory treatment, while offering limited practical guidance for clinicians making decisions about implementing COT. Current evidence regarding the effectiveness of COT is inconclusive. Consequently, while several countries use COT, supporting data are inconsistent and debatable. In such ambiguous contexts, ethical guidance becomes crucial. This paper provides an ethical examination of COT through the principlist framework proposed by Ross Upshur in 2002, initially developed to justify public health interventions during the 2002–2004 severe acute respiratory syndrome outbreak. We critically analyze the applicability of Upshur's principles of harm, proportionality, reciprocity, and transparency in decisions regarding the initiation of COT. Upshur's principlist framework serves as a valuable tool for ethically reflecting on the use of COT, offering guidance to support more ethically sound decision-making in psychiatric practice.

Keywords: Public health, Personal rights, Ethical framework, Psychiatric

Introduction

Since the 1950s, psychiatry in Western countries has gradually moved toward deinstitutionalization, shifting the focus from asylums to community-based care [1]. This transition was often accompanied by legal frameworks that permitted coercion to facilitate psychiatric assessment and treatment [2]. Countries including Australia, Belgium, England, Portugal, and the United States allow, under law, the coercion of individuals to receive care [3].

Compulsory outpatient treatment (COT)—also termed community treatment order, mandatory outpatient treatment, compulsory community treatment, or assisted outpatient treatment—legally obliges individuals with mental disorders to follow a treatment plan in a community setting [4]. Present in over 75 jurisdictions, COT aims to govern legally mandated care for individuals with significant psychiatric needs [5, 6]. It enables psychiatrists to define conditions patients must follow, such as taking prescribed medications and attending appointments, and can extend to other areas of life if necessary to achieve treatment goals [5].

Arguments supporting COT emphasize its clinical utility [7] and protective role for patients, including promoting treatment adherence [8], providing a less restrictive environment, reducing hospitalizations, and preventing repeated admissions [9]. Supporters also invoke society's responsibility to care for individuals with mental illness,

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suggesting that some patients may lack insight or decision-making capacity, justifying state intervention to protect their best interests [10].

The initiation of COT differs internationally. In countries like England, Sweden, and Portugal, COT is typically applied after hospitalization, whereas in Scotland, it can be implemented directly in the community [3]. Despite these differences, COT generally requires the presence of a mental disorder, risk of harm to self or others, and refusal of treatment [11].

COT poses medical, legal, social, and ethical challenges [10]. Ethical debates often frame the issue as a conflict between autonomy and beneficence, focusing on arguments for or against compulsory treatment in principle, rather than offering practical guidance at the clinical level. Nonetheless, COT continues to exist and its use is increasing [3, 12]. Discussions surrounding the Convention on the Rights of Persons with Disabilities (CRPD) have heightened ethical scrutiny, with divergent interpretations ranging from calls to abolish COT to proposals for capacity-based assessments prior to its initiation [10, 13]. Given these dynamics, the complete elimination of COT in the near future appears unlikely [14].

Recent global health crises, such as the COVID-19 pandemic, have highlighted the ethical considerations of state interventions restricting civil liberties for public health purposes [15]. In 2002, Ross Upshur proposed a principlist framework for ethically justifying public health interventions, adapting Beauchamp and Childress's standard principles [15, 16]. Upshur later applied these principles to regulate quarantine measures during the 2002–2004 SARS outbreak [17]. We propose that this public health ethics framework can also guide the ethical application of COT.

As previously noted [10], COT represents a significant restriction on a patient's freedom and self-determination. Yet, its current implementation cannot be ignored, particularly given the uncertain and controversial evidence base. In light of this ambiguity, ongoing ethical debate and careful analysis are essential to guide practice. We contend that Upshur's principlist approach offers a practical framework for clinicians seeking to apply COT ethically [16].

Main body

A necessary debate

Compulsory treatment, whether delivered in inpatient or outpatient contexts, represents a profound interference with an individual's fundamental rights and freedoms. COT involves legally compelling a person to undertake actions they might otherwise refuse. The case of Portugal, where constitutional amendments were required to integrate the Mental Health Law, underscores the significant legal and ethical weight of this issue [18]. COT remains one of psychiatry's most contentious topics [19]. Proponents argue that it enhances treatment adherence, helps prevent relapse, and reduces hospitalizations [6, 8]. It is often viewed as a less coercive alternative than repeated hospital stays, particularly for "revolving-door patients" who struggle to maintain recovery and adhere to treatment plans. Additionally, COT may lower the risk of harm to patients and others, alleviating public concerns about potential dangers posed by untreated psychiatric conditions [3]. Ethical arguments in favor also emphasize that sustained outpatient treatment may be more beneficial than frequent short-term hospitalizations [20]. Some authors [2] note that autonomy and beneficence are both prima facie principles, suggesting that prioritizing autonomy should not automatically outweigh beneficence; protecting a patient's health is equally important as respecting their autonomy.

In psychiatric emergencies, such as severe illness or imminent risk scenarios, beneficence understandably takes precedence over autonomy [10], justifying temporary restrictions of freedom. In community settings, however, the ethical justification for limiting autonomy is less clear and more controversial. Critics of COT raise concerns about encroachment on civil liberties and potential harm to the therapeutic relationship [19]. Others worry that COT could evolve from a tool meant to enhance liberty into a controlling mechanism [11]. The most significant criticism, however, stems from the lack of robust evidence demonstrating its effectiveness in reducing readmissions or improving quality of life [4, 21].

While some Australian studies suggest positive clinical outcomes [22], the largest randomized controlled trial (RCT) on the subject—the OCTET trial—found that COT did not lower readmission rates for patients with psychosis [23]. Further analysis indicated that COT was not cost-effective and that its duration did not significantly impact patients' long-term social outcomes [21, 24].

These findings have led to debate over whether RCTs are suitable for assessing COT effectiveness, given conceptual, methodological, and analytical limitations

[25]. Mustafa [19] argued that RCTs may fail to capture representative patient populations, suggesting that the negative results of OCTET may not generalize to the broader clinical population, and that discontinuing COT entirely could be premature.

Overall, the evidence on COT's effectiveness is inconsistent and contentious [6, 22]. Disagreement persists about the most appropriate methods for evaluating such interventions, dividing opinion between advocates for abolishing COT based on RCT data and those defending its continuation while questioning RCT validity [10].

This uncertainty generates ethical tension. From a principlist perspective, justifying an infringement of autonomy requires a reasonable likelihood of achieving a meaningful benefit [26]. Applying COT in situations where its efficacy is uncertain raises legitimate moral concerns. Nevertheless, until more definitive evidence emerges, there is a pressing need for ethical regulation of COT, which continues to be practiced and increasingly implemented in multiple countries [27].

A principle-led practice

Most individuals rarely face significant restrictions on their autonomy in health-related matters, making debates about the ethical responsibilities of the state to limit personal freedoms seem abstract. However, the COVID-19 pandemic brought this issue to the forefront, as governments worldwide implemented policies that curtailed civil liberties to control viral spread. These measures sparked both support and criticism, reigniting discussions on what constitutes acceptable state interference in individual rights [28, 29]. Although differing in scale, interventions like quarantine and COT share a common ethical question: under what circumstances is it morally permissible to restrict personal liberty for health-related purposes?

To address this, Ross Upshur [16, 17] developed a modified principlist framework to guide ethical public health interventions, particularly for quarantine. He proposed that justifiable public health action should satisfy four criteria: (a) harm, (b) proportionality, (c) reciprocity, and (d) transparency. While acknowledging that the model has limitations, Upshur emphasized its heuristic value, noting that it is intended as a practical guide rather than a definitive rule set [16].

Critics have questioned the relevance of principlism in psychiatry [26, 30]. Given the lack of conclusive evidence regarding COT, some argue that no universal ethical justification for its use exists [5]. Nonetheless, these same authors suggest that promoting patient autonomy in certain contexts could ethically support the application of COT [5]. Principlism has previously been applied to COT; for instance, Guillén [31] analyzed the intervention through the four classical bioethical principles—autonomy, justice, beneficence, and non-maleficence—and concluded that, as a therapeutic method, COT aligns with these principles. However, Guillén's work did not focus on practical guidance for COT implementation.

We propose that Upshur's framework offers a more suitable approach for establishing an ethically grounded practice for COT. By applying these principles, clinicians can navigate practical dilemmas associated with compulsory interventions. In the following discussion, we examine each of Upshur's four principles in the context of COT and suggest actionable strategies for their ethical application.

The harm principle

John Stuart Mill's harm principle asserts that the only legitimate reason for exercising power over a member of a civilized society against their will is to prevent harm to others, and that pursuing one's own benefit—physical or moral—does not justify such interference [32]. In clinical practice, this principle serves as an ethical guide for actions aimed at avoiding harm, whether to oneself or others. Upshur [16, 17] noted that the harm principle is arguably the foundational justification for implementing quarantine, as the legitimacy of enforced isolation depends on preventing potentially infected individuals from transmitting disease.

When applied to compulsory outpatient treatment (COT), legal frameworks typically require that there be a risk of harm to oneself or others. According to Mill's definition, however, the harm principle would ethically support COT only if there is a risk of harming others, not necessarily self-harm. Mill did acknowledge exceptions, suggesting that intervention could be justified for those unable to fully exercise rational judgment, such as children or individuals in states of delirium or intense emotional absorption [32]. This reasoning provides ethical grounds for acting in an individual's own interest when their capacity for judgment is compromised. In this respect, Mill's perspective aligns with Beauchamp and Childress's concept of soft or justified paternalism, where diminished decision-making capacity may justify medical intervention under the principle of beneficence [33].

Despite its ethical relevance, the harm principle has limitations when applied to COT. Critics argue that when the risk of harm—either to self or others—is significant, community-based treatment may be inappropriate, and hospital-based care may be more suitable. Thus, COT often addresses potential harm that is deferred rather than immediate, which weakens the harm-based justification for coercion. The argument is further undermined by the limited predictive ability of clinicians to anticipate self-harm or violence toward others [34, 35], meaning that an unacceptably large number of patients would need COT to prevent harmful outcomes. The lack of immediacy diminishes the harm principle's strength as justification for compulsory treatment.

Nevertheless, immediacy is not the only factor in assessing risk. The harm principle can still ethically support COT, though it requires clinicians to provide more robust justification than would be needed for inpatient treatment. Overreliance on the harm principle, however, may inadvertently contribute to stigma and the criminalization of people with mental illness by linking them to public danger through legal and forensic language [8, 20].

Given the dimensional nature of psychopathology, questions arise regarding what level of risk justifies intervention and whether risk quantification can ethically support coercion. While structured risk assessment tools can help organize patient information, they alone cannot justify compulsory measures. Ethical decision-making requires that interventions have a foreseeable and intended effect based on evidence. Risk assessment tools, particularly in non-immediate scenarios, often fail to accurately predict harm, offering no clear advantage over clinician judgment [36-38]. This is partly because serious violence among individuals with mental illness is rare, unlike rapidly transmissible infections, which carry higher potential harm [35]. Decisions based on risk scores lacking predictive validity are therefore ethically problematic, may lead to unjustified restrictions, reinforce discrimination, and hinder access to care for those assessed as low risk [35]. Consequently, clinical decisions should prioritize direct engagement with patients and their circumstances rather than rely solely on risk scores [34].

In conclusion, the harm principle provides partial ethical support for COT but carries notable limitations. Clinicians should apply it with caution, ensuring that the concept of harm is concrete and proximate rather than vague or hypothetical. Justification for restricting autonomy must clearly identify the value being protected and demonstrate a plausible connection between the psychopathological condition and a likely harmful outcome.

The proportionality principle

Originally articulated by Upshur [16], the proportionality principle emphasizes the use of the least restrictive or coercive means. In the context of COT, this principle is most accurately represented by proportionality itself, as it encompasses multiple considerations. It asserts that greater restrictions on liberty should only be imposed to protect fundamental human values, such as life or health, and should not be applied for purposes of lesser significance. The principle further acknowledges that multiple strategies exist to achieve a goal, and interventions should be applied in a stepwise manner. Specifically, coercive measures should be reserved for situations where less restrictive approaches—such as education, facilitation, or discussion—have proven ineffective [16].

For COT initiation, patients must agree to the psychiatrist's outpatient treatment plan. In legal systems where COT is contingent upon prior hospitalization, refusal of the treatment plan generally results in continued compulsory hospitalization. While COT imposes fewer restrictions than inpatient care, it still limits patients' freedoms within the community, as compliance with the treatment plan is required regardless of patient consent [5]. Consequently, in line with the proportionality principle, COT should not be implemented merely because it is less restrictive than hospitalization. Furthermore, patient disagreement alone does not justify overriding autonomy; discussions should occur following refusal to determine whether further coercion is warranted. Clinicians must remain vigilant to avoid transitioning from soft paternalism to hard paternalism [33, 39].

When COT is ethically warranted and proportionate, psychiatrists should confine the treatment plan to evidence-based interventions and only to those life areas essential for achieving specific therapeutic goals. The plan cannot justifiably infringe on broader rights such as privacy, intimacy, dignity, reputation, or personal identity. For example, patients may ethically deny community care team access to their home while still being required to undergo treatment. Issues related to privacy, reputation, and identity should be carefully weighed when considering COT, which already involves extensive monitoring and interference from health services and may exacerbate stigma and the perception of non-compliance [8]. Patients' refusals grounded in these rights must be acknowledged and respected rather than automatically interpreted as defiance.

Another key aspect of proportionality concerns the duration of COT. With accumulating evidence for relapse prevention in conditions such as schizophrenia and bipolar disorder [40, 41], clinicians may be tempted to use COT indefinitely to prevent relapse in patients who have achieved remission but are perceived at risk of discontinuing medication post-discharge. However, coercion is not ethically defensible if the patient retains decision-making capacity, even in the presence of strong evidence for relapse prevention—for instance, a patient recovering from a manic episode who refuses preventive treatment. While some individuals with impaired capacity may require extended periods of COT, duration should not be assumed solely based on psychiatric diagnosis, as mental illness does not automatically indicate incapacity [33]. Since COT focuses on treatment, it should aim to restore decision-making capacity and autonomy, particularly in the early stages of illness. Regular, detailed assessments of decision-making capacity are therefore essential to minimize time under liberty-limiting interventions.

In conclusion, clinicians should design evidence-based treatment plans that are limited to essential interventions, imposing minimal disruption on other aspects of patients' lives and for the shortest necessary duration, thereby upholding the ethical imperative to reduce interference with patients' fundamental rights.

The reciprocity principle

Upshur [16] described the reciprocity principle as the ethical obligation to provide support and compensation to individuals when public health interventions are required, particularly when compliance imposes burdens such as lost income or time.

In the context of COT, patients experience both explicit and implicit constraints on their autonomy within their own environment. Explicit constraints involve adhering to the conditions of the treatment plan, while implicit constraints encompass the pervasive sense of surveillance and the awareness that noncompliance could lead to compulsory hospitalization, often initiated through police involvement [8].

While delivering treatment may appear to fulfill the reciprocity principle, Engelhardt argued that beneficence should be integrated with respect for autonomy [42], meaning that interventions should not be based solely on external notions of what is "best" but should align with the individual's own understanding of their good, as emphasized by Scholten and Gather [43]. This alignment can be challenging in psychiatry, as some patients may lack insight into their condition and therefore be unable to recognize the benefits of treatment [33]. Consequently, COT should ensure that patients experience a clear, perceivable benefit.

Upshur [16] highlighted that coercive health measures inevitably involve sacrifices, including time and financial costs. Compliance with COT similarly entails burdens, such as medication costs, time commitments, or transportation needs. To uphold the reciprocity principle, necessary medications should be provided free of charge, and transportation costs for appointments should be covered. Alternatively, community-based outreach teams could reduce the burden on patients. While these measures may seem ambitious, they are feasible and consistent with the principles underlying successful health programs, such as the World Health Organization's tuberculosis strategy [8].

The transparency principle

Upshur [16] defined the transparency principle as the ethical obligation to ensure that all stakeholders are actively involved in the decision-making process and that this process remains as clear and comprehensible as possible, with decision-makers required to provide justification for their choices [15, 17]. Transparency is particularly important in the context of COT. First, it fosters accountability, ensuring that deliberations—especially those that limit fundamental rights—are thoughtful and well-reasoned. Second, transparency enables the appeal of decisions, which is crucial for reviewing prior judgments, overturning unjustified interventions, or reinforcing the legitimacy of appropriate ones. In contrast, opacity can create a Kafkaesque sense of confusion, increasing patients' feelings of powerlessness and distress, particularly in interactions with the legal system.

Clinicians should therefore strive to make decisions about COT as clear and transparent as possible, both in documentation and in communication with the patient. This requires a detailed analysis of each decision to initiate or continue COT. Simply asserting that the patient meets legal criteria is insufficient; the assessment must explain how the patient's mental state at that specific time impairs their autonomy and affects their decision-making capacity.

Evidence indicates that lack of insight in schizophrenia has a neurobiological basis, extending beyond simple denial [20, 44-46]. Grisso and Appelbaum [47] found that in hospital settings, 25–50% of patients with schizophrenia lacked decision-making capacity across four domains: expressing a choice, understanding, reasoning, and appreciation. In community settings, clinicians have even less information to assess decision-making capacity, though it is reasonable to assume that some patients remain unable to recognize their illness despite treatment and symptom improvement. Awareness of these findings may inadvertently lead clinicians to over-rely on assumptions of incapacity when implementing COT. Moreover, biases may arise whereby patients who agree with treatment are perceived as competent, and those who resist are considered incompetent [33]. To mitigate such biases, clinicians should maintain a degree of skepticism regarding presumed incapacity and, as Childress recommends, operate under a moral presumption of capacity, bearing the responsibility of demonstrating incapacity when necessary [33].

A direct and uncritical link between treatment refusal or the mere presence of a mental illness diagnosis and the assumption of incapacity would unjustly limit the autonomy of patients who retain decision-making ability, potentially creating a scenario in which individuals with mental illness could never ethically refuse treatment. Therefore, the assessment of decision-making capacity should serve as the central criterion for implementing COT, rather than relying on treatment refusal or diagnosis alone.

Nevertheless, evaluating decision-making capacity is challenging for clinicians due to the dimensional and fluctuating nature of psychopathology. Variations in symptom frequency and intensity complicate the translation of a patient's clinical state into a dichotomous determination of capacity. Multiple factors—including patient preferences, psychopathology, and clinical history—must be considered, and these elements often do not yield clear-cut outcomes, making the assessment ethically, clinically, and legally complex. Documenting and acknowledging these difficulties is itself an important aspect of transparency in decision-making. Transparency also requires that clinicians record the efforts made to encourage voluntary adherence to the treatment plan, as such documentation clarifies the decision-making process and demonstrates the necessity of coercive interventions when employed. While critics may argue that this approach is inherently cynical—because patients' views may ultimately be overridden—it remains essential to document and respect patients' perspectives, values, and reasoning [26]. Acknowledging patient input signals respect for autonomy, even if the final decision ultimately resides with the clinician.

Conclusion

Upshur's framework [16] offers a set of principles for guiding ethical public health interventions, which can be effectively adapted to govern compulsory treatment in the community. This framework not only enriches theoretical discussions but also supports ethically informed action in contexts where evidence for efficacy is mixed. Recognizing the relevance of Upshur's principles, researchers and policymakers might consider whether enhancing public health policies could provide a more ethical strategy for reducing compulsory psychiatric interventions, particularly in areas such as suicide prevention or violence reduction [34, 35, 48]. Coercion may offer immediate intervention, but it is often a limited solution for longer-term problems and may reflect systemic shortcomings in implementing less restrictive treatment options.

Furthermore, the availability of adequately resourced and innovative mental health services could offer alternatives that reduce the need to curtail individual rights in an already vulnerable population [49]. Until such systemic improvements are achieved, ethical frameworks grounded in widely recognized principles offer a practical method for guiding ethically sound decisions and actions regarding coercive treatment. The role of ethics in this context is significant, as adherence to ethical standards can help limit coercive measures and improve the quality of care for those under compulsory treatment, ultimately fostering a more dignified approach within existing medical and legal structures [50].

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