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When Treatment Outlasts the Decision

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Abstract

In psychiatry, decisions about capacity increasingly authorize treatments whose effects extend beyond the moment they are made. Using long-acting antipsychotic medications as a case study, this paper examines why treatment duration matters ethically. These medications can be stabilizing and are often accepted voluntarily, yet once administered, their effects cannot be easily reversed. As treatment duration increases, a gap emerges between how decisions are made and how long their consequences persist. Unlike other high-impact psychiatric interventions that carry structured safeguards, extended-duration medications are typically authorized through processes designed for short-term risk. As psychiatric treatments become more durable, the processes used to authorize them should more clearly reflect the weight of their consequences over time.

Keywords: decisional capacity, long-acting antipsychotics, treatment duration, autonomy, informed consent

Medicine generally presumes capacity unless there is reason to doubt it. A patient who refuses life-saving treatment may be assessed for decisional ability, but if they demonstrate understanding and reasoning, their refusal stands—even when clinicians believe it is unwise.

Psychiatry encounters questions of capacity more centrally. Decisions about treatment adherence, hospitalization, and risk tolerance often hinge on whether decisional authority is intact. Capacity determines who may decide for themselves and whose decisions may be overridden in the name of safety. It is often imagined as rare or dramatic - invoked in courtrooms, conservatorships, or public scandals. In practice, however, capacity is better understood as a spectrum (Appelbaum, 2007), ranging from routine clinical judgments that are informal and reversible to formal forensic determinations that are structured and carry enduring consequences. What is less examined is the growing space between these poles.

Capacity and the Spectrum of Clinical Decision-Making

At one end are the routine judgments embedded in everyday psychiatric care: whether to honor a patient's preference over guideline, whether to tolerate risk, whether to continue treatment as is. These determinations are informal, negotiated, and usually reversible. Their ethical tolerability lies not in their casualness, but in their limited scope. They can be revisited, and patients retain the ability to seek a second opinion, change clinicians, or stop treatment altogether.

At the other end are formal forensic evaluations—structured assessments conducted under legal scrutiny and bounded by explicit standards and procedural safeguards. These determinations carry greater authority because their consequences are profound: treatment over objection, continued confinement, suspension of bodily autonomy. Here, the weight of the decision is matched by visible process.

The Expanding Middle: Durable Decisions Without Formal Safeguards

Between these poles lies an expanding middle. Increasingly, clinical decisions carry durable, difficult-to-reverse consequences while remaining governed by informal processes designed for short-term risk management. In this space - neither fully routine nor formally adjudicated -authority extends beyond the safeguards meant to contain it. This represents a structural blind spot in psychiatric ethics.

This misalignment becomes especially visible in settings where authority is explicitly time-limited. In some jurisdictions, concerns have been raised that long-acting injectable antipsychotics can extend the effects of treatment beyond the period during which that authority was granted, effectively outlasting opportunities for review or reconsideration (California Office of Patients' Rights, 2021).

The underlying tension is straightforward: clinical and legal authorization occur at a moment in time, but the intervention itself persists.

When Duration Changes the Ethics of Treatment

One place this becomes visible is in the use of long-acting antipsychotic medications. For many patients, these medications are stabilizing and life-preserving. Their ethical justification rests on voluntariness and intact capacity. In practice, however, voluntariness can be difficult to disentangle

from context. The decision to accept a long-acting injectable is often made within ongoing clinical relationships shaped by concerns about relapse, hospitalization, and continuity of care. While not overtly coercive, these decisions may carry subtle pressures. For patients, the prospect of a medication that cannot be reversed once administered can be both stabilizing and unsettling - a commitment that feels qualitatively different from shorter-term treatments. Duration, in this sense, is not merely a technical feature of pharmacology - it is an ethical variable shaped by how choice is experienced.

Extended Duration Without Extended Oversight

This progression is most clearly seen within a single pharmacologic continuum. An oral antipsychotic requires daily participation, allowing for ongoing adjustment or discontinuation. Shorter-acting injectable formulations (e.g., 2 weeks) extend that decision over weeks while still permitting relatively frequent reassessment. Monthly and three-month formulations further lengthen the interval between decision and revision. With six-month formulations, a single clinical encounter can shape a patient's mental state for half a year.

Across this continuum, the medication itself remains unchanged, but the duration of its effects -and the opportunity to revisit the decision - changes substantially. What has not changed is the process by which these decisions are authorized. Existing practices - such as oral stabilization and scheduled follow-up - reflect partial recognition of these risks, but they do not constitute a duration-sensitive framework. Even when preceded by stabilization on shorter-acting formulations, there remains a discrete moment in which extended duration is approved, committing the patient to months of pharmacologic effect without any corresponding change in procedural rigor. What has shifted is the length of time a single determination can shape a patient's mental life.

The first FDA-approved six-month antipsychotic injection was authorized in 2021, with guidance requiring prior stabilization on shorter-acting formulations (U.S. Food and Drug Administration, 2024). Its introduction did not prompt any clearly defined shift in the policies or procedures governing how such decisions are authorized. Few systems exist to track or revisit these decisions once made. There is no widely implemented registry, duration-triggered review, or standardized mechanism for tracking these treatments across settings. Follow-up should occur during that interval, but there is no consistent, duration-sensitive framework guiding reassessment. The clinical relationship may

therefore proceed on a schedule that does not reflect the full temporal scope of the intervention. Six months represents a clinically and experientially significant interval.

Proportional Safeguards and the Case for Structural Recognition

A useful point of contrast - on the level of procedural safeguards rather than clinical equivalence - can be seen in electroconvulsive therapy (ECT). ECT is also voluntary in many cases and can produce effects that persist for weeks to months. Its safeguards, however, are grounded not only in duration but in its acute risks, cognitive side effects, and historical context. It is typically accompanied by explicit procedural structures: structured consent processes, formal capacity assessments, and detailed documentation (American Psychiatric Association, 2001), and, when administered involuntarily, defined legal oversight (Gazdag & Ungvari, 2017). These layers do not signal distrust; they reflect recognition that the intervention carries distinct ethical weight. The point is not that these interventions are clinically interchangeable, but that when psychiatry recognizes such weight - whether tied to risk, irreversibility, or consequence - it has historically responded with more visible safeguards. Duration represents one such dimension not yet consistently integrated into those structures.

Conclusion

There is a growing gap between the duration of psychiatric interventions and the structures used to authorize them. Capacity determinations that once governed short-term risk now underwrite months-long constraints on a patient's ability to alter the course of treatment, without the procedural visibility typically reserved for decisions of comparable weight. Some clinical choices should continue to feel heavy - not because they are forbidden, but because their consequences outlast the moment in which they are made.

As psychiatric interventions grow more durable, the safeguards authorizing them should become more proportionate. Months-long pharmacologic constraints may be ethically justified - but they should not be authorized through processes designed for short-term risk management. Professional organizations, licensing boards, and health systems should develop standards that reflect this shift: enhanced consent frameworks, duration-sensitive review points, and clearer documentation expectations. Not because clinicians cannot be trusted - but because the scale of authority has changed. Proportional safeguards are not a sign of suspicion. They are a recognition that power, when

extended over time, warrants structure.

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