
Coercive Treatment in Psychiatry

Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects, First Edition.

Edited by Thomas W. Kallert, Juan E. Mezzich and John Monahan.

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**Editors: Thomas W. Kallert, Juan E. Mezzich
and John Monahan**

 **WILEY-BLACKWELL**

A John Wiley & Sons, Ltd., Publication

This edition first published 2011 © 2011 by John Wiley & Sons, Ltd

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Registered Office: John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Other Editorial Offices: 9600 Garsington Road, Oxford, OX4 2DQ, UK
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK
111 River Street, Hoboken, NJ 07030-5774, USA

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Library of Congress Cataloging-in-Publication Data

Coercive treatment in psychiatry : clinical, legal and ethical aspects / editors, Thomas Kallert, Juan Mezzich and John Monahan.

p. cm.

Includes index.

ISBN 978-0-470-66072-0 (cloth)

I. Involuntary treatment—Moral and ethical aspects. I. Kallert, Thomas W. II. Mezzich, Juan E. III. Monahan, John.

R727.35.C64 2012

174.2'9689—dc22

2010054029

A catalogue record for this book is available from the British Library.

This book is published in the following electronic formats: ePDF 978-0-470-97854-2; Wiley Online Library 978-0-470-97857-3; ePub 978-0-470-97865-8

Set in 10.5/13pt Times by Thomson Digital, Noida, India

First Impression 2011

Contents

List of Contributors	vii
Introduction	xi
<i>Thomas W. Kallert, Juan E. Mezzich and John Monahan</i>	
SECTION 1 Conceptual and clinical aspects of coercive treatment	1
1. Person-centred psychiatry perspectives on coercion and cooperation	3
<i>Juan E. Mezzich</i>	
2. Coercive treatment and stigma – is there a link?	13
<i>Wolfgang Gaebel and Harald Zäske</i>	
3. Mandated psychiatric treatment in the community – forms, prevalence, outcomes and controversies	33
<i>John Monahan</i>	
4. Is it possible to define a best practice standard for coercive treatment in psychiatry?	49
<i>Tilman Steinert and Peter Lepping</i>	
5. How to de-escalate a risk situation to avoid the use of coercion	57
<i>Dirk Richter</i>	
SECTION 2 Legal aspects of coercive treatment	81
6. Psychiatry and the law – do the fields agree in their views on coercive treatment?	83
<i>Julio Arboleda-Flórez</i>	

7. Reducing discrimination in mental health law – the ‘fusion’ of incapacity and mental health legislation	97
<i>George Szmukler and John Dawson</i>	
8. Mental health care and patients’ rights – are these two fields currently compatible?	121
<i>Thomas W. Kallert</i>	
SECTION 3 Ethical aspects of coercive treatment	151
9. Cross-cultural perspectives on coercive treatment in psychiatry	153
<i>Ahmed Okasha and Tarek Okasha</i>	
10. Historical injustice in psychiatry with examples from Nazi Germany and others – ethical lessons for the modern professional	161
<i>Rael Strous</i>	
11. Paternalism in mental health – when boots are superior to Pushkin	175
<i>Tom Burns</i>	
SECTION 4 Users’ views on coercive treatment	185
12. The moral imperative for dialogue with organizations of survivors of coerced psychiatric human rights violations	187
<i>David W. Oaks</i>	
13. Resisting variables – service user/survivor perspectives on researching coercion	213
<i>Jasna Russo and Jan Wallcraft</i>	
14. Seventy years of coercion in psychiatric institutions, experienced and witnessed	235
<i>Dorothea S. Buck-Zerchin</i>	
15. Coercion – point, perception, process	245
<i>Dorothy M. Castille, Kristina H. Muenzenmaier and Bruce G. Link</i>	
SECTION 5 Coercion and undue influence in decisions to participate in psychiatric research	269
16. Ethical issues of participating in psychiatric research on coercion	271
<i>Lars Kjellin</i>	
17. Coercion and undue influence in decisions to participate in psychiatric research	293
<i>Paul S. Appelbaum, Charles W. Lidz and Robert Klitzman</i>	
Index	315

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Introduction

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The relevance of coercive treatment for psychiatry has been underestimated for a long period in the history of this discipline. It is only within the last two decades that it has been viewed as an increasingly important area for clinical and research initiatives. There may be a number of reasons behind this change of interest.

First, it has become clear that clinical procedures summarized under the term ‘coercive treatment’ are still more frequent than desired. Recent international studies showed that from 3% (Portugal) to 30% (Sweden) of all psychiatric inpatient episodes consist of involuntary hospital admission of general psychiatric patients [1]; these rates vary by a factor of 10 internationally, leading to speculations about the impact of specific features of national mental health service configuration and mental health legislation. A time series from the 1990s in 15 member states of the European Union indicated an overall tendency towards more-or-less stable rates of 10 to 20% in most countries [1]. As shown in another European multi-site study, approximately one-third of legally involuntarily admitted patients are currently subjected to individual coercive measures such as mechanical restraint, seclusion or forced medication within the first four weeks after admission; again, variation across clinical sites is enormous and rates can be as high as 60% [2]. A broad and robust base of empirical knowledge on such elements of service provision does not exist, however [3].

Second, interest in exploring the issue of coercive treatment has expanded beyond the psychiatric hospitals and now concentrates on diverse institutionalized settings for patient groups with high vulnerability regarding the use of coercive measures, such as forensic mental health hospitals, old-age homes, long-term care homes for chronically severely mentally ill or mentally disabled persons, and also general medical hospitals [4]. In the era of deinstitutionalization and community-orientation of service provision, new legal and clinical concepts involving elements of coercion such as outpatient commitment and leverage [5,6] were developed; evaluating their effects is an increasingly important and challenging field of services research.

Third, the complex and internationally diverse linkage of all forms of coercive measures to mental health legislation has become a field which must be assessed in much more detail, in particular when new forms of coercive treatment are to be introduced and existing legal frameworks must be adapted to such needs (see Chapter 7) [7].

Fourth, coercive measures are more and more seen as a sensitive human rights issue, and recent internationally binding documents like the UN Convention on the Rights of Persons with Disabilities [8] have been published which emphasize this position. The effects of protecting human rights in providing mental health care on population-based mental health outcomes are an area of interest for future research.

Fifth, ethical issues [9] associated with clinical practice and research on coercive measures have become of utmost importance. They range from exploring undue influences on research, and questions of properly assessing the ability to give informed consent (see Chapter 17) to attitudes of professionals towards coercive measures [10] and uncertainties about how psychiatric advance directives should be respected in emergency situations [11] which might require the use of coercive measures. The need to address such fields comes from different sources. These include historical examples like the criminal perversion of mental health care during the Nazi era (see Chapter 10), and the recent international movement to develop evidence-based guidelines on how to use coercive measures, for example in the context of the short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments [12].

Sixth, the development and critical analysis of strategies to reduce the use of coercive measures in different settings (e.g. [13]) are areas of high relevance for public mental health care and research.

Seventh, coercive measures are not only critical for shaping public opinion regarding psychiatry, but are the main area in which this medical discipline faces increasing criticism, particularly from the human rights perspective [14] voiced by users of mental health services and prominent international political bodies such as the Council of Europe.

Eighth, and most important from the point of view of the editors of this volume, coercive measures constitute and symbolize a core element of the relationship of

individual mental health professionals with their patients and of the dialogue of professional bodies, such as the World Psychiatric Association (WPA), with the different national and international users' organizations. Subjective experiences of coercive measures and outcomes of coercive measures in terms of adherence to treatment and satisfaction with treatment are important issues for this kind of relationship, and important clinical fields in themselves. That the needed, but long-neglected dialogue on this issue at the level of organizations was a realistic option was demonstrated by the successful WPA Thematic Conference *Coercive Treatment in Psychiatry: A Comprehensive Review*, 6–8 June 2007 in Dresden, Germany, which may have been the first international scientific event dedicated to this sensitive issue [15]. Whereas, traditionally, critical users' groups mount protests outside conference venues, this time most of them decided to come inside and engage in discussions with the conference organizers and other professionals. This rendered the conference a landmark for the WPA in pursuing dialogue between the treaters and the treated.

Organizing a volume that comprehensively explores important clinical, legal and ethical aspects of the highly sensitive and hotly debated issue of coercive treatment in psychiatry presented many challenges. Therefore, the editors conceptualized a book containing original chapters written by international authors from different cultural backgrounds. All are highly experienced and very well respected in the fields or research issues addressed in their contributions. Thus, the volume reflects the current state of the art in the individual themes and is subdivided into five sections:

- *Conceptual and clinical aspects of coercive treatment*
- *Legal aspects of coercive treatment*
- *Ethical aspects of coercive treatment*
- *Users' views on coercive treatment*
- *Coercion and undue influence in decisions to participate in psychiatric research.*

Additionally, the volume could be seen as a starting point for future international discussions and initiatives in this field aiming to minimize coercion. Its importance could go beyond its content, as a symbol of the commitment of psychiatrists globally to deal with a serious and sensitive issue responsibly and creatively.

The section on *conceptual and clinical aspects of coercive treatment* contains five chapters.

Juan E. Mezzich, the President of the WPA 2005–2008, during which period the WPA Dresden Thematic Conference took place, addresses *the issue of coercion and cooperation and psychiatry for the person*, and demonstrates convincingly that the framework of Psychiatry for the Person, a major WPA initiative, can be helpful for

such analyses. This initiative's fundamental goals involve the promotion of a Psychiatry of the Person (of the totality of the person and his/her health, ill and positive aspects included), a Psychiatry by the Person (with clinicians extending themselves as full human beings and professionals with high ethical aspirations), a Psychiatry for the Person (assisting the fulfilment of each person's life project) and a Psychiatry with the Person (in respectful collaboration with the person presenting for care). The conceptual and ethical bases of this initiative are enlightening, and its specific implications to improve diagnosis, clinical care and public health represent nothing less than a paradigmatic shift in our field.

Wolfgang Gaebel and Harald Zäske address the question of whether there is a *link between coercive treatment and stigma of mental illness*. They argue that there is a complex connection. The fact that compulsory treatment is administered within the treatment of mentally ill persons, but not of patients with somatic illness, shapes the public's impression that mentally ill persons are different from others, and potentially unpredictable and dangerous. In Germany, coercive treatment is subject to strict legal regulations. Nevertheless, occasions and justifications for coercive treatment in clinical practice may vary due to individual tolerance limits and competence in de-escalation techniques which in turn are influenced by beliefs, attitudes and professional experiences of the ward staff. Finally, this contribution considers whether the frequency of compulsory admissions and coercive treatment measures can be reduced by educational and stigma-orientated interventions.

John Monahan deals in much detail with the issue of *mandated psychiatric treatment in the community* and demonstrates the forms, prevalence, outcomes and controversies associated with this approach. He argues that much of the international debate on 'outpatient commitment' or 'community treatment orders' assumes that court-ordered treatment in the community is simply an extension of long-existing policies authorizing involuntary commitment as a hospital inpatient. In fact, outpatient commitment is only one of many forms of 'leverage' being used to mandate adherence to psychiatric treatment in community settings. In the social welfare system, benefits disbursed by money managers, and the provision of subsidized housing are both used to assure treatment adherence. Similarly, for people who commit a criminal offence, adherence to psychiatric treatment may be made a condition of probation. Favourable disposition of a case by a mental health court may also be tied to treatment participation. Psychiatric advance directives can be thought of as a form of 'antidote' to treatment mandated by others. This chapter does four things. First, it illustrates a new and broader perspective on requiring adherence to outpatient mental health services, called 'mandated community treatment'. Second, it provides estimates of the frequency with which various forms of leverage are applied to psychiatric outpatients in the United States, as well as of the use of psychiatric advance directives. Third, it summarizes preliminary empirical findings on the outcomes attributable to the different forms of leverage. Finally, it

addresses two controversial issues that often arise in discussions of mandated community treatment: the extent to which the use of leverage amounts to 'coercion', and the role of culture in understanding people's views of the legitimacy of mandated community treatment.

Tilman Steinert and Peter Lepping emphasize that the definition of a *best practice standard for coercive treatment in psychiatry* could ensure that unavoidable interventions are performed with the least possible harm to both patients and staff. They outline three different approaches that have been used to define a best practice standard: a viewpoint of personal virtue and wisdom; evidence; and consensus. Each has advantages and drawbacks. Personal virtue and wisdom has been the motor of most humanitarian reforms in psychiatry but is not a valid and reliable method. Empirical evidence is insufficient to provide answers for many ethical challenges. Consensus is highly dependent on the personal views of opinion leaders. A carefully balanced combination of evidence and consensus of multidisciplinary experts can currently be considered as the best approach to define best practice standards. However, each such standard can be valid only for the conditions of the time and will have to take into account cultural and historical aspects.

Dirk Richter explores the issue of *how to de-escalate a clinical risk situation to avoid the use of coercion*. This chapter outlines organizational and personal approaches for nonphysical interventions. After a review of current empirical research on de-escalation efforts, it gives a brief overview of the situational dynamics as the main cause of aggression and violence in psychiatric care. A general strategy is recommended which is based upon the following issues: safety and security assessment; establishing a rapport and a working relationship; identifying and dealing with substantive problems; dealing with feelings and emotions; and generation and exploration of options and alternatives. Several specific techniques (e.g. verbal and nonverbal interventions) are introduced and discussed.

The section on *legal aspects of coercive treatment* contains three chapters.

Julio Arboleda-Flórez analyses whether *the fields of psychiatry and the law agree in their views on coercive treatment*. He emphasizes that coercion is an element of some treatments in psychiatry, and it is contemplated in legislation, which often dictates parameters for involuntary admissions and use of restrictive treatments. A trend in recent years has been to widen the parameters required for commitment, thereby extending coercive elements of psychiatric treatments to less-immediate situations and into the community, as in assertive community treatment strategies and, most pointedly, in community treatment orders. Elements of coercion could appear in different ways that range from voluntary acceptance to seeming adherence to outright refusal and force. The author outlines how these elements comport with legal mandates and how they are justified in psychiatry and in law in a balance

between needs for protection and individuality and autonomy. Further, the ethics of coercion are reviewed from a point of view of human and civil rights, both negative and positive rights of mental patients.

George Szmukler and John Dawson propose *the 'fusion' of incapacity and mental health legislation to reduce discrimination in mental health law*. They argue that mental health legislation, as conventionally conceived, discriminates against people with a mental illness. The 'rules' governing involuntary treatment of patients with a 'mental' disorder are quite distinct from those governing involuntary treatment of patients with a 'physical' disorder. The latter respect the autonomy of the person who has decision-making capacity, while the former do not. In this chapter, they propose a legal framework for comprehensive legislation based on decision-making capacity that would cover all persons with impaired capacity, from whatever cause. They examine the contexts and distinct functions and characteristics of the common forms of (1) incapacity legislation and (2) mental health (or civil commitment) legislation. Principles are then proposed for their 'fusion' into a single scheme. They show that a statute combining the particular, and complementary, strengths of both incapacity and civil commitment schemes can be readily constructed, based on the incapacity criteria found in the Mental Capacity Act 2005 for England and Wales. Such legislation would be an important step in reducing unjustified legal discrimination against mentally disordered persons and in providing a sound basis for 'coercive' treatments in psychiatry. Consistent ethical principles would be applied across all medical law.

Thomas Kallert explores the issue of whether *the fields of mental health care and patients' rights are currently compatible*. In detail, this chapter addresses the following questions from a European perspective: first, are the human rights of mental health patients sufficiently guaranteed and respected? The European Convention on Human Rights, the UN Convention on the Rights of Persons with Disabilities, and the practice of the European Court of Human Rights serve as examples to analyse if and how these rights are considered. Second, do new approaches in the field of mental health care endanger patients' rights? Outpatient commitment and laws on mental health care reporting are taken as examples. Third, can promising initiatives for improving patients' rights be identified? Revisions of national mental health laws, the elaboration of best practice guidelines for the use of coercive measures, and the formulation of psychiatric advance directives are analysed regarding their potential to improve patients' rights. Fourth, is autonomy still the supreme principle guiding recent socio-legal developments with regard to mental health care? The right of the individual patient to choose a so-called personal (financial) health care budget for chronic mental illness (as defined in the German socio-legal system) and the concept of leverage from the social welfare system are two examples examined. Fifth, are there legal areas that need clearer definitions in order to respect patients' rights? The patient's freedom to choose a psychiatric

hospital for inpatient care, and involuntary placement and treatment in long-stay care homes are two examples from Germany of such areas of concern. In general, the analysis of the five questions presented in this chapter demonstrates that compatibility of mental health care and patients' rights seems to be more of a general aim for health politics and the field of psychiatry, albeit an extremely important intention, than a reality at present.

The section on *ethical aspects of coercive treatment* contains three chapters.

Ahmed Okasha and Tarek Okasha address the issue of *cross-cultural perspectives on coercive treatment in psychiatry* and demonstrate that individual autonomy is valued in European and American cultures but is not empowering for the traditional, family-centred societies in Arab, sub-Saharan African, Indian and Japanese cultures. This difference may affect the use of involuntary hospital admission and informed consent, amongst other practices, in traditional versus Western societies. In traditional societies, the decision for involuntary or voluntary admission for children and adolescents is totally the responsibility of the family. Neither the judicial system nor the civil law has a role. In some traditional societies in Africa, South East Asia and the Middle East, the perception of mental illness varies between rural and urban areas. In rural areas it is still considered to be due to possession by evil spirits, magic, the evil eye or the wrath of ancestors. To use coercive treatment and restraint to exorcise the evil eye spirit is socially acceptable and if not applied the society will consider the family as negligent. The patients' acceptance of their family decision on involuntary placement in non-Western cultures may surprise Western practitioners. Patients are often grateful to their family for pursuing the path to get rid of the evil influence. Although there are no scientific studies of patient's perception in those cultures available, it is the impression of the authors that it does not leave any scar or anger or rejection, as the patients perceive themselves as being led back to the path of virtue. Thus, this chapter discusses the transcultural ethical aspects of implementing coercive management of psychiatric disorders, with special emphasis on the conflict between the human rights values of Western culture and the social and religious conformity of some traditional societies.

Rael Strous explores the theme of *historical injustice in psychiatry*, presents examples from Nazi Germany and others, and derives ethical lessons for the modern professional from his analysis. He argues that along with the tremendous responsibility of the psychiatry profession comes tremendous power. Unfortunately, although this occurs relatively rarely, this power inherent in clinical and research psychiatry may be abused. History does provide us with some important examples of crossing the boundaries of ethical health care in individuals with mental illness. Much of this unethical behaviour emanates from boundary violations. It is thus critical to learn basic concepts of ethical practice during training. However, learning the concepts alone is not enough. Ethics training without a focus on clinical and

research psychiatric practice with examples from history would be fundamentally lacking. As a model to explain concepts of medical ethics, a brief explanation of four cardinal ethical principals is presented as well as examples from the past where these concepts have been ignored or violated. Providing vivid historical examples of unethical practice increases the chance that lessons may be learned and that concepts will be applied in a more appropriate manner.

Tom Burns addresses the issue of *paternalism in mental health*. He shows that mental health legislation has received enormous attention internationally in the era of deinstitutionalization, particularly as societies become more risk averse. The response has been framed within a libertarian tradition and the language is almost exclusively about autonomy and partnership. Apart from risk, patient autonomy has gone from being one of the principles in the discourse surrounding mental health legislation to being the principle one. Paternalism and beneficence are discarded as discredited. Practice, however, is still recognisably paternalistic in most developed countries. This disjunction between the public language and common practice leads to sometimes tortured and unconvincing definitions (to permit current practice) and unhelpful confusion in the public mind about what psychiatry is. Contrary to the widespread belief within mental health that everyone else has abandoned paternalism, there are cogent and respectable critiques of autonomy as a dominant ethical principle. These critiques encourage a less damning view of paternalism, seeking to place it alongside other ethical goals in society. These challenges come from within economics, the law, political philosophy and, perhaps most surprisingly, from some feminist authors. These critiques are briefly outlined with the modest ambition of encouraging debate in this area. While patient autonomy is important, it does not preclude the legitimate consideration of restriction of liberty in a patient's best interests. A debate which reflects more accurately what we do (rather than think we ought to do) may be more helpful in informing policy and legislation.

The section on *users' views on coercive treatment* contains four chapters.

David W. Oaks offers thorough reflections on *the moral imperative for dialogue with organizations of survivors of coerced psychiatric human rights violations*. He describes how coerced mental health procedures sever the human relationship between mental health professionals and mental health clients, creating an insurmountable power imbalance and immense human suffering. While some individual mental health professionals question this inequality, there are barriers to institutional change. David W. Oaks argues that one possibility to begin to address this power imbalance is open, mediated dialogue between representatives of organizations of mental health professionals and representatives of organizations of psychiatric survivors, that is, individuals who identify as having experienced coerced human rights violations while undergoing psychiatric care. Civil dialogue could explore three categories of coercive psychiatry: (1) physically forced psychiatric care, for

example involuntary electroconvulsive therapy against the clearly expressed wishes of the subject; (2) allegations that some mental health professionals provide fraudulent information, such as inaccurate descriptions of the effects of psychiatric medications; (3) the necessity for more choices for mental health care, especially peer-run alternatives, beyond the conventional medical model approach.

Jasna Russo and Jan Wallcraft address in much detail the *service user/survivor perspective on research on coercion*, and particularly explore some of the structural obstacles to including service user/survivor perspectives in psychiatric research on coercion. Without aiming to provide a systematic or complete review, they take a closer look at several psychiatric studies on coercion, and discuss their overall approaches and the methodologies applied. The standpoints of the authors of this chapter are informed by their own research practice, by their activism in the international movement of psychiatric survivors, and by their personal experiences of forced or coercive treatment. This contribution aims to extend the debate on the ethics of coercion beyond the notions of ‘treatment effectiveness’ and ‘perceived coercion’ by raising questions about how coercive methods impact individual lives. The second part of the chapter outlines some of the principles and values that the authors consider essential for comprehensive and responsible research on coercion.

The editors are extremely grateful for Dorothea S. Buck-Zerchin’s contribution which is entitled ‘*Seventy Years of Coercion in Psychiatric Institutions, Experienced and Witnessed*’. Dorothea Buck was born in Germany in 1917 and can therefore be called a contemporary witness. She had five stays in psychiatric hospitals between 1936 and 1959 and was subjected to various forms of coercion, such as forced sterilization, cold wet sheet packs and forced injections, and was never granted a single conversation to inform her about the origin or meaning of her psychotic episodes. Facing the historical development of psychiatry and its effects on today’s mental health system, she challenges biological psychiatry, which rejects communication with patients, and demands a paradigm shift toward a psychosocial system based on the wealth of patients’ experiences that provides alternatives to psychiatry, such as the therapeutic principles of ‘Soteria’ and Yrjö Alanen’s ‘need-adapted treatment’.

Dorothy Castille, Kristina H. Muenzenmaier and Bruce Link contribute an original research paper entitled *Coercion: point, perception, process*, with a clear focus on users’ views. They investigated the implications of outpatient commitment for perceptions of coercion in a sample of people committed and voluntarily presented to outpatient psychiatric treatment through New York State’s Kendra’s Law. Using a perceived coercion scale that shows evidence of reliability and validity, they found no significant difference in perception of coercion between those with and without court-ordered treatment. To understand this finding, the authors conducted open-ended interviews of 11 persons without court orders and 9 persons with court orders. Qualitative interviews revealed three perspectives that helped to understand

why there were no differences in perceived coercion between these groups: the ubiquity of coercion, conformity over confrontation, and valued services. Study participants stressed the importance of a collaborative, mutually respectful relationship with the case manager, flexibility in application of the treatment plan, and goal-directed recovery orientation as amongst the factors that made even people who were objectively coerced feel less so.

The volume's final section on *coercion and undue influence in decisions to participate in psychiatric research* contains two chapters.

Lars Kjellin's chapter presents *ethical issues of participating in psychiatric research on coercion*, and discusses these in the context of international declarations on ethics of medical research and current issues in psychiatric research ethics. Experiences from a large European multi-centre study and a Nordic study of coercion in psychiatry are presented. Researchers have to be careful and sensitive when approaching involuntarily admitted patients, in particular, to ask for informed consent to participate in research. The author argues that possible benefits for future psychiatric patients, subjected to coercive measures in psychiatric care, from methodologically and ethically sound studies will most likely be greater than the possible risks of harm to participating patients.

In their chapter on *coercion and undue influence in decisions to participate in psychiatric research*, Paul Appelbaum, Charles W. Lidz and Robert Klitzman outline a theory of voluntary consent to research and of factors that may constrain it, based on the doctrine of informed consent. From this perspective, only influences that are external, intentional, illegitimate and causal may negate voluntariness. Of particular concern in the research setting are offers, pressures and threats, which may unduly influence or coerce potential subjects. Assessment of coercion and undue influence in research settings is challenging because of the need to take contextual factors into account. Research on the nature and prevalence of constraints on voluntariness is limited, with many gaps in current knowledge. In particular, it is unclear whether patients with psychiatric and substance use disorders are particularly susceptible to influences that constrain voluntariness. The discipline of psychiatry stands at the beginning of systematic study of voluntariness, coercion and undue influence in research, which promises to provide answers to many important questions in research ethics.

By comprehensively exploring important clinical, legal and ethical aspects of coercive treatment in the way outlined above, the editors very much hope

- to increase the visibility of the issue within the discipline of psychiatry, but also for all individual persons, bodies and organizations involved or interested in dealing with the themes addressed in the volume;

- to decrease resistance from various circles of diverse professions to deal competently with all the sensitive and controversial issues referred to as coercive treatment;
- to encourage further open discussions, at different levels, including the one of representatives of organizations of mental health professionals and representatives of organizations of psychiatric users/survivors;
- to stimulate further, urgently needed empirical research in the individual themes addressed;
- to increase activities towards defining better standards and procedures on how to deal with the challenges of this issue; and
- to give a crystal clear signal that it is absolutely essential, for all clinical and research work in the field of coercive treatment in psychiatry, to act according to the highest ethical standards in the best interest of our patients.

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