Journal of Psychiatric and Mental Health Nursing

WILEY

DEBATE ESSAY OPEN ACCESS

Coercive Measures in Psychiatry Can Hardly Be Justified in Principle Any Longer—Ethico-Legal Requirements Versus Empirical Research Data and Conceptual Issues

Dirk Richter

Department of Health Professions, Bern University of Applied Sciences, Bern, Switzerland

Correspondence: Dirk Richter (dirk.richter@bfh.ch)

Received: 26 June 2024 | **Revised:** 18 September 2024 | **Accepted:** 9 October 2024

Keywords: coercive measure | ethical justification | mental disorder | mental health care

ABSTRACT

Aim: To review the scientific and empirical evidence that is usually accepted for the ethical and legal justification of coercion in psychiatry.

Method: Five key criteria are examined as follows: (1) the demonstrable existence of a mental disorder; (2) the effectiveness of psychiatric measures; (3) the use of coercion as last resort and as least possible restriction; (4) the benefit of the person affected by the coercive measure and (5) the restoration of the affected person's autonomy.

Results: (1) The existence of a demarcation between a mentally ill and a mentally healthy state cannot be confirmed; (2) Pharmacological and psychotherapeutic interventions in psychiatry are not even moderately effective; (3) Coercive measures are usually not used as last resort and as least restrictive measure; (4) Most people affected by psychiatric coercion do not benefit from the measures; (5) It is at least unclear whether autonomy is affected by a mental illness and whether it can be restored through a coercive psychiatric measure.

Discussion: None of the central ethical and legal criteria for the use of coercion in psychiatry are clearly and unambiguously fulfilled according to current research.

Implications: Psychiatric coercion can hardly be justified any longer.

The question of the legitimisation of coercion in the context of psychiatric treatment has long preoccupied mental health care (Szasz 1997; Szmukler 2018). With reference to the UN Convention on the Rights of Persons with Disabilities (UN CRPD) (United Nations 2006) and the WHO Quality Rights Approach (Funk and Bold 2020), Zinkler and von Peter (2019) have recently outlined an alternative to the current coercion practice, which amounts to exclusively voluntary support. Contrary to these approaches, however, many countries and regions are seeing an increase in coercive measures such as involuntary hospitalisation, restraint or seclusion. This is the case throughout Switzerland (Obsan 2023), for example, or in the Netherlands (Vruwink et al. 2021). In addition, the discussion in psychiatric care is currently partly moving in the direction of expanding measures against the will of affected persons. In the United States, for instance, regional administrations are trying to consider coercive measures against a person's will as a means of coping with homelessness and the associated mental health problems (Kerman, Kidd, and Stergiopoulos 2023).

Psychiatric nursing is involved in coercive measures in various ways. The dilemmas and challenges in dealing with measures against a person's will are particularly evident in nursing care (Haines et al. 2024). The challenges are exacerbated by the difficult contextual conditions, such as the consequences of austerity in many healthcare systems (Whittington, Aluh, and

Caldas-de-Almeida 2023). On the one hand, nurses try to realise autonomy, recovery and empowerment, while on the other hand, the focus is on averting danger and ensuring the safety of everyone involved (Manderius et al. 2023). Human rights have long been a point of reference for legitimising coercion in psychiatry. The UN CRPD from 2006, which has already been mentioned, started a considerable discussion in psychiatry about the legitimisation of psychiatric measures against people's will. While, on the one hand, the violation of human rights through coercion in psychiatry has been recognised, on the other hand, the consequences of not using coercion have been pointed out, as well as human rights that are safeguarded through coercive measures (Appelbaum 2016). This is, among others, the right to life, which should be safeguarded by measures taken against the will of a suicidal person. Within the United Nations, there are various conventions that both disapprove of coercive interventions and justify measures against a person's will under certain circumstances. In the relevant literature, there is even talk of the Geneva impasse in this context (Martin and Gurbai 2019). It can be concluded from this discussion that the human rights argument alone does not sufficiently delegitimise the use of coercion.

In my opinion, the legal and ethical legitimisation of interventions against a person's will is even more relevant to psychiatry and psychiatric care than the human rights argument. Biomedical ethics is based on the well-known principles of beneficence, non-maleficence, justice and autonomy (Beauchamp and Childress 2019). These principles also guide the use of coercion in psychiatry (Steinert 2017). The German Ethics Council has published a comprehensive statement on benevolent coercive measures and defined the legitimising conditions (German Ethics Council 2018). These include—in addition to the determination of capacity—the benefit of the person concerned (including the subjective assessment of the measure), the coercive measure as a last resort, the restoration of a self-determined and autonomous life and the effectiveness of the measure as a whole.

As the European Court of Human Rights has ruled, it is also necessary to establish a '...true mental disorder...' (Winterwerp v Netherlands 6301/73 [1979] ECHR). Without such a finding, coercion may not be used in the healthcare system. In the absence of such a finding, coercion is only permissible outside of medicine, for example, in the judicial system.

At present, nurses and other mental health professionals, as well as ethical research and legal practice, assume that coercion is either justifiable in principle or can be legitimised in exceptional situations if the above assumptions and conditions apply (Chieze et al. 2021). Interestingly, however, there is hardly any scientific literature that has comprehensively tested these assumptions for their empirical evidence. However, there are various individual research results that make this possible. In the following, I will therefore analyse whether the aforementioned legal and ethical conditions for the use of coercion in psychiatry are met from an empirical and scientific perspective. It is important in this context that the facts analysed here relate to the fundamental handling of coercion in psychiatry from an ethical, legal and medical perspective. This is not about individual cases in clinical practice, but about the foundations on the basis of which laws, regulations and guidelines are developed.

Methodologically, the best available scientific evidence for the questions listed below has been researched and presented.

1. Does psychiatry have a valid disease model?
2. Are psychiatric therapies effective?
3. Are coercive measures used as a last resort and as the least restrictive measure possible?
4. Are psychiatric coercive measures taken for the benefit of the persons affected?
5. Can the autonomy of people affected by coercion be restored at all?

1 | Does Psychiatry Have a Valid Disease Model?

The identification of a 'true mental disorder' implies a valid disease and diagnostic model. However, there are currently a large number of models to explain mental health problems, some of which are fundamentally contradictory (Richter and Dixon 2023). According to recent psychiatric taxonomic research and basic neuroscientific research, the validity of the DSM and ICD classification systems used today is highly doubtful (Lilienfeld and Treadway 2016). One of the problems is the differentiation of various disorders from one another (Kotov et al. 2017). Current taxonomic approaches such as the 'Research Domain Criteria' (RDoC) (Cuthbert 2014), the 'Hierarchical Taxonomy of Psychopathology' (HiTOP) (Kotov et al. 2017) or the 'General Psychopathology (p-factor)' approach (Caspi et al. 2014) have been developed against the backdrop of empirical research in the neurosciences, which found that the research results were incompatible with the conventional DSM and ICD classification systems.

A further problem, which is even more fundamental and significant for the topic discussed here, is the difficulty of distinguishing disordered from non-disordered mental states. This distinction has already been regarded historically in the research literature (Kendler, Muñoz, and Murphy 2010) and also currently predominantly as arbitrary (Eaton et al. 2023). Human psychological characteristics are almost invariably dimensional or continuous in nature (Conway and Krueger 2021). The attempt to differentiate these dimensions into sick/healthy or normal/abnormal is, according to the relevant research, '... an entirely fictional and baseless notion' (Lahey 2021, S. 3). This means that no medical-biological criteria are apparently used to draw the line between ill and non-ill, but rather, according to Steven Hyman, the former director of the US National Institutes of Mental Health, a social decision is made (Hyman 2021). Summarising the above research findings, a valid disease model of psychiatry that distinguishes between mentally ill and mentally healthy on the basis of medical criteria cannot be assumed. There is therefore no objectifiable medical-psychiatric determination of a mental disorder as a prerequisite for coercive measures within the healthcare system; at least not beyond changeable and controversial social values.

Similar methodological problems also exist with regard to the determination of mental capacity. This is also a dimensional construct that is also influenced by temporal and

sociocultural factors. As with the determination of an 'illness', there are no 'hard' cut-offs; instead, decisions are made that are co-determined by social assumptions and attitudes. In clinical practice, the attribution of capacity and incapacity is a 'normative judgement' (Trachsel, Hermann, and Biller-Andorno 2014, S. 224); see also Banner (2012).

2 | Are Psychiatric Therapies Effective?

From an ethical perspective, the aim of measures taken against a person's will is to improve the health of the person concerned. This requires effective therapeutic interventions. Medical coercion may only be used if the measure can achieve an improvement in health. However, according to a recent umbrella review, pharmacological and psychotherapeutic interventions in psychiatry are generally not even moderately effective (Leichsenring et al. 2022). The effect sizes found in this umbrella review are 0.36 for pharmacotherapy and 0.34 for psychotherapy. According to the convention used by the Cochrane Collaboration, moderate effectiveness can be assumed from an effect size of 0.5 and strong effectiveness from 0.8 (Zeng et al. 2023). It should also be noted that the participants included in these studies were volunteers. People who are treated against their will can be expected to have lower therapeutic motivation and lower expectations on the impact of the treatment (Meynen and Swaab 2011), which usually impacts negatively on effectiveness.

In addition, psychiatric interventions have been shown to have only a weak effect on suicidality, a key indication of coercive measures. According to a meta-analysis, psychiatric therapies have only a very weak effect on suicidal thoughts, suicide attempts and deaths by suicide (Fox et al. 2020). In summary, this means that the criterion of the effectiveness of a therapy accompanying the coercive measure is not met for most of the people affected by coercion.

3 | Are Coercive Measures Used as a Last Resort and as the Least Restrictive Measure Possible?

The use of coercion as a last resort presupposes that a psychiatric care system has been established in advance that effectively seeks to prevent admissions to inpatient treatment. These are, for example, crisis resolution teams or home treatment services, which should be available nationwide to prevent people with mental health problems from involuntary hospitalisation. According to a review, however, these services have so far only been fully implemented in England (not in the rest of the United Kingdom) and Norway (Lloyd-Evans et al. 2018). In other countries, outpatient treatment programmes are only sporadically available prior to inpatient admission. This applies, for example, to inpatient-equivalent treatment in Germany (Nikolaidis et al. 2024) or home treatment approaches in Switzerland (Stulz et al. 2020) which, despite positive study results, are not yet available across the board. In addition, many other crisis management options have not been exhausted. These include non-medical crisis houses or peer-run respites (Spiro and Swarbrick 2024).

A widespread restriction in the treatment of people with mental illness is the closed ward door. However, minimising restrictions requires that measures are implemented to keep restrictions as low as possible. One of these measures is the open ward door. There is empirical evidence that closed doors do not contribute significantly to the prevention of absconding and suicide attempts (Huber et al. 2016). In a recent Norwegian non-inferiority study, open doors proved to be non-inferior to closed ward doors in all respects (Indregard et al. 2024). However, many professionals in psychiatric care are very reluctant to open ward doors (Kalagi et al. 2018) and the opening of wards where people have to stay against their will is not widespread. In summary, this means that coercion is predominantly not used as a last resort and as the least possible restriction.

4 | Are Psychiatric Coercive Measures Taken for the Benefit of the Persons Affected?

Beneficence and non-maleficence are core arguments for justifying medical measures against a person's will. The defence against danger alone, in particular the danger to other persons, could also be achieved by non-medical coercion. The police and judiciary should be able to do this. It has already been stated above that psychiatric therapies are not really effective from the perspective of professional expertise. There is also evidence on the consequences of coercive measures from a psychiatric perspective, for example, a non-negligible risk of physical harm and death (Kersting, Hirsch, and Steinert 2019). A comparative observational study recently also found that isolation measures have negative consequences for the mental health of those affected (Baggio, Kaiser, and Wullschleger 2024). Another perspective—and one that is even more relevant to the issue at hand—is that of the persons affected by coercion. According to ethical guidelines such as those of the German Ethics Council, the persons concerned would have to subsequently consent to the measure. The subjective assessment by the persons concerned after a coercive measure has been carried out would generally have to be positive in order to determine their mental health and legitimise the measure.

However, several systematic reviews come to the consistent conclusion that the vast majority of people who have experienced psychiatric coercion do not see it this way (Aguilera-Serrano et al. 2018; Akther et al. 2019; Chieze et al. 2019). Instead of the positive effect, the people affected tend to experience punishment, powerlessness and humiliation. In summary, this means that psychiatric coercion is at best experienced by a minority as a measure to promote mental health, but for the most part does not lead to the well-being of the people affected.

5 | Can the Autonomy of the People Concerned Be Restored at all Through Coercion?

Restoring the autonomy of the person concerned is another justification for the use of coercion. Autonomy and a person's

free will are related concepts that are also discussed in the context of neuroscience (Müller and Walter 2010). Personal autonomy (Buss and Westlund 2018) and in particular free will (O'Connor and Franklin 2022) are among the most controversial concepts in philosophy and there are profound scientific reasons that make free will appear to be an illusion (Sapolsky 2023).

In view of the conceptual ambiguities, it is completely unclear whether personal autonomy as such can be affected by mental disorders. Moreover, autonomy is always a question of perspective. People who have to undergo psychiatric treatment against their will often experience a loss of autonomy rather than a regaining of autonomy as a result of involuntary admission (van den Hooff and Goossensen 2014). This means that it is at least unclear whether autonomy is affected by a mental illness and whether it can be restored through a coercive psychiatric measure.

6 | Conclusions

The above analysis suggests the following findings: (1) psychiatry does not have a valid disease model that can clearly distinguish between disorder and non-disorder; (2) psychiatric therapies are not even moderately effective; (3) coercive measures are predominantly not used as a last resort and as the least possible restriction; (4) psychiatric coercion is predominantly not used for the benefit of the persons concerned; and (5) it is unclear at a conceptual level whether people's autonomy can be reduced by a mental illness and whether it can be restored by a coercive measure. In summary, this means that none of the five central ethical and legal criteria for the use of coercion in psychiatry are clearly and unambiguously fulfilled according to the current state of research. There is insufficient evidence for the effectiveness of coercive measures in psychiatric care (see recently Hofstad et al. 2024). Psychiatric coercion can therefore hardly be justified any longer from an ethical and empirical perspective.

The above analysis therefore comes to the same conclusion as the human rights argumentation of Zinkler and von Peter (2019): psychiatric treatment should in principle only be voluntary. However, it goes without saying that an immediate abolition of psychiatric coercion would result in considerable problems and dilemmas (Richter 2023). At present, prisons and other institutions in the legal system are not appropriate places to provide psychosocial support for people in crisis.

Furthermore, it is not to be expected that coercion in psychiatric care will be viewed negatively in politics and the legal system any time soon. This has two consequences for psychiatry in general and for nursing and psychiatric care in particular. Firstly, efforts must be made—together with those affected and other professions in psychiatric care—to ensure that coercion in psychiatry is abolished in the medium to long term. In this context, some authors may even see the need for active resistance or conscientious objection (Gadsby and McKeown 2021; Sidley 2018). While only a minority of experts are of the opinion that the abolition of coercion is possible (Birkeland et al. 2024), experts with lived experience put forward many arguments in favour of abolition (Suslovic 2024).

Secondly, however, it is still necessary to work towards reducing coercion on every ward and in every community service. For example, there is increasing evidence of racial and ethnic disparities in coercive measures in inpatient care, which cannot be tolerated in principle (Singal et al. 2024). It is imperative that nurses and other mental health professionals examine in each individual case whether alternatives to measures against the person's will are also available in the current care system.

Ethics Statement

The author has nothing to report.

Conflicts of Interest

The author declares no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

References

Aguilera-Serrano, C., J. Guzman-Parra, J. A. Garcia-Sanchez, B. Moreno-Küstner, and F. Mayoral-Cleries. 2018. "Variables Associated With the Subjective Experience of Coercive Measures in Psychiatric Inpatients: A Systematic Review." *Canadian Journal of Psychiatry* 63, no. 2: 129–144. https://doi.org/10.1177/0706743717738491.

Akther, S. F., E. Molyneaux, R. Stuart, S. Johnson, A. Simpson, and S. Oram. 2019. "Patients' Experiences of Assessment and Detention Under Mental Health Legislation: Systematic Review and Qualitative Meta-Synthesis." *BJPsych Open* 5, no. 3: e37. https://doi.org/10.1192/bjo.2019.19.

Appelbaum, P. S. 2016. "Protecting the Rights of Persons With Disabilities: An International Convention and Its Problems." *Psychiatric Services* 67, no. 4: 366–368. https://doi.org/10.1176/appi.ps.201600050.

Baggio, S., S. Kaiser, and A. Wullschleger. 2024. "Effect of Seclusion on Mental Health Status in Hospitalized Psychiatric Populations: A Trial Emulation Using Observational Data." *Evaluation & the Health Professions* 47, no. 1: 3–10. https://doi.org/10.1177/01632787231164489.

Banner, N. F. 2012. "Unreasonable Reasons: Normative Judgements in the Assessment of Mental Capacity." *Journal of Evaluation in Clinical Practice* 18, no. 5: 1038–1044. https://doi.org/10.1111/j.1365-2753.2012.01914.x.

Beauchamp, T. L., and J. F. Childress. 2019. *Principles of Biomedical Ethics*. 8th ed. Oxford: Oxford UP.

Birkeland, S., T. Steinert, R. Whittington, and F. A. Gildberg. 2024. "Abolition of Coercion in Mental Health Services–A European Survey of Feasibility." *International Journal of Law and Psychiatry* 94: 101992. https://doi.org/10.1016/j.ijlp.2024.101992.

Buss, S., and A. Westlund. 2018. "Personal Autonomy." In *Stanford Encyclopedia of Philosophy (Spring 2018 Edition)*, edited by E. N. Zalta. https://plato.stanford.edu/cgi-bin/encyclopedia/archinfo.cgi?entry=personal-autonomy.

Caspi, A., R. M. Houts, D. W. Belsky, et al. 2014. "The P Factor: One General Psychopathology Factor in the Structure of Psychiatric Disorders?" *Clinical Psychological Science* 2, no. 2: 119–137. https://doi.org/10.1177/2167702613497473.

Chieze, M., C. Clavien, S. Kaiser, and S. Hurst. 2021. "Coercive Measures in Psychiatry: A Review of Ethical Arguments." *Frontiers in Psychiatry* 12: 790886. https://doi.org/10.3389/fpsyt.2021.790886.

Chieze, M., S. Hurst, S. Kaiser, and O. Sentissi. 2019. "Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review." *Frontiers in Psychiatry* 10: 491. https://doi.org/10.3389/fpsyt.2019.00491.

Conway, C. C., and R. F. Krueger. 2021. "Rethinking the Diagnosis of Mental Disorders: Data-Driven Psychological Dimensions, not Categories, as a Framework for Mental-Health Research, Treatment, and Training." *Current Directions in Psychological Science* 30, no. 2: 151–158. https://doi.org/10.1177/0963721421990353.

Cuthbert, B. N. 2014. "The RDoC Framework: Facilitating Transition From ICD/DSM to Dimensional Approaches That Integrate Neuroscience and Psychopathology." *World Psychiatry* 13, no. 1: 28–35. https://doi.org/10.1002/wps.20087.

Eaton, N. R., L. F. Bringmann, T. Elmer, et al. 2023. "A Review of Approaches and Models in Psychopathology Conceptualization Research." *Nature Reviews Psychology* 2, no. 10: 622–636. https://doi.org/10.1038/s44159-023-00218-4.

Fox, K. R., X. Huang, E. M. Guzmán, et al. 2020. "Interventions for Suicide and Self-Injury: A Meta-Analysis of Randomized Controlled Trials Across Nearly 50 Years of Research." *Psychological Bulletin* 146, no. 12: 1117–1145. https://doi.org/10.1037/bul0000305.

Funk, M., and N. D. Bold. 2020. "WHO's QualityRights Initiative: Transforming Services and Promoting Rights in Mental Health." *Health and Human Rights* 22, no. 1: 69–75.

Gadsby, J., and M. McKeown. 2021. "Mental Health Nursing and Conscientious Objection to Forced Pharmaceutical Intervention." *Nursing Philosophy* 22, no. 4: e12369. https://doi.org/10.1111/nup.12369.

German Ethics Council. 2018. *Benevolent Coercion–Tensions Between Welfare and Autonomy in Professional Caring Relationships*. Berlin: German Ethics Council. https://www.ethikrat.org/fileadmin/Publikationen/Stellungnahmen/englisch/opinion-benevolent-coercion.pdf.

Haines, S., R. Stanton, C. Anderson, and A. Welch. 2024. "Ethical Challenges for Nurses Delivering Coercive Interventions in Community Mental Health Settings: A Scoping Review." *International Journal of Mental Health Nursing* 33: 750–759. https://doi.org/10.1111/inm.13290.

Hofstad, T., O. Nyttingnes, S. Markussen, et al. 2024. "Long Term Outcomes and Causal Modelling of Compulsory Inpatient and Outpatient Mental Health Care Using Norwegian Registry Data: Protocol for a Controversies in Psychiatry Research Project." *International Journal of Methods in Psychiatric Research* 33, no. 1: e1980. https://doi.org/10.1002/mpr.1980.

Huber, C. G., A. R. Schneeberger, E. Kowalinski, et al. 2016. "Suicide Risk and Absconding in Psychiatric Hospitals With and Without Open Door Policies: A 15 Year, Observational Study." *Lancet Psychiatry* 3, no. 9: 842–849. https://doi.org/10.1016/S2215-0366(16)30168-7.

Hyman, S. E. 2021. "Psychiatric Disorders: Grounded in Human Biology but not Natural Kinds." *Perspectives in Biology and Medicine* 64, no. 1: 6–28. https://doi.org/10.1353/pbm.2021.0002.

Indregard, A.-M. R., H. M. Nussle, M. Hagen, et al. 2024. "Open-Door Policy Versus Treatment-as-Usual in Urban Psychiatric Inpatient Wards: A Pragmatic, Randomised Controlled, Non-Inferiority Trial in Norway." *Lancet Psychiatry* 11, no. 5: 330–338. https://doi.org/10.1016/S2215-0366(24)00039-7.

Kalagi, J., I. Otte, J. Vollmann, G. Juckel, and J. Gather. 2018. "Requirements for the Implementation of Open Door Policies in Acute Psychiatry From a Mental Health Professionals' and Patients' View: A Qualitative Interview Study." *BMC Psychiatry* 18, no. 1: 304. https://doi.org/10.1186/s12888-018-1866-9.

Kendler, K. S., R. A. Muñoz, and G. Murphy. 2010. "The Development of the Feighner Criteria: A Historical Perspective." *American Journal of Psychiatry* 167, no. 2: 134–142.

Kerman, N., S. A. Kidd, and V. Stergiopoulos. 2023. "Involuntary Hospitalization and Coercive Treatment of People With Mental Illness Experiencing Homelessness-Going Backward With Foreseeable Harms." *JAMA Psychiatry* 80, no. 6: 531–532. https://doi.org/10.1001/jamapsychiatry.2023.0537.

Kersting, X. A. K., S. Hirsch, and T. Steinert. 2019. "Physical Harm and Death in the Context of Coercive Measures in Psychiatric Patients: A Systematic Review." *Frontiers in Psychiatry* 10: 400. https://doi.org/10.3389/fpsyt.2019.00400.

Kotov, R., R. F. Krueger, D. Watson, et al. 2017. "The Hierarchical Taxonomy of Psychopathology (HiTOP): A Dimensional Alternative to Traditional Nosologies." *Journal of Abnormal Psychology* 126, no. 4: 454–477. https://doi.org/10.1037/abn0000258.

Lahey, B. B. 2021. *Dimensions of Psychological Problems: Replacing Diagnostic Categories With a More Science-Based and Less Stigmatizing Alternative*. New York: Oxford UP.

Leichsenring, F., C. Steinert, S. Rabung, and J. P. A. Ioannidis. 2022. "The Efficacy of Psychotherapies and Pharmacotherapies for Mental Disorders in Adults: An Umbrella Review and Meta-Analytic Evaluation of Recent Meta-Analyses." *World Psychiatry* 21, no. 1: 133–145. https://doi.org/10.1002/wps.20941.

Lilienfeld, S. O., and M. T. Treadway. 2016. "Clashing Diagnostic Approaches: DSM-ICD Versus RDoC." *Annual Review of Clinical Psychology* 12: 435–463. https://doi.org/10.1146/annurev-clinpsy-021815-093122.

Lloyd-Evans, B., B. Paterson, S. Onyett, et al. 2018. "National Implementation of a Mental Health Service Model: A Survey of Crisis Resolution Teams in England." *International Journal of Mental Health Nursing* 27, no. 1: 214–226. https://doi.org/10.1111/inm.12311.

Manderius, C., K. Clintståhl, K. Sjöström, and K. Örmon. 2023. "The Psychiatric Mental Health Nurse's Ethical Considerations Regarding the Use of Coercive Measures–A Qualitative Interview Study." *BMC Nursing* 22, no. 1: 23. https://doi.org/10.1186/s12912-023-01186-z.

Martin, W., and S. Gurbai. 2019. "Surveying the Geneva Impasse: Coercive Care and Human Rights." *International Journal of Law and Psychiatry* 64: 117–128. https://doi.org/10.1016/j.ijlp.2019.03.001.

Meynen, G., and D. F. Swaab. 2011. "Why Medication in Involuntary Treatment May Be Less Effective: The Placebo/Nocebo Effect." *Medical Hypotheses* 77, no. 6: 993–995. https://doi.org/10.1016/j.mehy.2011.08.029.

Müller, S., and H. Walter. 2010. "Reviewing Autonomy: Implications of the Neurosciences and the Free Will Debate for the Principle of Respect for the Patient's Autonomy." *Cambridge Quarterly of Healthcare Ethics* 19, no. 2: 205–217. https://doi.org/10.1017/S0963180109990478.

Nikolaidis, K., S. Weinmann, S. Döring, et al. 2024. "Stationsäquivalente Behandlung (StäB) im Vergleich mit vollstationärer Behandlung: 12-Monats-Follow-Up Ergebnisse einer mittels Propensity-Score gematchten retrospektiven Kohortenstudie." *Psychiatrische Praxis* 51, no. 2: 92–98. https://doi.org/10.1055/a-2177-6113.

Obsan. 2023. "Fürsorgerische Unterbringung in Schweizer Psychiatrien (Involuntary Detention in Swiss Mental Health Care)." https://ind.obsan.admin.ch/de/indicator/obsan/fuersorgerische-unterbringung-in-schweizer-psychiatrien.

O'Connor, T., and C. Franklin. 2022. "Free Will." In *Stanford Encyclopedia of Philosophy (Winter 2022 Edition)*, edited by E. N. Zalta and U. Nodelman. https://plato.stanford.edu/entries/freewill/.

Richter, D. 2023. *Menschenrechte in der Psychiatrie–Prinzipien Und Perspektiven Einer Psychosozialen Unterstützung Ohne Zwang (Human Rights in Psychiatry–Principles and Perspectives of a Psychosocial Support Without Coercion)*. Köln: Psychiatrie-Verlag.

Richter, D., and J. Dixon. 2023. "Models of Mental Health Problems: A Quasi-Systematic Review of Theoretical Approaches." *Journal of Mental Health* 32, no. 2: 396–406. https://doi.org/10.1080/09638237.2021.2022638.

Sapolsky, R. M. 2023. *Determined: Life Without Free Will*. London: Bodley Head.

Sidley, G. 2018. "Colluding With Prejudice? Mental Health Nurses and the Mental Health Act." In *Critical Mental Health Nursing: Observations From the Inside*, edited by P. Bull, J. Gadsby, and S. Williams, 106–123. Monmouth: PCCS Books.

Singal, S., D. Howell, L. Hanna, et al. 2024. "Race-Based Disparities in the Frequency and Duration of Restraint Use in a Psychiatric Inpatient Setting." *Psychiatric Services* 75, no. 4: 308–315. https://doi.org/10.1176/appi.ps.20230057.

Spiro, L., and M. Swarbrick. 2024. "Peer-Run Respite Approaches to Supporting People Experiencing an Emotional Crisis." *Psychiatric Services* 0: 20230599. https://doi.org/10.1176/appi.ps.20230599.

Steinert, T. 2017. "Ethics of Coercive Treatment and Misuse of Psychiatry." *Psychiatric Services* 68, no. 3: 291–294. https://doi.org/10.1176/appi.ps.201600066.

Stulz, N., L. Wyder, L. Maeck, et al. 2020. "Home Treatment for Acute Mental Healthcare: Randomised Controlled Trial." *British Journal of Psychiatry* 216, no. 6: 323–330. https://doi.org/10.1192/bjp.2019.31.

Suslovic, B. 2024. "Abolition of Involuntary Mental Health Services." In *Encyclopedia of Social Work*. NASW Press and Oxford University Press. https://doi.org/10.1093/acrefore/9780199975839.013.1677.

Szasz, T. 1997. "The Case Against Psychiatric Coercion." *Independent Review* 1, no. 4: 485–498. http://www.jstor.org/stable/24560781.

Szmukler, G. 2018. *Men in White Coats: Treatment Under Coercion*. Oxford: Oxford University Press.

Trachsel, M., H. Hermann, and N. Biller-Andorno. 2014. "Urteilsfähigkeit: Ethische Relevanz, konzeptuelle Herausforderung und ärztliche Beurteilung." *Swiss Medical Forum* 14: 221–225. https://doi.org/10.5167/uzh-101848.

United Nations. 2006. "UN Convention on the Rights of Persons with Disabilities." https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html.

van den Hooff, S., and A. Goossensen. 2014. "How to Increase Quality of Care During Coercive Admission? A Review of Literature." *Scandinavian Journal of Caring Sciences* 28, no. 3: 425–434. https://doi.org/10.1111/scs.12070.

Vruwink, F. J., A. Wierdsma, E. O. Noorthoorn, H. L. I. Nijman, and C. L. Mulder. 2021. "Number of Seclusions in The Netherlands Higher in the 7 Years Since the End of a Nationwide Seclusion-Reduction Program." *Frontiers in Psychiatry* 12: 778793. https://doi.org/10.3389/fpsyt.2021.778793.

Whittington, R., D. O. Aluh, and J.-M. Caldas-de-Almeida. 2023. "Zero Tolerance for Coercion? Historical, Cultural and Organisational Contexts for Effective Implementation of Coercion-Free Mental Health Services Around the World." *Healthcare* 11, no. 21: 2834. https://www.mdpi.com/2227-9032/11/21/2834.

Zeng, L., L. Yao, Y. Wang, et al. 2023. "Presentation Approaches for Enhancing Interpretability of Patient-Reported Outcomes in Meta-Analyses: A Systematic Survey of Cochrane Reviews." *Journal of Clinical Epidemiology* 158: 119–126. https://doi.org/10.1016/j.jclinepi.2023.03.027.

Zinkler, M., and S. von Peter. 2019. "End Coercion in Mental Health Services—Toward a System Based on Support Only." *Laws* 8, no. 3: 19. https://www.mdpi.com/2075-471X/8/3/19.