



Benevolent Coercion – Tensions between Welfare and Autonomy in Professional Caring Relationships

OPINION · EXECUTIVE SUMMARY & RECOMMENDATIONS

The full text of the Opinion as well as all publicly available information and documentation of the German Ethics Council accompanying the work on benevolent coercion are available at <https://www.ethikrat.org/en/topics/society-and-law/benevolent-coercion>.

Published by the German Ethics Council

Jägerstraße 22/23 · D-10117 Berlin

Phone: +49/30/20370-242 · Fax: +49/30/20370-252

Email: kontakt@ethikrat.org

www.ethikrat.org

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Title of the original German edition: Hilfe durch Zwang? Professionelle
Sorgebeziehungen im Spannungsfeld von Wohl und Selbstbestimmung

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English translation: Beatrice Gutmann

Layout: Torsten Kulick

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>> EXECUTIVE SUMMARY

Subject and objectives of this Opinion

- 1) In this Opinion *coercion* denotes the overriding of another person's will. Coercion is called "benevolent" if it is performed with the intention of preventing the recipient from harming herself,¹ i.e. if it is conceived as being helpful to her. Harm to the self occurs not only when a person is harmed physically or emotionally as a consequence of an action, omission, or refusal to accept a procedure, but also when their social relationships are damaged. Coercion used to suppress behaviour that harms someone else rather than oneself will not be discussed in this Opinion, even though in practice the distinction between harming oneself and harming others can be difficult to draw.
- 2) By *will* we generally understand a person's ability to originate their actions autonomously and to consider them their own. The degree

¹ In the interest of gender equality, this Opinion uses "she" and "he" alternately.

of *self-determination* underlying the will can vary depending on a person's external situation, their internal state, or their developmental stage within the human lifespan. Even small children have a will which they can assert over against others. However, the will needs to evolve over the course of human development until it acquires the degree of reflexivity required for fully responsible actions, which alone constitute genuine self-determination. An action is *fully responsible* if the person taking it is able to consent, refuse, or choose between different available options, if he understands what he intends to carry out or refrain from (including the consequences and secondary consequences foreseeable for him), and if he can place his decision in the context of the vision he has for his life.

- 3) A person is incapable of acting with full responsibility if she is temporarily incapable, no longer capable, or generally incapable of adequately understanding her life situation and the consequences of her decisions and actions, or of acting accordingly. Such an incapacity can be due, for example, to age, illness, or physical or psychological limitations. Being unable to act fully responsibly does not mean, however, that a person has no will. She can still express her wishes and strivings: she may want to move around, accept or refuse a medical procedure, etc. To distinguish these cases from the case of genuinely fully responsible actions in the emphatic sense, legal scholars use the term "*natural will*". When determining whether the overriding of another person's will amounts to coercion, it is immaterial whether or not their will is fully responsible. Overriding someone's natural will also constitutes coercion.
- 4) The present Opinion treats coercive measures in the context of the caring and healthcare professions. Thus, the following reflections are solely concerned with *professional caring relationships*. In this context, coercion can take the form of one person using direct and unmediated force on another person's body in order to restrict or eliminate the range of decisions and actions available to them. In the caring

professions coercion in this narrow, primary sense of the term occurs, for instance, when a patient with dementia who is thrashing about and presenting a danger to herself is physically held down or strapped to the bed by a caregiver. Secondly, there can be mediate coercion, e.g. locking the door to the ward or withholding a walking frame from a patient who is dependent on it in order to restrict her movement.

However, coercion is not limited to the body. A person's psychological state can also be interfered with coercively. Again, there can be direct coercion in the form of threats of negative consequences if the purpose of these threats is to overpower or neutralise the other person's opposing will. The will can also be overridden indirectly by withholding relevant information from a person or misrepresenting the facts to him in order to induce him to take a particular action or decision. This constellation also includes concealing medical drugs in food or drink because the patient would otherwise refuse to take them.

Despite its undeniable importance in the context of professional caring relationships, *structural coercion* – for instance institutions subjecting residents to fixed daily schedules that hamper or eliminate their ability to exercise self-determination when going about their day – will not be covered in this Opinion. This kind of coercion is not benevolent in the present sense of the term, but rather derives from institutional and organisational necessities.

- 5) This Opinion of the German Ethics Council has three *objectives*. First, we wish to raise public awareness of the problems and complexities around benevolent coercion and of the tensions between welfare and self-determination in the context of professional caring relationships. Second, we want to point out to politicians, legislators, and anyone involved in the practice of these professions the shortcomings in the regulations governing this field and in their implementation, and we formulate recommendations to contribute to the solution of these problems. Third, we aim to support the caring and healthcare professions in the ongoing reorientation of their self-conception and their

practices as professional caregivers. In this endeavour we are guided by the principle that the framework, structures, and processes of this field should be designed in a way that allows coercion to be avoided whenever possible. It must be admitted, however, that emergencies can arise in which the option of using coercion against a recipient of care must be considered as a last resort. This Opinion aims to provide orientation regarding situations of this kind as well.

Ethical foundations and core assumptions

- 6) Professional *care* should of course always promote or at least maintain the welfare of the recipients of care. On the other hand, it should respect their self-determination, especially in circumstances in which the decisions someone makes regarding herself are difficult or even impossible for others to understand. A conflict between these two equally fundamental principles occurs whenever respecting someone's self-determination entails allowing them to put themselves at risk of serious harm. In these situations the question arises whether violating someone's self-determination by means of coercion can be considered benevolent.
- 7) The question under what circumstances coercive measures intended to serve the recipient's welfare are benevolent cannot be answered by reference to a notion of welfare defined in abstract or general terms. Rather, the challenge lies in determining where the line should be drawn between on the one hand, an individual's decisions that must be respected, and on the other hand, permissible interference for the sake of the welfare of the person concerned. Here the following considerations must be taken into account: First, no definition of welfare could be convincing unless it accords a prominent place to a person's subjective experience of herself. Therefore an individual's welfare should never be determined in the abstract, much less by reference to the interests of third parties, but rather by reference to the individual's

own point of view. Second, it must be assumed that the concept of welfare represents a multilayered and complex category which comprises not only a person's occurrent subjective wishes and preferences, but also their individual biography (including past preferences, values, and goals) as well as societal and cultural ideals of the good life and basic norms (e.g. human dignity). Third, there is sufficient empirical evidence for the claim that an individual's subjective assessment of her own welfare is not always static but rather undergoes a process of change or development, depending on circumstances.

- 8) In this Opinion the concept of *self-determination* is used as an umbrella term to cover the whole spectrum of possible gradations between elementary expressions of will, for instance in a small child, and the fully responsible self-determination of adults. Self-determination presupposes certain fundamental conditions and abilities which make it possible in the first place. It is these physical and psychological preconditions of living a self-determined life whose core can be jeopardised by a person's situational decisions, available options for action, or expressions of will. In a paradoxical situation of this kind, the application of benevolent coercion is intended to resolve the acute dilemma by serving as a last resort for protecting and (re-)establishing the essential physical and psychological conditions of living a self-determined life.
- 9) When determining under what circumstances coercive measures aimed at preserving or restoring someone's capacity for self-determination can be considered legitimate, defining the distinction between fully responsible decisions on the one hand, and voluntary decisions which do not meet the criteria for full responsibility on the other, is of paramount ethical and legal importance. This distinction constitutes the demarcation between soft paternalistic and hard paternalistic interference with someone else's decisions. *Paternalism* denotes actions which, firstly, consciously override someone else's expressions of will and secondly, are done with the sole or at least

primary intention of protecting the recipient from putting himself or his fundamental interests at serious risk. An action is called *soft paternalistic* if the person performing it can be certain that the recipient would consent to the action were he currently able to make fully responsible decisions or determine his will accordingly. The recipient of a soft paternalistic measure is incapable of deciding against it in a manner that is fully responsible. His opposing natural will does deserve to be acknowledged as a form of self-determination and an expression of dignity; however, it does not possess the same degree of dignity as a fully responsible decision. In contrast, an action is called *hard paternalistic* if it overrides the fully responsible and thus truly self-determined decision of another person. This distinction yields different requirements for the possible justification of paternalistic coercive measures: the more closely a self-determined decision approaches the criteria for full responsibility, the more significant are the argumentative hurdles any justification of coercive measures needs to clear.

- 10) There is a broad consensus regarding the claim that under certain conditions soft paternalistic acts can be morally legitimate, provided the care recipient is *undoubtedly not yet capable, no longer capable, or temporarily or permanently incapable* of making a fully responsible decision in the given situation. In addition, in order to be considered truly legitimate in situations of this kind soft paternalistic measures must meet the following criteria:
 - » The coercive measure must aim at developing, fostering, or restoring the recipient's capacity to live a self-determined life in the context of the available possibilities and the physical and psychological preconditions essential to this aim. This holds true even if the capacity to act with full responsibility can no longer be achieved.
 - » The coercive measure must be suitable, necessary, and appropriate (i.e. the extent and duration of interference must be commensurate) with respect to these aims.

- » The prevention of a primary harm must not cause undue or potentially irreversible harm (“secondary vulnerability”).
 - » The coercive measure must be the only possible way to prevent the harm in question or achieve the stated aim.
 - » The measure should be such that the recipient would consent to it were he currently capable of making fully responsible decisions.
- 11) In a situation in which the *fully responsible nature of a decision can reasonably be doubted*, the above criteria must be supplemented by the rule that the person’s resources for living a self-determined life, which do exist in principle, should be activated as much as possible in the given situation by giving appropriate assistance, or that at least these resources must not be damaged substantially by the coercive measure. If the uncertainty about the fully responsible nature of the decision cannot be resolved, the evidence for and against must be weighed, and a clear preponderance in favour of a probable absence of full responsibility must be established. In this kind of doubtful case, only soft paternalistic coercive measures which aim at the limitation of (further) damage are legitimate. Further, the harm to be prevented must be significant and of a kind that could have a substantial negative impact on the person concerned. This certainly includes emergencies in which a person’s self-harming actions would very likely lead to his death and there is no time to investigate whether he is acting fully responsibly. The same verdict applies in cases in which it is not someone’s physical existence that is at risk but rather the cognitive, social, and affective capabilities on which his future capacity to produce self-determined decisions and actions depends. In these cases especially, preventing someone from causing harm to himself can turn out to be a blessing for him later despite the use of coercion. However, if the self-harming actions do not threaten the person’s life or his future capacity for self-determination, things look quite different. Suppressing such harmful actions by means of coercion could in and of itself cause significant harm, e.g. to the recipient’s self-respect.

- 12) Hard paternalistic coercive measures aimed at overriding an individual's *undoubtedly fully responsible* decision for the sake of their welfare cannot be justified in the context of professional caring relationships. Being an end-in-oneself lies at the core of human dignity. It establishes one's right never to be used as a mere means to someone else's ends and not to be externally controlled in how one acts and leads one's life. The right to self-determination also includes the right to reject help from third parties even if this help turns out to be indispensable for securing and fostering one's own welfare. Therefore it is morally legitimate for a patient to make a fully responsible decision to refuse a medical procedure, even if it is medically indicated and failing to carry it out would put the patient at risk of grave harm or even death. Consequently, third parties, too, are morally obligated to respect such acts of self-determination.

- 13) The people or groups of people who are subject to benevolent coercion in the context of professional caring relationships usually possess a very high degree of vulnerability. Many recipients of care (e.g. individuals with mental illness, disabilities, dementia, etc.) face serious limitations while simply going about their daily lives, and thus are less able than others to look after their own interests. The limitations inherent in someone's primary vulnerability (illnesses etc.) often give rise to further limitations within their life situation with regard to subjective factors. One can identify a form of *secondary vulnerability* here, which concerns the cognitive, motivational, and especially the volitional factor. Repeated experiences of coercion can accumulate and cause a more or less pervasive sense of being disrespected in the recipient, no matter how "benevolent" others might consider them. This can turn into open rebellion or social shame as well as a loss of self-confidence and self-respect. However, self-confidence and self-respect are crucial components of the experience of one's own dignity as a human being. This is connected with the experience of a strong feeling of belonging to a community and a society which accepts all its members as equal in rights, duties, and life opportunities. By virtue

of being an experience of powerlessness and defenselessness, any experience of coercion can severely damage this feeling of belonging in connection with a sense of self-respect and self-confidence, and can in fact lead to social exclusion.

- 14) The secondary consequences of using coercion in professional caring relationships include *damage to the relationship of trust* between the recipients of care and the professionals and institutions that provide it. Regardless of whether or not an institution for children, youth, the mentally ill, the elderly, or the disabled considers or perhaps actually employs coercive measures, as the case may be, more often than not the individuals concerned feel that they are “inevitably” “forced to be” in a relationship of dependency on the professional caregivers. In this context the feeling of powerlessness and defenselessness is enhanced if acts of care are carried out via benevolent coercion.

- 15) Making decisions about coercion is not part of the daily routine of professional caring relationships and poses special challenges for the caregivers’ *judgment*. Particularly in situations in which there is time pressure or limited knowledge about the care recipient, a professional caregiver’s ability to arrive at a judgment that is adequate to the situation can be severely tested. However, even after the most careful assessment of a situation a caregiver involved in measures of benevolent coercion can be caught in a feeling of *moral perplexity*, insofar as all available courses of action are morally problematic. The use of coercion can be experienced as a violation of the important value of the recipient’s self-determination, while refraining from using coercive measures can seem like a lack of care in the face of the imminent danger of self-harm on the part of the recipient, which can cause the caregiver to feel equally guilty. Thus, when a caregiver feels impelled in an extreme situation to make the tragic decision of disregarding their fundamental obligation to respect others’ fully responsible decisions and does override another person’s self-determination with the aid of coercive measures, the moral perplexity that gave rise to this

choice should not be dismissed. However, coercive measures of this kind cannot be morally justified. In addition, caregivers acting in this way are subject to legal sanctions.

- 16) The acts of care involving benevolent coercion that are evaluated in this Opinion are embedded in professional settings where they are carried out by individuals with specific professional roles and responsibilities. Therefore, the fundamental trains of thought regarding the legitimacy of using benevolent coercion in acts of care must be elaborated more specifically in an ethics of professional caregiving.
- 17) In general, when answering questions of professional ethics one must keep in mind the interaction between three different tiers of responsibility in which any professional act of care (including acts of benevolent coercion) is always embedded by virtue of being performed under the aegis of an institution (a hospital, a home for the elderly or disabled, child protective services, etc.). On the micro-level there is the personal responsibility of each professional caregiver in their immediate relationship with a recipient of care. On the meso-level there is their personal responsibility as a member of a team which shapes the caregiving and assumes shared responsibility for it as a *systemic entity*. On the macro-level there is the responsibility of senior management, which is perceived as corporate in nature. This tier is responsible for the implementation of appropriate regulations and especially for the institutional framework within which the members of the organisation fulfill their responsibilities on the micro- and meso-levels. In addition, with respect to systemic factors the relevant political players such as the legislative authorities should also be included since they determine the regulatory framework of the health-care system and make decisions regarding the specific allocation of resources. If the interactions between these different tiers are disregarded, the common feeling – frequently complained about by caring professionals – of lacking realistic options for implementation and

of impotently facing abstract moral imperatives of what ought to be done is intensified.

- 18) A widely acknowledged demand of professional ethics in the fields of nursing, care of children and youth, and medical care states that processes should be arranged in such a way that both the recipient of care and those who are legally responsible for her (e.g. parents, authorised agents, legal guardians) are involved. In principle, this right to participate extends to all phases of a professional intervention, from the initial assessment of the care recipient's life situation to the vetting of possible courses of action, the decision to choose a particular intervention, and its implementation, debriefing, and evaluation. Making sure that care recipients participate in the process as extensively as possible constitutes a fundamental building block of establishing trust between caregivers and care recipients and can significantly reduce the probability of having to use coercive measures of any kind.
- 19) Coercive measures must only ever be used as a last resort. Therefore, they always have to be preceded by the attempt to use appropriate explanations and transparency in order to convince the care recipient of the necessity of the proposed intervention and to obtain his informed consent. In this endeavour, considerations of practicability (such as the amount of effort expended, time pressure, etc.) must not play any role. One must take special care to ensure that the attempt to convince does not morph into persuasion, and that the recipient's realistic decision space is not intentionally restricted by dramatising the situation, withholding information about possible alternatives, and similar manoeuvres. Indeed, such actions could be said to fall under the umbrella of benevolent coercion themselves. Here, professional caregivers have to act highly sensitively, especially in situations in which consent is ultimately given without full conviction but rather after long deliberation, hesitantly, or even reluctantly.

- 20) These considerations of professional ethics entail several additional criteria for the justification of benevolent coercion which mostly relate to the procedures by which it is carried out.
- » Professional acts of care must meet the quality standards of the relevant discipline, i.e. the act in question must be professionally appropriate. In the case of coercive measures, the execution of the coercive act must also be professionally appropriate. In other words, there must be a twofold justification by reference to professional standards, both of the measure itself and of its coercive implementation.
 - » It has to be determined to a sufficient degree of certainty whether or not the recipient of care is capable of making a fully responsible decision regarding the proposed measure.
 - » The presence of the above-mentioned criteria – namely, the person’s welfare, including their own subjective assessment; the measure being necessary to restore the capacity for leading a self-determined life; coercion as a last resort; secondary vulnerability; potential consent in hindsight; etc. – must be ascertained to a sufficient degree of certainty, and any available scope of discretion must be clarified.
 - » The care recipient must be taken seriously as a person and must participate in the preparation, implementation, and aftercare of the measure in question.
 - » In the case of children and youth, parents or other guardians must participate in the decisions about the use of coercive measures. In the case of adults, the same holds for authorised agents or legal guardians if applicable.
 - » The relevant criteria must be implemented and secured through appropriate procedures. This includes, for instance, a professionally qualified and responsible individual ordering and supervising the coercive measure, as well as documenting the pivotal reasons for the measure, its implementation, and the type and duration of monitoring of the effects.

Legal foundations and regulations

- 21) Current legislation does allow for legitimate uses of benevolent coercion; indeed, it actually calls for it in certain cases and under certain conditions. The *Bundesverfassungsgericht* (Federal Constitutional Court) has set down that applying a medical treatment or a five-point or seven-point restraint to a patient against his natural will constitutes a serious infringement of his basic rights to physical integrity and freedom of movement. Nevertheless, the Court has stated, legislative authorities are not prohibited in principle from permitting interferences of this kind under certain conditions if they are in service of the recipient's other fundamental rights and interests protected by the *Grundgesetz* (Basic Law). The fundamental liberties protected by the Basic Law do include the right to use one's freedom in ways that third parties may judge to be contrary to the obvious and objective interests of the person invested with that freedom. This effectively grants each person a "right to illness", which precludes the option of using coercive measures against someone's "free will".

However, a person might be temporarily incapable of mustering a fully responsible act of will regarding possible treatments for her illness because that illness prevents her from grasping the necessity of particular measures or from acting accordingly. If in this situation there is no conclusive indication that her refusal has indeed arisen from a fully responsible act of will, then the state's duty to protect citizens' life and physical integrity becomes the most important priority. In this case the duty to protect must be invoked because of the person's enhanced need for protection, insofar as she is unable to understand the concrete necessity of a given measure and would therefore be at risk of life and limb without being able to freely arrange for her own protection.

- 22) The Federal Constitutional Court has also inferred from the state's duty to protect that the legislative bodies have to permit coercive medical treatment if severe, imminent damage to someone's health,

including the risk of death, can be averted by performing a treatment that is not excessively invasive and that has a high chance of success, and if the recipient refuses the procedure by his natural will solely because his illness has compromised his ability to understand the situation and form appropriate judgments. However, the Court has also stipulated that the legislative authorities must take the patient's liberties which are in abeyance into consideration as much as possible. For instance, the patient's fully responsible will must be respected even if it can only be inferred from the available evidence, especially from statements the patient made in the past or from the quality of the occurring expressions of his natural will. Only if this is impossible, i.e. if there is no conclusive evidence proving that the patient's refusal to accept the treatment arises from a fully responsible act of will, his opposing natural will may be overridden as a last resort.

- 23) It is the view of the Federal Constitutional Court that respect for an individual's self-determination entails the obligation of having to make sure ahead of any medical procedure that the patient is sufficiently capable of insight and judgment regarding the proposed measure, so that she can determine her will freely and hence bindingly. If this is not the case, her free will may be ascertained by reference to an advance medical directive or wishes regarding treatment stated in the past. If a patient is incapable of insight and judgment and opposes a proposed measure by her natural will, an attempt to convince her of the necessity and reasonableness of the measure must first be made before coercive treatment may be administered as a last resort.
- 24) As far as procedural regulations are concerned, the Federal Constitutional Court prescribes that coercive measures to be used against a patient must be ordered by a physician. Further, there must be effective judicial and legal protection, and all coercive measures taken against the recipient's will must be documented, including the fact that they were indeed coercive, the manner of implementation, the pivotal reasons, and the monitoring of their effects.

- 25) The legal framework provided by the basic rights and liberties is supplemented on the level of international law by the relevant human rights conventions. In addition to the European Convention on Human Rights, the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child, which in Article 12 includes the key clause about the child's participation in any proceedings affecting him, are especially important. These conventions embody an approach that is oriented towards the subject and beholden to human rights emancipation, which occasions an in-depth enquiry into the central questions regarding the concept of a fully responsible will and its demarcation from the natural will. Such an enquiry also heightens sensitivity to the danger of using treatments that are humiliating or violate human dignity. Regarding the reports issued by the Committee on the Rights of Persons with Disabilities which critique the implementation of the stipulations of the United Nations Convention on the Rights of Persons with Disabilities in German law and German legal practice, the Federal Constitutional Court has determined that while the Committee's comments should be taken into account, they do not constitute binding international law.

Benevolent coercion in psychiatry

- 26) This Opinion extensively addresses the discipline of psychiatry as representative of the entire field of medical practice since it was in the practice of psychiatry that public awareness of the problem of benevolent coercion originated. In addition, a number of verdicts of the highest courts regarding coercive measures have highlighted a significant need for reform both in the legislation governing this field and in psychiatric practice. On the one hand, this has posed considerable challenges for psychiatric care; on the other hand, it has initiated a dynamic process of developing alternatives to coercive measures and of deeper reflexion within the field of psychiatry.

- 27) Whenever a patient is incapable of making fully responsible decisions, situations can arise – not just in psychiatry but in all medical specialties – in which the patient refuses a measure which appears indispensable to his health and welfare. The question whether or not it can be legitimate in these situations to administer the required measure coercively has long been the subject of controversy, especially in psychiatry. If a coercive measure is intended to prevent a mentally ill patient from causing harm to herself or from suffering harm by refusing medical treatment, it constitutes “benevolent” coercion in the sense used in this Opinion. Historically, however, psychiatric practitioners have often used coercion against the mentally ill not only for the purpose of providing professional help to an individual by averting harm, but also for a different purpose: to protect society from the socially challenging or threatening behaviour of the mentally ill.
- 28) Psychiatric illnesses like schizophrenia or severe depression often compromise a patient’s ability to make fully responsible decisions. These conditions can impair perception, thinking, feeling, motivation, and behaviour to such an extent that patients affected by them are incapable of understanding the significance or implications of a given situation, arriving at their own judgment about the situation, or of acting accordingly. From a psychiatric point of view, coercive measures appear necessary when a patient’s perception of reality is distorted due to a disease-induced crisis and he is subject to impulses which put him at high risk of inflicting permanent and serious harm on himself, including suicide. Depression, anxiety, and schizophrenia are correlated with a significantly higher rate of suicidal behaviour. Under these circumstances, the patient may be unable to control the impulses arising from within by his will, or they may be ephemeral states of consciousness that do not correspond to the declarations of will made by him before and after the illness-induced crisis. From a professional perspective it follows that in these cases treatment should be administered, if necessary even against the patient’s currently evident natural will, especially if his life is in danger. Thus, psychiatrists

maintain that the use of coercive treatment and other coercive measures can be minimised but not completely eliminated.

- 29) Like other fields of practice, psychiatry makes use of *coercive measures that restrict or eliminate freedom*, for instance restricting or entirely suppressing someone's freedom of movement by committing or restraining them. Moreover, *coercive treatment* is sometimes administered, which includes measures of psychiatric treatment and care such as diagnostic examinations, electroconvulsive therapy (ECT), or specific diets if they are enforced against the patient's will.

- 30) In recent years, the legal foundation of the use of coercive measures in psychiatry has been challenged from a human rights and fundamental rights perspective a number of times. Former patients and groups with in-depth knowledge of psychiatry have called for an unconditional ban of coercive treatment. They justify this demand primarily by reference to the prohibition of torture and cruel, inhumane, or humiliating treatment or punishment set down in various human rights conventions. Even so, such a ban cannot categorically prohibit all coercive measures used in the care of psychiatric patients. For instance, people with mental illness sometimes refuse to take medication even though a careful assessment has shown that the treatment is clearly medically indicated even if administered coercively. If the patient is incapable of understanding or assessing the consequences of refusing the treatment due to her illness, and if her illness and her refusal represent a serious risk of exclusion and of compromising her long-term ability to lead a self-determined life, then – provided everything has been tried and failed to convince the patient of the necessity of the treatment – coercive treatment does not constitute a cruel, inhumane, or humiliating treatment in the sense specified in the prohibition of torture, and thus does not violate the patient's human rights.

- 31) Just like other kinds of patients, the mentally ill have the right to appropriate medical care that aims at reducing their suffering and

restoring their health. Psychiatric care satisfying the standards of current state-of-the-art science should be accessible to all without discrimination. For the purpose of reducing suffering or restoring health coercive measures may be indicated if there are no other alternatives and if the patient is no longer capable of grasping the necessity of the treatment or of acting accordingly. However, public authorities are obliged to prevent any and all abuse of coercive measures in psychiatry and to reduce their incidence to an absolute unavoidable minimum by means of protective legal mechanisms. These include keeping documentation of coercive measures, their implementation, the pivotal reasons, and of how the effects were monitored, and providing effective legal and judicial protection. In addition, other options of medical and social support and self-help should be promoted if they are capable of preventing the necessity of coercive psychiatric measures, and if they help individuals with psycho-social limitations lead a self-determined life connected with the society around them.

- 32) If a patient has a legal representative (parents or a legal guardian of a child, a legal proxy acting under a power of attorney or a court-appointed legal representative of an adult), coercive measures that restrict or eliminate freedom may only be performed with the representative's consent. Any such measures may be carried out only if the patient is incapable of insight or judgment, if he is a serious danger to himself, and if the danger cannot be remedied by any other less drastic means. If the patient is to be *deprived of freedom by being placed in an institution*, or if his freedom is to be *restricted in another way* on a regular basis or for a significant period of time, then approval from a court based on an expert psychiatric evaluation is required, except in emergencies.
- 33) The German state legislation relating to involuntary commitment and mental illness (*Psychisch-Kranken-Gesetze*), respectively, permits the *involuntary commitment* of a mentally ill person not only for the protection of others, but also for the protection of the person herself,

provided she is putting herself at great risk and the imminent harm cannot be averted in any other way (crisis intervention). So-called civil commitment is initiated by the relevant administrative authority and must be approved by a court on the basis of an expert psychiatric evaluation. In addition, there are state laws governing the use of *further measures depriving the patient of liberty* while committed. The Federal Constitutional Court has recently demonstrated the need for extensive reform in this area.

- 34) Generally speaking, medical treatment may be performed only with the patient's consent, or in the absence of his consent only with his legal representative's consent, or in the case of an emergency based on the presumed will of the patient. Physicians are required by civil law as well as professional regulations to maintain records of all measures and results pertaining to the patient's treatment.
- 35) Regarding the special circumstances of overriding a patient's natural will by coercive treatment, none of the laws in effect at the beginning of the present decade fulfilled the appropriate human rights and constitutional rights standards, as determined by the Federal Constitutional Court, the *Bundesgerichtshof* (Federal Court of Justice), and other German courts. In some German states, the relevant state legislation lacks regulations regarding coercive treatment altogether to this day. However, most states have reformed their legislation in this area. The question whether these new regulations do meet the required fundamental rights and human rights standards is still contentious.
- 36) When it comes to psychiatric practice, the *guidelines* published by the relevant expert bodies are of great significance. They are formulated based on the most up-to-date scientific knowledge and aim to provide security and orientation to the professionals administering care. While physicians themselves remain crucial to identifying the most suitable treatment in each individual case and taking responsibility

for their choices, the guidelines are widely accepted by medical professionals and thus form an important contribution to the realisation of good clinical practice.

- 37) When making ethical judgments regarding benevolent coercion in psychiatry, it is not enough to consider individual actions or courses of action in isolation. Rather, the personal attitudes and opinions underpinning the actions as well as the concrete decision-making procedures and communication processes must be taken into account. Moreover, each patient's specific situation should be considered when evaluating particular measures. Finally, the preconditions for benevolent coercion to be morally legitimate cannot be defined in abstract or general terms, but rather are the result of concrete lines drawn by individuals who need to justify their choices. Therefore, the use of benevolent coercion must be subject to a *procedure of scrutiny involving multiple steps and criteria*.
- 38) From a normative point of view, it is important to distinguish between a care recipient's right to the restoration of his mental health and assuaging of his mental suffering and his rights to self-determination, humane treatment, and equal participation in society. Based on these distinctions coercive measures may be indicated as part of appropriate psychiatric care if there is good reason to assume that they can avert the danger of a patient causing serious harm to himself while lacking a fully responsible will and that they can restore his mental health. Here, the benevolence of the measures taken must be assessed both in terms of mitigating the patient's current subjective and objective suffering and of preserving his interest in a life free from mental illness and his options for leading a self-determined life and participating equitably in society.
- 39) It is a necessary precondition for coercive measures to be legitimate that *the patient's capacity for self-determination* has been assessed and it has been ascertained that she is incapable of originating fully

responsible decisions or actions in the given situation because her capacity for self-determination is impaired. However, neither the mere fact of a psychiatric illness having been diagnosed nor the possibility or necessity of treating it as determined from the point of view of psychiatry in and of themselves imply that a person's capacity for self-determination is impaired. Similarly, refusing medical treatment should not instantly be interpreted as a sign of an impaired or absent capacity for self-determination. Rather, it must be determined in each individual case based on the given situation and the problem to be addressed whether or not someone's capacity for self-determination is compromised. Furthermore, a specific justification must be given for why this prevents the care recipient from originating fully responsible decisions or actions in this concrete situation.

- 40) Situations can occur, especially in psychiatry, in which coercion applied against someone's evident will is judged to be benevolent by the standards of third parties but is experienced as traumatic on the part of the recipient. These individual responses to coercive measures must be factored into the overall evaluation of the benevolent aims that can realistically be accomplished because they can counteract the intended purpose of the measure and undermine the patient's trust in the medical field and/or his social environment. This is especially important in the case of patients with chronic mental illness where the goal of restoring their health becomes less and less relevant because it is most likely unachievable. Instead, individuals in this category should be given the opportunity to lead a life that is acceptable to them, including equal participation in society, despite having a more or less debilitating mental disability.
- 41) An important means of ascertaining a patient's will is an *advance declaration of will* (e.g. an advance medical directive). From a medical and ethical point of view, the patient should receive appropriate counselling from a physician and then make a joint decision about the future course of action to be taken in case of illness or loss of the

ability to give consent. These wishes should be set down in a medical directive. Drawing up such a directive also serves as an expression of a cooperative relationship between physician and patient and of mutual respect. It can form a suitable basis for conversations between physician and patient in future crisis situations and can thereby help to prevent or reduce the use of coercive measures.

- 42) One of the primary goals of treating psychiatric illnesses is to enable patients to handle their illness as well as any conflicts or crises that may occur in such a way that they can master their affairs and their daily lives according to their own standards. Therefore, a *therapeutic approach beholden to human dignity* is geared towards the patient as a person; the patient must always be included in the treatment process as an active participant. The use of coercive measures to treat the mentally ill inherently conflicts with this requirement. Even if coercion is justified in a specific, exceptional situation, this does not mean that it may be used again in subsequent crisis situations without a thorough assessment. Rather, the use of coercion presupposes in every single case that the temporary restriction of freedom which it involves is undertaken with the realistic expectation of overcoming crises that might lead to self-harm, of resolving conflicts, restoring the patient's control over her actions, and especially promoting – or preserving, if necessary – her capacity for self-determination and participation in society in the long term. In the realisation of such a person-centred approach coercive measures can only ever be acceptable temporarily. In any case, it is necessary to convey the long-term perspective to the patient from the beginning, and to examine jointly in hindsight whether the use of coercion did indeed contribute to her self-determination and participation and was therefore justified.

Benevolent coercion in the care of children and youth

- 43) Child and youth support services encompass a broad spectrum of types of social work spanning general support for children, youth, and their families (e.g. daycare centres, services and activities for youth, and family education), specific help with child rearing in special circumstances (e.g. if the parents' child-rearing capabilities are limited), and so-called intensive educational measures, which in especially dramatic crisis situations include committing adolescents displaying extremely challenging behaviour to a closed ward. The paramount principles informing the structure of child and youth services are (a) *preventing* the development of precarious biographies in children and youth, (b) *integrating* the individuals concerned into society while preserving their unique character, and especially (c) allowing children, youth, and their parents or families to *participate* in the planning and execution of professional help.

The welfare of children and youth is at the centre of child and youth services. It must be secured and promoted through targeted educational interventions, for instance by facilitating the unfolding of an individual's developmental potential. If decisions have to be made about the medical treatment of minors, these are the parents' responsibility in principle. However, children do have the right to participate in any decisions affecting them in the form of having their opinion heard and taken into account.

- 44) The child and youth services run by the state have undergone fundamental change over the last few decades. Until the 1980's, the dominant approach in the field was focused on deficits, so that "difficult" children and youth were usually perceived as abandoned or neglected, evading work, or delinquent. In the course of the *educational turn*, the coercive nature of the "total institution" of the care home came to be scrutinised critically, and alternatives based on progressive educational ideas started springing up, e.g. alternative child care centres, shared houses for adolescents, and other forms of assisted living

arrangements. Approaches of conforming education to the attributes and needs of children gained increasing acceptance. The pedagogical measures based on these ideas build on the existing skills and developmental potential of the child or youth and take special care to honour their right to self-determination and participation in decision-making processes in an age-appropriate way. The chief purpose of these reforms was the restoration of the essential core of all educational interventions: to establish relationships between educators and children or youth that are characterised by mindfulness and trust and are therefore sustainable. Interventions are always embedded in an interactive relationship between an educational professional and the individuals under his care.

- 45) Like punishments, the coercive elements of an educational intervention often form the sobering climax of an escalation, as inevitable as they may appear in an acute crisis. In addition to their antecedents, such interventions have an aftermath that threatens to counteract their intended effect. Coercion can damage or destroy the educational relationship, which depends on mindfulness and trust, because it often leaves children and youth experiencing themselves as the mere object of devaluing or humiliating treatment. If care recipients respond with severe opposition, professional caregivers are often overwhelmed, especially if there are not enough staff in a given situation to provide individual responses to the problems at hand. This increases the danger of further escalation. Hence, coercive measures often have the opposite effect of how they were intended; they don't succeed at diminishing challenging behaviour and calming the situation down.
- 46) The same holds for professional educational relationships, which are often confronted with a *pedagogical paradox*, since aiming to promote a sense of responsibility and self-determination in children and youth across the course of their development sometimes requires educational measures that override the child's current level of self-determination and thus seem to counteract the original educational goal.

These measures include all forms of coercion. However, forgoing these measures entirely equally detracts from the aim of educational interventions, namely promoting children and adolescents' development into fully responsible personalities. This aim presupposes being sensitive to their specific experiential world and surroundings. At the same time, it necessitates changes in their daily routines. Developmental processes have to be instigated, sometimes against the child's or youth's opposition.

- 47) Occasionally, *different professional perspectives can collide*, for instance regarding the involuntary commitment of adolescent care recipients to youth institutions, because here child and adolescent psychiatrists play an important role alongside the educational experts. The former evaluate the individuals to be committed and are responsible for any supportive treatment that may be necessary during their stay. However, educational and psychiatric expert bodies differ in their assessment of the necessity of this kind of commitment. From the point of view of child and adolescent psychiatrists, even medium and long-term measures that deprive the recipients of freedom often turn out to be necessary and useful, at least for children and youth who have certain risk factors, such as an unstable or conflicted social environment, a history of failure in different youth institutions, or on-going substance abuse. In contrast, educational expert bodies tend to highlight novel methods for dealing with "difficult" children and youth based on cooperation and respect, which in their view are successful.
- 48) In part, the different logical frameworks for arriving at knowledge and action found in educational versus psychiatric approaches result from the different situations in which they are used. Child and adolescent psychiatrists mainly operate in acute crisis situations in which urgent help is needed. Hence they obviously concentrate on psychopathological disturbances and mainly employ scientifically validated therapeutic interventions. On the other hand, child and youth services in the field of social education focus on the long-term

care and support of children and youth in difficult life situations, as well as the sustainable development and promotion of the care recipients' own resources so that they can shape and master their lives successfully. Consequently, both perspectives are professionally valid. The tensions that tend to arise between them must not be resolved in favour of one of the two poles. Problems in this area usually occur because a collaboration based on mutual understanding could not be established and the accomplishment of the fundamental goals is being made more difficult or even impossible by interventions from the other "camp".

- 49) In virtue of the *specific triangular relationship* between the child or youth, her legal representative (usually the parents), and the state authorities exercising their duty to protect the child, the different forms of coercion in the context of child and youth services have one feature in common. Due to the primacy of parental care, any intervention affecting the child or youth requires the representative's consent. This can result in problematic constellations: In order to divest a benevolent professional intervention of its coercive nature, age-appropriate consent from the child or youth as well as the parents' consent are required. If both are lacking, then the measure is as it were doubly coercive: it is coercive towards the child or youth whose welfare is at stake, and towards the parents, who are equally bound to care for and serve the child's welfare. Even if the representatives consent to the measure out of their own free will, their consent does not negate the coercive nature of the measure since it still overrides the will of the child or youth in question.
- 50) *Intensive educational approaches involving coercive measures* represent a special form of coercion used in child and youth services. These approaches are often part of a firmly established and, more importantly, easy-to-understand system of privileges enacted in residential youth institutions to modify behaviour. There are two kinds of systems of privileges: point and level systems. In a point system, the child or

youth “earns” points for specific kinds of behaviour, which are added up over time and can then be exchanged for desired things or activities. In a level system, rule-conforming behaviour is rewarded by advancing to another level that includes more privileges, while rule violations are punished by getting relegated to a lower level with fewer privileges.

Another intensive educational measure that is coercive in nature is the use of time-out rooms. These so-called “crisis rooms”, “calm-down spaces”, “isolation rooms”, or even “reflexion chambers” are used to isolate a child or youth for a certain amount of time in order to calm them down and terminate their challenging behaviour. Such intensive educational approaches are unjustifiable because they lead to experiences of powerlessness on the part of the child or youth and to external compliance based on resignation, thereby defeating the original benevolent intentions.

- 51) The *welfare of children* is the central concern of the law governing the use of benevolent coercion in child and youth services. This concern manifests concretely in the rule of attempting to avert all forms of danger to life and limb, and especially of fostering the child’s development and molding him into a responsible and autonomous personality capable of living in a community. The framework for securing and promoting the child’s welfare mainly rests on these basic presuppositions, namely, the substantial requirements to respect the child’s subjectivity and individuality as well as his right to be raised non-violently, and the structural requirements set down by the relevant human rights legislation, articles of the Basic Law, and sub-constitutional legal regulations which establish the primacy of parental care and the state’s mandate of watching over children.
- 52) Children and youth must be included as participants in any measure taken by public child and youth services in accordance with their current level of maturity. They have their own right to receive counselling, to be taken into care, and – provided they are entitled to services

– the right to express wishes and make choices. If support for child-rearing and integration into society is needed, children and youth should receive counselling and participate in the development of a roadmap for the interventions.

- 53) One of the essential elements of the welfare of children is their legally protected *right to be raised non-violently*. When bringing up children one must encourage them to respect others; therefore one obviously must not engage in degrading treatment towards the child oneself. This principle entails certain restrictions regarding the use of coercion when enforcing parental commands or prohibitions. For instance, coercive measures must not cause emotional wounds and must not be of a degrading character. When it comes to state authorities, the dictate of non-violence and the principle of respect for the child are even more obligatory, especially for youth services (either statutory ones or private ones commissioned by state authorities). However, state authorities can only take action if and to the extent to which the child herself, her guardians, or a court order has instructed them.
- 54) According to the Basic Law *parents have the right as well as the duty to care for their child*. They are responsible for the child's welfare. Therefore, in principle, acts of care involving benevolent coercion may be used in child and youth services only at the parents' request and within the scope of their authority. If an act of care involving benevolent coercion is opposed to the parents' will, it is only permissible if and to the extent to which interference with the parents' primacy of care is authorised by the state's duty to watch over the children. Consequently, parental care fundamentally serves as a protective shield for the child, even if the proposed measures are, or are meant to be, benevolent. The state becomes involved in its function of watching over the family if the child's welfare is in jeopardy or if either the parents or the child request an intervention. The primary duty of the state consists in enhancing the parents' competence as caregivers, for instance

by offering child-rearing support. The state only has the right to intervene in parental caregiving if support measures are unlikely to succeed and the child's welfare would otherwise be in jeopardy.

- 55) Coercive measures are often experienced as humiliating by the child or youth in question. In addition, far too little is known about the long-term consequences of using coercion in child and youth services. However, obtaining empirical evidence would be a necessary, albeit not a sufficient condition for the moral justification of restrictions or deprivations of liberty and of restrictive or confrontational educational approaches in the field of child and youth services.
- 56) The specific problem with justifying coercion in child and youth services consists in acknowledging the legitimate and indeed imperative goal of helping the child or adolescent develop into a fully responsible person, while on the other hand not treating him as an instrument in the service of that goal in concrete situations, which would violate his dignity. This holds for all forms of benevolent coercion in professional educational constellations, i.e. bodily coercion, restricting or depriving someone of liberty, intensive educational approaches involving coercive elements, as well as coercive therapeutic measures.
- 57) Only if the child or youth is not (yet) capable of full responsibility can benevolent coercion ever be justified. It has to be ascertained in each individual case and context whether the child or youth is capable of making fully responsible decisions, bearing in mind that this capacity may already exist in minors. A general rule based on age ranges, while set down in law for good reason, is not appropriate for ethical evaluations because it does not do justice to the child's or youth's individuality. Determining whether the capacity for full responsibility is present or not can often be difficult, especially in the case of adolescents. Nonetheless, it must be assessed all the more carefully and conscientiously, and the reasons for one's assessment must be made transparent.

Benevolent coercion in nursing and disability care

- 58) Coercive measures are also used in professional nursing towards people requiring a high degree of assistance, support, and care. This category includes individuals with complex special needs and elderly people who are dependent on care. These two groups of people are affected not only by measures restricting their freedom but also by educational or rehabilitative measures intended to activate them which are performed against their will. Another shared attribute of these groups is that they tend to live in care homes where they are subject to structural coercion. However, this type of coercion is not covered in this Opinion.
- 59) For the elderly the significance of benevolent coercion increases, especially if they are dependent on care. Coercion used to suppress deviant or obnoxious behaviour, e.g. of individuals with dementia who are dependent on care, is often justified by reference to these patients' welfare and the care required to maintain it. In situations in which a decision has to be made for or against a nursing patient's self-determination, caregivers are often worried that they will incur guilt for failing to care sufficiently for a dependent patient, or that they will be held responsible if, for instance, a nursing patient is injured in a fall which could have been prevented by bedrails. This can drive caregivers to employ measures that deprive patients of liberty or to enforce acts of care coercively.
- 60) The fields of elderly and disability care have also seen a shift in their professional self-conception from an *orientation focused on deficits to one focused on competencies*. This can cause conflicts if staff or relatives are leaning towards the competency-based approach to old age while the patient herself holds the deficit view. Caregivers might try to enforce particular exercises or activities for training and rehabilitation against an elderly person's will because from a professional point of view they serve to preserve or promote skills, self-determination,

participation, and quality of life. Yet many elderly people reject such measures based on the belief that positive change is not possible in old age.

- 61) With respect to helping elderly people with disabilities be more active, it must be noted that these individuals' biographies often include comprehensive care but little or no encouragement to develop independent initiative and self-determination. Often these persons were even considered "unteachable". The reason for this is that until well into the 1990's, many of the institutions providing care for the disabled were following an approach of "provision and care" rather than one of fostering resources. As a consequence, certain forms of dependency such patients exhibit were (and still are) the result of institutional practices. In particular, elderly people with special needs do not always receive the right incentives to be active that might be feasible given their potential for plasticity.
- 62) Regarding the living situation of the elderly, moving into a residential institution can become an important matter, especially if the person's family does not have sufficient resources to care for them at home (anymore). Elderly people often experience this move as being forced on them against their will. This problematic constellation cannot be solved merely by expanding the range of ambulant and part-residential types of care. In addition, families must consider the question how the care of elderly family members should be handled in good time and must determine what kind of arrangement they prefer.
- 63) In principle, the legal regulations governing professional acts of care involving coercion in service of the recipient's welfare are the same in the context of elderly and disability care as they are in the treatment of the mentally ill. The basic rights and human rights of people who are dependent on care entail their right to appropriate medical care and nursing aimed at mitigating their suffering and restoring their health. Coercive measures might be indicated in this context if the patient

is no longer capable of grasping the necessity of a particular treatment or of acting accordingly and if no other alternatives are available. Nevertheless, state authorities are obliged to prevent any and all abuse of coercive measures by means of protective legal mechanisms, and to reduce their use to the absolute unavoidable minimum.

- 64) The task of carrying out the work of nursing and care in a way that serves the recipients' welfare encounters limitations not only in dependent patients' resistance to particular benevolent acts, but also in the professional caregivers themselves. Their working conditions, especially in elderly care, are characterised by a high workload, understaffing, and dissatisfaction with how the work is valued, low pay, and a lack of career opportunities. Professionals in this field describe themselves as overstretched and emotionally exhausted.
- 65) Professional nurses should determine carefully in each individual situation whether the quality of self-determination articulated by a nursing patient positively falls below the threshold of a fully responsible volitional process, whether there is well-founded reason to doubt their full responsibility due to specific impairments of their health or cognitive functions, or whether a patient's will is fully responsible beyond reasonable doubt, at least in a given context of action.
- 66) Institutions providing elderly or disability care often have *complex structures of responsibilities*. Thus, in order to prevent responsibility for existing shortcomings from being prematurely attributed to a single individual, or alternatively to the organisation running the institution or to the care system as a whole by overgeneralisation, it is necessary to conduct a detailed analysis of the coercive acts in question in order to identify their actual causes, which are often multi-layered.
- 67) Especially in the field of professional care of the elderly and the disabled, the characteristic *volatility* of these individuals' processes of determining and articulating their own will must be taken into account.

Their will can exhibit different degrees of autonomy and determinacy at different times. Hence manifold ambivalences, ambiguities, and gradations are to be expected.

- 68) Coercion always begins in the mind of the person who feels entitled, or even obligated, to perform particular coercive measures. Especially if professional caregivers have a one-sided, deficit-focused view of old age and disability, they tend to overlook or underestimate the resources that are in fact available to the care recipient for determining and articulating her will independently. For the same reason, they can inadvertently strengthen existing dependency relationships through their acts of care (even though these are often altruistically motivated). This is closely tied to a disregard for the high variability of the phenomena of old age and disability. Honouring the unique life history of each nursing patient demands not only acknowledging their individuality, but also encountering them with respect. This includes taking the patient's articulations of his will seriously as part of his welfare even if the process of will formation is impaired or leaning in a direction which runs counter to the caregivers' notion of a well-lived life.
- 69) As desirable as it may be to preserve and foster the potential for action and self-determination in nursing patients, one has to guard against overlooking their changing needs or withdrawing from them in case the successes desired by caregivers do not materialise. The respect due to old and disabled people must not be conditional upon the caregivers' expectations of how these individuals should be performing, but must be reliably granted to every human being until their death. In cases of nursing patients who suffer from illness, social isolation, or neglect, motivating them to participate in measures that help them to be more active may be difficult initially, although these activities may seem necessary to staff to restore, preserve, or develop the individual's resources. In this situation the whole range of motivational techniques using positive incentives and reinforcement should first

be employed. More forceful efforts of getting a nursing patient to be active despite their repeated refusal already fall under the umbrella of coercion as understood in this Opinion. Such efforts should only be made on the condition that they have been explained to the patient in a comprehensible way before being undertaken and are subject to critical monitoring. It is important for the nursing patient to develop a discernible, sustainable motivation to continue with the activities of her own accord not too long after the beginning of their implementation based on the beneficial effect she perceives the activities to have on her subjective well-being. Conversely, this implies that enforced activities which the recipient continues to reject over a significant period of time are not justified, even if professionally considered they would most likely benefit her state of health.

- 70) So-called *mechanical measures that restrict freedom* must be subject to in-depth scrutiny which should investigate whether alternative forms of action are available in principle and whether the actual means employed are commensurable with the situation. Further, the degree of invasiveness, frequency, and duration of the interventions must be taken into account, as well as their concrete impact on the patient's self-experience and on their level of trust in the caring environment. Generally, the required degree of justification increases in proportion to the degree of invasiveness, frequency, and duration of the coercive measures employed.

Bodily restraints in particular – for instance being strapped to a bed or chair – not only pose a significant risk of physical harm through injury or strangulation, but can also violate the nursing patient's dignity due to their traumatising effects. Therefore, using such measures on a regular basis is out of the question. However, even in the case of less dramatic restrictions of bodily movement – which range from bedrails, bedside tables, removing walking frames or other physical aids, to installing trick locks or keeping doors locked – it must be carefully determined whether these measures do in fact serve the recipient's welfare rather than merely making the caregivers' life

easier or protecting third parties, and whether there really is no alternative. Given the inherent safety risks of bodily restraints, it must be assumed that in the majority of cases mechanical restraints – the use of which is in decline, though still far too frequent – have no plausible ethical justification.

- 71) When it comes to using psychotropic medication in order to *restrain* residents in care homes for the elderly or disabled *via medical or chemical means*, the possibility cannot be excluded that the use of such medications may be medically indicated in certain acute situations of intense or extreme agitation, suicidal tendencies, or depression, and that they might mitigate the patient's suffering considerably despite his occurrent incapacity to consent to the treatment. However, due to the significant degree of invasiveness of this type of intervention and the risk of changes to the recipient's personality, especially strict criteria of diligence must be applied to the concrete diagnosis, determination of medical indication, and dosage of the medication, as well as to the regular reassessment of the necessity of continuing the treatment. In care facilities, psychotropic medications are commonly prescribed abusively, i.e. without a personal assessment of the patient and without close monitoring of their individual state of health. These medications can have countless negative side-effects impairing the waking state and the health of vulnerable patients who usually already have been suffering from multiple kinds of damage prior to receiving this treatment.
- 72) When participating in coercive measures, professional caregivers often experience significant *uncertainty about their actions* as well as *moral conflicts*. On the one hand, they feel obligated to respect others' declarations of will and to care for the welfare of the patients for whom they are responsible. On the other hand, the will of the person in question may be impossible to determine, it may vary significantly depending on their state on a given day, or it may run counter to the standards which from a professional perspective constitute good

care. Professional caregivers often have to make far-reaching decisions under time pressure and under conditions of lacking important knowledge (e.g. about the patient's will, the actual consequences of particular actions, or the probability of harm occurring). Further, even tried and tested moral principles have to be applied freshly each time based on an individual's judgment and the unique circumstances of a given situation. Consequently, strengthening caregivers' faculty of judgment, e.g. by implementing ethical support services, is particularly important.

- 73) The non-negotiable goal of minimising the use of coercive measures as much as possible must not be understood to be the responsibility of individual caregivers. Rather, a sustainable reduction of overt and covert coercive measures presupposes *increased efforts on the professional, cultural, and legislative levels*. As important as it may be to establish an appropriate framework of (social) legislation in order to provide the necessary financial resources and staff in the field of nursing and care, one must guard carefully against assuming that unjustified coercive measures can be eliminated simply by using financial or legal instruments. Even sanctions imposed by criminal law run the risk of merely causing a shift to a different technique of coercion rather than substantially reducing the amount of coercion that actually takes place, unless they are accompanied by genuine change in the attitudes of professional caregivers and corresponding innovations in the policies, procedures, and communication processes employed at care facilities.

>> PRINCIPLES AND RECOMMENDATIONS

A. Universally applicable principles and recommendations

A1. In professional caring relationships, using coercion to prevent the recipient from harming him- or herself should be avoided whenever possible. If a coercive measure must nonetheless be considered, the context of the act must be moulded in such a way that esteem and respect for the individual and their self-determination are reliably maintained. Allowing recipients of care to participate to the greatest extent possible in all phases and situations of professional care that involve benevolent coercion is an immediate expression of this esteem and respect. The principles and recommendations for the use of benevolent coercion in professional caring relationships stated below presuppose that it is being used as a last resort. This has two implications. First, these recommendations are intended to contribute to the development of frameworks, structures, and processes which allow coercion to be avoided whenever possible. Second, they are meant to provide well-founded orientation in situations of acute crisis or distress of the care recipient in which using coercion as a last resort is an acceptable option.

A2. Coercive measures may only be considered if the recipient's capacity for self-determination is impaired so severely that they are incapable of making fully responsible decisions. Neither having been diagnosed with a mental illness or cognitive impairment, nor being a minor, nor refusing a measure that may be medically indicated in and of themselves preclude the existence of full responsibility. Instead, it has to be determined in each concrete situation whether a sufficient capacity for insight, judgment, or action regarding the proposed measure is present. If this cannot be established beyond reasonable doubt and the uncertainty cannot be resolved, the evidence for and against the presence of full responsibility must be weighed, and a clear preponderance in favour of its probable absence must be found. The criteria for establishing the presence of the required capacities for insight, judgment, and action which constitute full responsibility must be specified and developed in a transdisciplinary fashion.

A3. Coercive measures are only permissible if they aim to develop, promote, or restore the recipient's capacity for leading a self-determined life within the context of the available possibilities and the physical and psychological preconditions essential to this aim. This holds true even if the capacity to act with full responsibility can no longer be achieved.

A4. If a particular measure is to be implemented coercively, both it and its coercive implementation must be indicated from a professional (medical, educational, nursing, etc.) point of view. Coercive measures are indicated only if the recipient is at high risk of causing serious harm to herself.

A5. Coercive measures may only be carried out if they are suitable, necessary, and appropriate for their purpose. In this regard, the following considerations must be taken into account:

- » Before enacting any measure coercively, an attempt must have been made to obtain voluntary consent or cooperation from the recipient of the measure. This includes providing sufficient information and trying to motivate the recipient in an appropriate and considerate way

to voluntarily cooperate with the measure or at least permit it to be performed. The recipient must be given the opportunity to shape the circumstances and the execution of the measure in a way that makes it acceptable from his point of view.

- » If the use of a coercive measure is being considered, all other less invasive means at one's disposal that could accomplish the same goal must have been exhausted. The chosen form of the intervention must put the least strain on the recipient and pose the least danger of secondary harm (e.g. humiliation, traumatisation, or loss of trust). All direct and indirect negative consequences must be factored into this assessment. Moreover, it must be ensured that the duration of the coercive measure is as short as possible and the risk of harm, including possible (re-)traumatisation, is minimised.
- » The expected benefit of the coercive measure for the recipient must significantly outweigh the drawbacks experienced by her. When gauging this ratio, both the current and the future welfare of the recipient must be taken into account. This frequently involves difficult judgments and trade-offs. These must substantially incorporate the recipient's perspective, including her fears, needs, wishes, and personal circumstances.

A6. Efforts must be made to maximise the care recipient's participation. The intended goal and execution of the measure must be explained to her in a manner that is appropriate to her personal capacities and situation. Further, her opinion must be adequately taken into account and she must be given the opportunity to participate as much as possible in any decisions regarding the concrete implementation of the measure.

A7. All coercive measures must be debriefed with the recipient. The reasons for taking the measure(s) in question must be explained and discussed with him. The recipient's responses must be heard, not least to allow him to process what he has experienced. If the recipient is a child or youth, they should receive the age-appropriate care and support necessary to allow them to participate optimally in any decisions about the measure and its execution. In case of individuals who are mentally ill or cognitively

impaired, assistance with participating according to their specific impairments must be offered.

A8. Any measure may only be performed coercively if the recipient would share the goal of the measure were she currently able to make fully responsible decisions or if she would judge it to be right and necessary in hindsight. In order to determine her presumed will, her past declarations of will and any other available information containing clues to her will and preferences must be considered.

A9. In general, it is the responsibility of the care recipient's legal proxies – especially his parents or other guardians, healthcare proxies, or legal guardians – to establish his will or presumed will and enforce it. Only in emergencies may a professional caregiver who is ordering or implementing coercive measures assume this role. Therefore, the recipient's legal proxy must be involved in the decision-making process in good time. If this is not possible, he must be notified after the fact.

A10. Insofar as can be done professionally, a concrete set of criteria should be developed which can justify the use of specific coercive measures in particular situations. Professional standards for the implementation of these measures must be established in order to make decision-making processes more objective and minimise the use of coercion. The expert bodies responsible for this should formulate appropriate professional instructions for making decisions about, and for the justification of, specific coercive measures. Further, they should raise awareness of these problematic actions in their members.

A11. Coercive measures that are especially intense or long-term, such as depriving someone of liberty by committing them to a closed institution or ward, or applying coercive treatment over a period of time, may only be performed if the above-mentioned prerequisites have been established as fulfilled in advance by an external and impartial entity, e.g. a court of law, possibly based on an expert evaluation (this does not include emergencies

which do not permit delays; emergencies, however, still have to be appraised retroactively). Furthermore, procedural safety mechanisms have to be in place (e.g. procedural attendants, guardians ad litem, or patients' ombudspersons).

A12. It must be ensured that the duration of any coercive measure is as short as possible. In addition, the recipient of the measure must be monitored at appropriate, regular intervals in order to determine whether the prerequisites for using coercive measures still obtain.

A13. Recipients of care must be involved in the planning and implementation of measures aimed at preventing coercion. Any other participants in the process – e.g. professional caregivers, parents or guardians of children, legal representatives of adults acting under a power of attorney or appointed by a court, courts of law, relatives, care-related organisations, ombudspersons, etc. – must also be included. More effective communication among the participants should be encouraged with the aim of coordinating both their efforts to avoid coercive measures and the course of action in the event of coercion having to take place.

A14. Existing policies and procedures regarding quality management, including error reporting systems and complaints management, should also cover coercive measures.

A15. Due to their exceptional character coercive measures must be carefully documented and evaluated at regular intervals. Documentation must include not only information about the purpose, reasons, extent, and course of the coercive measure that was implemented, but also a subsequent evaluation by the recipient of the measure, if possible. This is necessary in order to assess the impact and adequacy of the measure and to clarify grey areas.

A16. Institutions as well as courts of law and other authorities that deal with coercive measures should be required to collect anonymised information about the actual incidence of these measures. This data should be

made publicly available for scientific and statistical purposes as part of quality management, and to keep the general public informed.

A17. All staff involved in coercive measures should be professionally trained, as is already mandatory in parts of the field. Training courses in the prevention of coercion and violence, e.g. deescalation skills, and information about patients' rights are especially important in this regard.

A18. Maintaining a respectful attitude towards people suffering from mental illness, children and youth, and nursing patients is an essential precondition for averting coercive measures. This attitude encompasses sympathy for the care recipient's precarious situation and openness to her physical, psychological, cultural, and religious needs as well as her need for participation and involvement. Professional caregivers must be given many opportunities, both during their vocational training and as qualified professionals, to develop and practice this respectful attitude. Reliably ensuring an appropriate staff-patient ratio is a necessary precondition for this.

A19. Cultural and language barriers between professional caregivers and the recipients of care can increase the likelihood of coercive measures being employed. In order to prevent such outcomes, caregivers' intercultural competencies should be fostered. Further, structures minimising cultural and language barriers should be established, e.g. hiring bilingual or bicultural staff, providing easy access to interpreting services, or improving staff communications through continuing education programmes.

A20. Professional caregivers who have participated in coercive measures should receive support and supervision in order to cognitively and emotionally process their own experiences in exercising coercion. This support should be offered by their institution. Such procedures not only benefit the caregiving staff but also help to minimise the use of coercion.

A21. In hospitals with psychiatric wards, care homes, and child welfare authorities, institutionalised staff committees should be established to

evaluate the use of coercion prospectively and retrospectively. Conferring among colleagues in this way should serve the purpose of making intellectually well-founded and responsible decisions about using coercive measures to prevent a patient from harming himself (e.g. ethics consultations in a hospital), as well as reflecting on and evaluating the use of coercive measures retrospectively (e.g. case conferences at a public authority).

A22. The supervisory authorities in charge of an institution should examine in each concrete case whether the use of coercive measures was justified, and they should have the power to sanction unjustified uses. Salary schemes that abet the use of coercion through misguided incentives must be corrected.

A23. Research into the actual incidence and impact of coercive measures as well as their causes, prevention, and possible ways of averting them should be promoted. In particular, this should include research on informal and structural coercion and the uncovering of covert instances.

A24. The general public should be made aware of the ethically and legally problematic aspects of using coercive measures against the mentally ill in crisis situations, children and youth from difficult social and familial backgrounds, as well as the elderly and disabled dependent on care. Here, the media have an important role to play by reporting on the topic in a manner that is appropriate and does justice to its complexities.

B. Principles and recommendations – psychiatry

Regarding the care of the mentally ill, in addition to the above-mentioned universal principles the following considerations must be taken into account:

B1. Decisions about using a coercive measure to treat a patient should first be discussed in a cross-disciplinary team which includes the caregivers and

then be made jointly if possible, while observing the rule that the final responsibility rests with the treating physician and that obtaining a guardian's consent (parents or other guardians, proxies, or legal guardians) will usually be necessary. If the team cannot agree on how the patient's welfare is best to be served, whether she possesses the capacity to make fully responsible decisions, or what the least harmful means of treatment is, then guidance should be sought from a clinical ethics advisory service. In hospitals with psychiatric wards, the members of the hospital's ethics committee should be specially trained for this purpose.

B2. Advance directives or other advance declarations of will provide information about a patient's will and her preferences regarding possible future treatment and care. Institutions should educate patients about the possibility of declaring their will in advance and assist them in drawing up the corresponding documents, so that patients' wishes and preferences can be carried out more accurately in crisis situations and individual assessments of the use of particular (coercive) measures can be implemented more effectively as part of crisis management. In case of repeated bouts of illness, past experience of treating the patient as well as the patient's retrospective evaluation of these treatments must be consulted. If possible a medical treatment agreement should be created that can serve as a solid foundation for making decisions in the future.

B3. In-patient facilities should be designed in a way that facilitates the deescalation of conflicts, e.g. by creating retreat spaces, free spaces, access to a garden, or small wards. When planning buildings to house psychiatric care units such design requirements should be included.

B4. Patients should have the option of contacting an independent agency to make a complaint. This agency should provide counselling and support patients in asserting their rights. Patients should be informed of this service at the beginning of treatment. Institutions and their staff should be obligated to cooperate with the complaints bodies and inform patients of the results.

B5. The visiting commissions mandated by mental health legislation should be extended comprehensively to cover all regions of the country and to serve as an effective instrument for controlling the use of coercive measures in all institutions for the mentally ill. The scope of their authority should include not only coercive measures performed in accordance with mental health law but any and all coercive measures, independent of their legal foundation.

B6. The occurrence of crisis situations and the coercive measures they often entail can be reduced if psychiatric conditions are diagnosed and treated at an early stage. Therefore, low-threshold access to psychiatric care should be available across the country, for instance in the form of community-based mobile teams providing out-patient care and improved care for the mentally ill by general practitioners. Proactive support services for people with mental health conditions, e.g. offered by social psychiatric services or other forms of community-based care, should be extended and funded consistently. Further, mental health education for the individuals concerned and other services facilitating self-care and self-motivated prevention of future crises should be promoted, and peers (former patients) should be recruited to support patients in crisis situations by serving as recovery guides.

C. Principles and recommendations – child and youth services

Regarding the care of children and youth, in addition to the above-mentioned universal principles the following considerations must be taken into account:

C1. In order to render coercive measures in the care of children and youth legitimate, the parents' or other guardians' consent must usually be obtained. Without the consent of parents or guardians whose authority encompasses the proposed coercive measure, such measures may only be performed in emergencies in which the parents cannot be reached in

time, or if the parents themselves pose a substantial danger to the child's welfare.

C2. Coercion used against children and youth must not involve corporeal punishment, emotional wounding, or other degrading forms of treatment, even if the parents consent to it. The choice of treatment must be based not only on the idea of the person the child will one day become, but must always take her current wishes and needs into account as well.

C3. Coercive educational measures in the context of intensive educational approaches must be carefully documented and evaluated with respect to their impact and efficacy. This documentation must be made available to regulatory authorities.

C4. Reliable care should be provided for children and youth in foster families and institutions. Organisations running institutions for children and youth and public authorities responsible for child and youth services should collaborate in order to prevent individuals from having to change institutions or caregivers, and to enable support to continue beyond their 18th birthday. If a decision needs to be made about placing a child in a home or a foster family, or about returning her to her family of origin, the child's own will as an expression and component of her welfare must be included as a material consideration.

C5. Child and adolescent psychiatrists play an important role in crisis intervention, while child and youth services focus on long-term care and support of children and youth. Cooperation between these two groups should be improved with the aim of minimising the use of coercion. This includes coercive administration of psychotropic drugs, the use of which must be monitored by a specialist at regular intervals.

C6. Communities and public authorities responsible for child welfare services must be obligated to enable their staff to care for children and youth in an individual, intensive, and participative way, keeping the number of

cases per staff member to a professionally viable level. The administrative tasks of maintaining documentation and appropriate monitoring must not be completed at the expense of personal care for children and youth. Staff hours should be planned and adjusted accordingly. Public authorities responsible for child welfare services and organisations running institutions for children and youth should establish case conferences in order to confer with peers and formulate decision-making guidelines for difficult cases prospectively, and to reflect critically on the actual use of coercive measures retrospectively.

C7. The state guidelines for care homes for children and youth should enjoin all institutions and individuals involved to adopt the goal of minimising the incidence of deprivations of liberty through involuntary commitment (e.g. to residential homes) or through coercive measures based on intensive educational approaches. The supervisory authorities in charge of an institution should examine in each concrete case whether the use of coercive measures was or is justified. They should be able to intervene if it is not.

C8. Submitting a precis of a valid educational approach should be a mandatory requirement for care homes to be granted an operating licence. This precis should describe how the right of children and youth to be raised non-violently will be safeguarded. The actual implementation of the proposed approach should be documented and monitored by the relevant public authorities at regular intervals.

C9. Institutions should be funded at a level that makes educational approaches centred on children's rights possible.

C10. Institutions providing child and youth services should establish procedures for complaint management, allowing children and youth who wish to make a complaint to turn to a trusted adult within the organisation without fear of negative consequences. Complaints management needs to be documented, and the resulting decisions should be discussed with the

child or youth in question. In addition, easily accessible independent complaints bodies (ombudspersons) should be established across the country. Children and youth should be informed of the possibility of contacting an ombudsperson in any meetings they attend in which support measures are planned. In residential institutions, staff members of the complaints organisation should also proactively seek contact with children or youth who have been subject to coercive measures or are at risk of being subject to them.

C11. Every future reform of the laws relating to child and youth services should secure and strengthen the effective rights of children and parents to participate materially in any procedures in which support measures are planned.

C12. Further scientific research on different types of placement as well as on the impact and outcomes of different educational approaches and interventions should be conducted. Data should be collected on the incidence of coercive measures, the reasons for using them, their efficacy, and any negative consequences. In particular, qualitative data on the subjective experiences of children and youth should be captured. For this purpose suitable programmes for the promotion of relevant research should be formulated, e.g. by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth.

D. Principles and recommendations – senior care and care for the disabled

Regarding the care of the elderly and the disabled, in addition to the above-mentioned universal principles the following considerations must be taken into account:

D1. The elderly and the disabled usually require long-term care and support for their needs, which often increase over time. Therefore, caregivers

and therapists must take care to respect the dignity of this group of care recipients, even when the individual preferences of its members conflict with caregivers' professional self-conception.

D2. Persons with disabilities and the elderly themselves, as well as everyone involved in their professional and familial systems of care, should make the utmost effort to ensure that care recipients can make a self-determined, uncoerced decision to move into a care home. The planning skills required to act with sufficient foresight should be enhanced by preventive counselling.

D3. In order to minimise the use of coercion in elderly care, staff should be familiar with the symptoms and progressive course of geropsychiatric illnesses, especially dementia. They should be able to understand the specific symptoms, assess them, and treat patients professionally and respectfully. Continuing education and training should be obligatory.

D4. Mild forms of coercion are often a direct consequence of one-sided, deficit-oriented ideas of old age and disability and insufficiently questioned personal values and preferences on the part of staff. Therefore, continuing education and training fostering critical self-reflection in caregiving professionals is a material component of sustainably reducing and eliminating the use of coercive measures.

D5. Since psychotropic medication poses the risk of causing changes to a patient's personality, especially strict criteria of diligence must be applied to the required diagnosis, determination of medical indication, and dosage of these drugs. In addition, a specialist physician must reassess regularly whether it is necessary to continue the treatment. Care providers should document all forms of coercion including the administration of sedatives, and should implement measures to reduce their incidence.

D6. The facilities and staff requirements in institutions providing elderly or disabled care should be such as to allow for individualised care and

support of nursing patients and people with disabilities. In particular, to effectively avoid structural coercion the number of staff and their working hours should be determined based on the needs of the recipients of the care and support to be provided. In order to deescalate conflicts, sanctuaries and free spaces for residents as well as manageable care units should be created.

D7. It is not only the number, but also the attitude of professional caregivers and institutions that determines how nursing patients and the disabled are treated, and hence whether they are likely to be subject to coercive measures. The attitudes and moral concepts of caregiving staff have a material impact on their ability to perceive the needs of residents in care homes for the elderly or disabled. Therefore, the development of a respectful attitude in professional caregivers should be fostered, especially their capacity for mindfulness, sensitivity, and empathy, as well as the ability to reflect on their own values.

>> DISSENTING VOTE

In a dissenting vote, Franz-Josef Bormann expressed reservations regarding the central concept of full responsibility. In order to carry the normative load imposed on it, the term should have been defined more clearly in the Opinion.

Members of the German Ethics Council

Prof. Dr. theol. Peter Dabrock (Chair)
Prof. Dr. med. Katrin Amunts (Vice-Chair)
Prof. Dr. iur. Dr. h. c. Volker Lipp (Vice-Chair)
Prof. Dr. med. Claudia Wiesemann (Vice-Chair)

Constanze Angerer
Prof. Dr. iur. Steffen Augsberg
Prof. Dr. theol. Franz-Josef Bormann
Prof. Dr. med. Alena M. Buyx
Prof. em. Dr. iur. Dr. h. c. Dagmar Coester-Waltjen
Dr. med. Christiane Fischer
Prof. em. Dr. phil. habil. Dr. phil. h. c. lic. phil. Carl Friedrich Gethmann
Prof. Dr. rer. nat. Dr. phil. Sigrid Graumann
Bishop Prof. Dr. theol. Martin Hein
Prof. Dr. med. Wolfram Henn
Prof. Dr. iur. Wolfram Höfling
Prof. Dr. (TR) Dr. phil. et med. habil. Ilhan Ilkilic
Prof. Dr. rer. nat. Ursula Klingmüller
Stephan Kruij
Prof. Dr. phil. Dr. h. c. Dipl.-Psych. Andreas Kruse
Prof. Dr. phil. Adelheid Kuhlmeier
Prof. Dr. med. Leo Latasch
Prof. Dr. theol. Andreas Lob-Hüdepohl
Prof. em. Dr. iur. Reinhard Merkel
Prof. Dr. phil. Judith Simon
Prof. Dr. med. Elisabeth Steinhagen-Thiessen
Dr. phil. Petra Thorn

Office

Dr. rer. nat. Joachim Vetter (Head of Office)
Dr. theol. Katrin Bentele
Carola Böhm
Ulrike Florian
Dr. phil. Thorsten Galert
Steffen Hering
Christian Hinke
Petra Hohmann
Torsten Kulick
Dr. Nora Schultz