

# The Last Resort? An Overview of the Political Discussion and Research on the Use of Compulsory Drug Treatment in Psychiatry

Tania M. Lincoln Kolja Heumann Maria Teichert

Clinical Psychology and Psychotherapy, Department of Psychology, University of Hamburg, Germany

## Keywords

Compulsory treatment · Forced medication · Human rights · UN Convention on the Rights of Persons with Disabilities · Schizophrenia · Psychiatric care

## Summary

The discussion on the use of compulsory drug treatment is reignited by changes in legal regulations. The following article introduces the aspects of the legal framework, outlines core positions of the ongoing political discussion, and by following empirical studies considers questions on how frequently compulsory drug treatment is used, how it is experienced and valued by those affected, and whether it is provably effective. Epidemiological studies show that the frequency of compulsory drug treatment varies considerably in Germany and internationally. Qualitative data in different contexts suggest that forced medication is associated with fear, anger, shame, and helplessness for many of those affected and can be traumatizing. Retrospective studies show that forced medication is evaluated as the right treatment in hindsight by about half of those affected. Robust empirical evidence for an immediate or long-term effect of forced medication with regard to aggression, agitation, and symptoms is absent. Therefore, from an empirical point of view compulsory treatment appears to be rather not justified. However, methodologically sound studies are difficult to conduct for ethical reasons. Furthermore, due to the variations in prevalence it is doubtful whether the room to waive compulsion and to apply milder agents has been sufficiently utilized in all clinics. Promising approaches for the prevention of compulsory treatments lie in a stronger outreach treatment, the systematic use of milder agents in crisis situations, treatment agreements, and the development of psychological treatment alternatives. The potential of such alternatives should be used and explored more rigorously.

## Schlüsselwörter

Zwangsbehandlung · Zwangsmedikation · Menschenrechte · UN-Behindertenrechtskonvention · Schizophrenie · Psychiatrische Versorgung

## Zusammenfassung

Die Diskussion über den Einsatz medikamentöser Zwangsbehandlung ist durch veränderte Rechtsgrundlagen neu entfacht. Der folgende Beitrag führt in die Aspekte der rechtlichen Grundlagen ein, gibt Kernpositionen der laufenden politischen Diskussion wieder und geht anschließend anhand empirischer Untersuchungen den Fragen nach, wie häufig medikamentöse Zwangsbehandlungen zum Einsatz kommen, wie sie von den Betroffenen erlebt und bewertet werden und ob sie nachweislich effektiv sind. Aus epidemiologischen Studien wird ersichtlich, dass die Häufigkeit von Zwangsmedikation innerhalb Deutschlands und international erheblich variiert. Qualitative Daten in verschiedenen Kontexten weisen darauf hin, dass Zwangsmedikation bei vielen Betroffenen mit Angst, Ärger, Scham und Hilflosigkeit einhergeht und traumatisierend sein kann. Retrospektive Untersuchungen zeigen, dass Zwangsmedikation von etwa der Hälfte der Betroffenen im Nachhinein als richtig bewertet wird. Belastbare empirische Belege für eine unmittelbare oder längerfristige Wirkung von Zwangsmedikation im Hinblick auf Aggressivität, Erregung und Symptomatik fehlen. Aus empirischer Sicht erscheinen Zwangsbehandlungen demnach eher nicht gerechtfertigt, wobei belastbare Studien aus ethischen Gründen auch schwer zu erbringen sind. Aufgrund der ausgeprägten Schwankungen in der Prävalenz ist ferner fraglich, ob der Spielraum, auf Zwang zu verzichten und mildere Mittel anzuwenden bislang bereits in allen Kliniken hinreichend ausgeschöpft wurde. Vielversprechende Ansatzpunkte für die Vermeidung von Zwangsbehandlungen liegen in einer stärker aufsuchenden Behandlung, dem systematischen Einsatz milderer Mittel in Krisensituationen, Behandlungsvereinbarungen und der Weiterentwicklung von psychotherapeutischen Behandlungsalternativen. Das Potenzial solcher Alternativen sollte stärker genutzt und erforscht werden.

## Introduction

The German Bundestag revised the federal law governing compulsory treatment of mentally ill patients on January 17, 2013. §1906 of the Civil Code (BGB) regulates the conditions under which treatment is allowed against a person's natural will. According to this new regulation, compulsory treatments are once again permitted as a 'last resort,' beyond the justifiable emergency.

Two representatives of the German Society for Psychiatry, Psychotherapy, Psychosomatics, and Neurology (Deutsche Gesellschaft für Psychiatrie, Psychotherapie, Psychosomatik und Nervenheilkunde, DGPPN) served as consultants for the legislation. A new regulation was required after the German Federal Constitutional Court (Bundesverfassungsgericht) had declared in 2011, in 2 rulings on compulsory hospitalization, that the compulsory treatment of mentally ill persons who are behaving in ways that endanger themselves or others is unconstitutional (for a more detailed presentation, see box 1).

The fact that the legislative process was so rapid is mainly due to pressure from representatives of the DGPPN, who had complained in their statement [DGPPN, 2012a] of a 'substantial legal uncertainty for clinical practice' and called for new legislation to be passed in a timely manner. The loophole in

the law, they said, forces 'the medical staff to withhold promising help from their patients and to consign the "mentally ill" to the whims of fate' [DGPPN, 2012b]. This, they argued, would render 'reasonable help inaccessible, medical services could not be provided, and the "free" will decision of the mentally ill would become a cynical excuse to legitimize long-term custody'. According to the DGPPN, the regulation runs counter to the self-conception and professional ethics of psychiatrists and means long-term isolation from society for the patients. The need for forced medication was further justified by the DGPPN on the grounds that otherwise there would be an increase in less humane forms of treatment, such as restraint and seclusion. Another argument was that, in retrospect, the patients often approve of the decision for compulsory treatment [DGPPN, 2013a]. In several statements, leading representatives of the DGPPN also cited case studies that illustrate the problems presented by the existing legal 'loopholes' and demonstrate that forced medication is the only feasible approach to certain crisis situations (for an example, see box 2).

The DGPPN thus welcomed the new regulation on medical compulsory measures, 'because it addresses the personal rights of the patients as well as, in individual cases, the medical opinion that there is an urgent need for treatment to avert impending significant harm to health' and points to 'a transparent, practical,

### Box 1. Legal foundations.

Compulsory treatments are governed by the Hospitalization Law (UBG) and Mentally Ill Law (Psych KG) of the federal states. Involuntary hospitalization has been permitted hitherto in most federal states on the basis of so-called measures of direct coercion with a doctor's order, to prevent behavior that is harmful to oneself or others [Gaebel and Falkai, 2010; Marschner, 2013]. With regard to the regulation of forced medication, the laws of the states differ, in some cases quite substantially. Whereas in Bremen, Mecklenburg-Western Pomerania, North Rhine-Westphalia, Saarland and Saxony, compulsory treatment is permissible only when there is a threat to the life or health of the person being held, in Bavaria, Berlin, Brandenburg, Lower Saxony and Thuringia, such treatment is also permitted according to the currently applicable Psych KG or UBG, if justified by the urgency of the treatment measure [Steinert and Kallert, 2006].

Under federal Custodianship Law, a guardian or authorized person with the appropriate area of responsibility or power of attorney (for health-care or consent to treatment measures) can substitute for the patient's consent to hospitalization (according to §1906 of the Federal Civil Code or the Psych KG or UBG), if the patient is unable to give consent due to illness. There was no explicit statutory provision at the beginning of 2013 that permitted compulsory treatment by a caregiver during hospitalization [Marschner, 2013].

The guidelines for compulsory measures were changed in January 2013, however, with an adjustment of the custodianship law. The background to this development was the UN Convention on the Rights of Persons with Disabilities (UNCRPD – see box 3), which took effect in Germany in 2009, and which strengthens and specifies the human rights of disabled people [Aichele and von Bernstorff, 2010]. In 2 rulings of the Federal Constitutional Court in 2011, it was decided that in Rhineland-Palatinate and Baden-Wuerttemberg there is insufficient legal basis for compulsory treatment in hospital treatment orders. According to the decision of March 23, 2011 (2 BvR 882/09), compulsory treatment with antipsychotic medications for patients under a hospital treatment order is judged a 'serious invasion' of basic rights under Article 2, Paragraph 2, Sentence 1 of the Basic Law and is subject to the most stringent requirements in individual cases. The decision of October 12, 2011 (BvR 633/11) states that there should be 'no neuroleptic treatment for distrust and hostility toward the medical practitioner because of personality disorders'. Consequently, the German Federal Court of Justice (Bundesgerichtshof) ruled that the former Custodianship Law provided insufficient authority for compulsory treatment of the mentally ill (decisions of June 20, 2012, XII ZB 99/12 and XII 130/12).

The legal uncertainty thus facing the medical practitioner was terminated on January 1, 2013 with the 'Law on Legal Custodianship for Consent to a Medical Measure'. It identifies the conditions under which compulsory measures may be applied, namely if '1) the person under custodianship due to a mental illness ... cannot recognize the necessity of the medical measure or cannot act in accordance with this understanding, 2) the medical compulsory measure ... is necessary to prevent imminent serious damage to health, 3) the serious damage to health cannot be averted by any other reasonable measure, and 4) if the expected benefits of the medical compulsory measure clearly outweigh the expected impairment' (§1906 Par. 3 Nos. 1–4 BGB). Although the conditions are now formulated somewhat more explicitly, the law basically allows the existing practice to continue. The rights of patients were not particularly enhanced by the law.

The extent to which the UBG and Psych KG of the federal states now provide sufficient authority for compulsory treatment is legally controversial. Changes in the laws governing involuntary hospitalization are therefore expected in the future; Baden-Wuerttemberg and Hamburg have already made adjustments based on the BGB (Civil Code).

**Box 2.** Case study from the assessment of Sabine Herpertz [DGPPN, 2012c] on a draft law on custodianship regarding consent to a medical compulsory measure from December 10, 2012.

‘Patient A, who until the onset of his illness was a very capable middle-aged man, has suffered for many years from schizophrenia with a delusion of persecution. While prognosis was favorable at first with medication, he attempted suicide many years ago, after discontinuing the antipsychotic medication, with subsequent severe disability, in part due to a brain injury. In the summer of this year he began to cut back and then discontinue his medication on his own, refused regular fluid and food intake, and was admitted to our hospital on a court order to prevent self-endangerment. Mr. A refused almost all fluid intake offered by the nursing staff, as well as by relatives, for fear of poisoning. Due to the new legal situation, the supervisor could not obtain authorization for medical treatment against the patient’s will from the District Court. Given the mortal threat posed by the refusal of fluid intake, we decided on day 5 of treatment to deliver intravenous fluid in order to maintain life functions; confused, no longer capable of communication and displaying psychomotor restlessness, the patient required restraint. After rehydration, the intravenous fluid intake had to be stopped again, because the patient again refused any therapy. When he lost consciousness, and the mortal threat was renewed, fluids were given again. Since the patient’s natural will could no longer be expressed, it was possible to give him an antipsychotic medication, which led to a significant improvement of his mental ability and reduction of his delusions. After an insufficiently long time on medication, the patient refused further medication, and rapidly deteriorated again. These ups and downs went on for weeks, until 1 week of continuous medication stabilized him at the initial level.’

and legally verifiable solution’ [DGPPN, 2013b]. However, other institutions and people criticized that the corrections in the legal basis for compulsory treatment did not go far enough.

The Monitoring Body for the UN Disability Rights Convention (UN CRPD), which is based at the German Institute for Human Rights (Deutsches Institut für Menschenrechte), criticized the draft bill in a statement [Monitoring-Stelle zur UN-BRK, 2013], because of serious concerns about how it would be brought into conformity with the goals of the UN CRPD, which had initiated a paradigm shift away from the principle of care towards a policy of rights, including those of people with mental disorders [Aichele, 2013] (for the main content of the UN CRPD, see box 3). The Monitoring Body refers to the human rights requirement to further develop the system of voluntary psychiatric care. The aim is to integrate the idea of using ‘milder agents’ into the system, arising from the constitutional principle of proportionality. The patient associations themselves are additional important voices in the debate. The Federal Association of Users and Survivors of Psychiatry in Germany (Bundesverband Psychiatrie-Erfahrener, BPE e.V.), in a statement by Board member Ruth Fricke [BPE, 2012], and in accordance with the recommendations of the UN Special Rapporteur (box 3), even called for the complete repeal of §1906 BGB and instead recommended a change in the support system to prevent compulsory measures. The German Federal Chamber of Psychotherapists (Bundespsychotherapeutenkammer, BPtK) also insists on the development of alternative treatment options: ‘The legislature has by no means exhausted all the options to protect patients from compulsory treatments’, said the President of the BPtK, Rainer Richter, in criticizing the new regulation [BPtK, 2013]. There is no regulation, he pointed out, that obliges the psychiatric hospitals to offer a treatment agreement to patients who have recurrent mental illnesses. Prof. Dr. Thomas Bock [Bock, 2012], director of the Specialized Outpatient Clinic for Psychosis and Bipolar Disorders (Spezialambulanz für Psychosen und Bipolare Störungen) at the Hamburg-Eppendorf University Hospital, expressed a similar view in a statement of December 12, 2012 on the occasion of the debate in the Bundestag. He stressed that compulsory treatment ‘is

never just the result of logical progression of the disease’, but ‘is always also the result of fear, lack of trust, and an unsuccessful relationship’, and that means that the ratio of compulsory treatments to alternative care services, such as integrated care or peer-to-peer counseling, could be significantly reduced. Even from the ranks of psychiatric hospitals there are critical voices. Prof. Dr. Martin Zinkler, head of the Department of Psychiatry, Psychotherapy, and Psychosomatics in Heidenheim, complained that the DGPPN has missed the chance to understand that this issue is a challenge to further develop the profession, and that in recent years, far too little has been invested in the development, research and use of preventive measures, and alternatives to forced medication [Zinkler, 2013]. In another article, he describes some positive experiences from his hospital that were caused by the uncertain legal situation. There were 3 patients for whom compulsory treatment would have been sought under the old legislation; instead, the patients were told that there would be no compulsory treatment, but still were nevertheless advised to take medication. The doctors discussed the matter with the patients and the patients finally agreed to take medication. The period during which compulsory measures were de facto prohibited also meant that milder agents were increasingly and successfully utilized at his hospital [Zinkler and Kousseimou, 2013].

These positions raise 2 key questions. One is the fundamental question of whether a compulsory treatment can be justified in some cases as a last resort for people who, ‘because of illness, are incapable of giving consent’, despite the invasion of their autonomy, since the purpose is to re-establish their autonomy and capacity for insight (see the case study in box 2). The answer to this question cannot be based on empirical evidence alone, since it is also a political question that requires weighing of various values. From the perspective of the UN CRPD (box 3), it should have become clear that treatment of persons against their will is in conflict with legal positions on human rights. The distinction between persons ‘capable of insight’ and persons ‘not capable of insight because of illness’, to whom the right to decide for themselves is being denied, thus providing the justification for compulsory treatment, is not

**Box 3.** Selected core aspects of the UN Commission on the Rights of Persons with Disabilities and its importance for the compulsory treatment of mentally ill people.

The UN Convention on the Rights of Persons with Disabilities was adopted by the United Nations (UN) General Assembly in late 2006. The purpose of this Convention is to protect and guarantee the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities. Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments that could prevent them, in interaction with various obstacles, from having full, effective, and equal participation in society (Art. 1).

The principles of this Convention, under Art. 3, include 'a) respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; b) non-discrimination; c) full and effective participation and inclusion in society; d) respect for difference and acceptance of persons with disabilities as part of human diversity and humanity'.

Art. 12, 14, 15, and 25 are particularly relevant to the issue of compulsory treatment. Art. 12 protects the legal capacity for treatment, including the ability to make decisions regarding matters of personal health. Art. 14 (Liberty and Security of the Person) states that '(1) the signatory states shall ensure a) that persons with disabilities, on an equal basis with others, enjoy the right to liberty and security of person; b) are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.' Art. 15 (Freedom from Torture) states: '(1) No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation'. Finally, Art. 25 (Health) states: 'The signatory states recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. The signatory states shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular ... the signatory states shall provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons'. Germany and 132 other countries (as of July 2013) have made a binding commitment in joining the UN CRPD and are obliged to respect and observe the rights of people with disabilities. This means, under Art. 4, 'to adopt all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention; to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities' as well as 'to promote the training of professionals and staff working with persons with disabilities in the rights recognized in this Convention' ([www.un.org/disabilities/convention/conventionfull.shtml#top](http://www.un.org/disabilities/convention/conventionfull.shtml#top)). Referring to this convention, UN Special Rapporteur Juan E. Méndez, in his latest report on torture and inhuman treatment or punishment [Human Rights Council, 2013] recommended, among other things, an absolute ban on all compulsory medical interventions against people with disabilities without their consent, including the administration of mind-altering drugs such as neuroleptics as well as long- and short-term restraint and seclusion. He also called for having services in the community, instead of compulsory treatment and hospitalization, that correspond to the expressed needs of people with disabilities, to respect the autonomy, decisions, dignity and privacy of patients, and to emphasize alternatives to the medical model of mental health.

supported by the text of the UN CRPD. Empirical studies of actual practice, however, may provide information as to whether forced medication has short- and long-term positive effects, and thus may facilitate resolving this issue.

The second relevant question is whether forced medication in current practice is actually used as sparingly as possible, and whether therefore legal protection for the status quo was the right step, or whether there is actually still untapped scope for reducing compulsory practices. This question could in principle be answered more clearly by empirical studies, if it could be shown that the frequency of forced medication is overall consistently low and that milder agents are well researched and systematically utilized.

The following article approaches these questions at first empirically, examining when, by whom, and how often forced medication is used in Germany, how it is experienced and evaluated by patients, and whether it has proven effective. Finally, on this basis, we present an evaluation that re-examines the ethical and political considerations and identifies treatment alternatives.

### What Is Meant by Forced Medication?

Generally speaking, compulsory treatment means a medical treatment against the declared or demonstrated will of the

patient [Steinert and Kallert, 2006]. This requires a distinction between restrictive measures such as restraint and seclusion, and medical treatments that include not only the compulsory administration of medication, but also other measures, such as force-feeding or electroconvulsive therapy, which are used against the will of the patient. Although this article focuses on forced medication, we also report results of larger representative studies whose findings relate to a broader definition of compulsory measures (forced medication, seclusion, and restraint), making this clear at the appropriate places. Forced medication refers to the administration of oral or injected medication against the will of the person concerned. Studies are generally based on a restrictive definition of forced medication, which is that the treatment also violates the physical integrity of the person, e.g., by restraint. Broader definitions also include the threat of force or the use of psychological pressure [Steinert and Kallert, 2006]. In many studies, the term is not explicitly defined.

### How Frequently Does Compulsory Treatment Occur?

There are no reliable, representative figures on the prevalence of forced medication. Steinert and Kallert [2006] reported 2 earlier studies in a hospital in Zurich, where 12% of ad-

mitted patients in 1981 and 16% in 1988 had been forcibly given injections. A survey at the University Hospital in Basel [Finzen et al., 1993] reported that 31% of 199 patients had had experience with forced medication, of whom 19% were during the current stay. A study at the University Hospital in Munich [Naber et al., 1996] showed that for 14 months, 3% of all new admissions and 16% of patients in closed acute-care wards had received forced medication or had been restrained. A more recent study from Germany, which compared inpatient schizophrenia treatments in 7 hospitals, found prevalences of forced medication of 0.4% to 5.6% for the group of patients with schizophrenia [Janssen et al., 2005]. However, the prevalences of forced medication reported in these studies are not directly comparable, due to large differences in the definitions, target populations, and length of time.

The already clear regional and institutional differences are also evident in a study of the overall incidence of compulsory measures (forced medication, restraint, and seclusion) at 10 psychiatric hospitals in Germany [Martin et al., 2007]. The prevalence of such measures at the hospitals in this study ranged from 2.2 to 13.5%. It was also shown that in hospitals where compulsory measures were deliberately deemphasized in everyday clinical practice, there was a comparatively small number of compulsory measures used.

Some studies from other European countries found similar prevalences. In a Norwegian study by Husum et al. [2010], 9% of involuntarily admitted patients were forcibly given depot medication, which in this study showed distinct variations from one ward to another (0–88%). Prevalence variations of this magnitude were also found in Finland [Kaltiala-Heino et al., 2003] and Greece [Bilanakis et al., 2011]. In contrast, several studies from USA suggest lower prevalence rates [Hoge et al., 1990; Zito et al., 1989]. It was interesting that in these studies, the proportion of patients who refused medication was lower than in the German studies. A comparative study by Steinert et al. [2010], which examined the percentage of restraints and seclusion used among the total hospitalized patient population in 11 countries, showed considerable differences between countries: for seclusion, the percentage ranged from 0 (Iceland, England) to 16% (New Zealand), and for restraint from 0 (Iceland) to 8% (Germany, Finland). Moreover, whereas restraints in Japan were reported to have an average duration of 98 h, in England, where mechanical restraints are prohibited, restraint lasted only 10–20 min. Germany was somewhere in between, with an average duration of 10 h, but there were also considerable differences among hospitals in Germany [Ketelsen et al., 2007].

Dressing and Salize [2004], looking at compulsory hospital admissions, investigated whether such differences within the EU can be explained by differences in legislation. They examined the legislation of 15 EU countries and related this to the frequency of hospitalizations. It was found that in countries where legal counsel for patients is mandatory (Austria, Belgium, Denmark, Ireland, Netherlands, Portugal), there is a

significantly lower rate of compulsory hospitalization. This study shows that legal frameworks can explain some of the differences in the frequency of compulsory measures. However, this finding cannot be applied directly to forced medication, for which other factors could also be crucial.

In summary, we can state that the prevalence of any compulsory measures varies significantly among wards, hospitals and countries, and that this is likely associated with personnel, legal, and structural factors.

### **Who Is Affected by Forced Medication?**

Several studies agree that patients with schizophrenia are the most common target group for forced medication, followed by patients with addictive and bipolar disorders [Husum et al., 2010; Jarrett et al., 2008; Knutzen et al., 2011]. The most commonly reported triggers for forced medication are actual or threatened violence against others, damage to property, and self-endangerment [Jarrett et al., 2008; Knutzen et al., 2011]. The substances administered are mostly antipsychotic drugs [Gaebel and Falkai, 2010].

Several review articles found no evidence that compulsory measures are associated with gender or age [Jarrett et al., 2008; Newton-Howes and Mullen, 2011], but there is a consensus that they are associated with more frequent and involuntary admissions [Finzen et al., 1993; Jarrett et al., 2008; Knutzen et al., 2011; Newton-Howes and Mullen, 2011]. Furthermore, patients who receive compulsory treatment seem more likely to come from an immigrant background than those who are not treated compulsorily [Gudjonsson et al., 2000, 2004; Knutzen et al., 2011], although this was not the case in all studies [Newton-Howes and Mullen, 2011].

Forced medication therefore seems to be most often used in crisis situations with patients who are more severely disturbed and have less ‘insight’ into their illness, whereby the intervention is for the purposes of both treatment and safety [Gaebel and Falkai, 2010] (box 2). The indication that patients with an immigrant background may be affected more frequently also suggests that communication problems could play a role, and that discriminatory attitudes towards immigrants may influence treatment decisions.

### **How Are Compulsory Treatments Experienced and Evaluated by Those Affected?**

First of all, patients’ judgment as to whether they have experienced a compulsory measure often does not tally with the documentation of the hospital or their legal status. Smolka et al. [1997] interviewed 36 patients who had been subjected to various compulsory measures, both shortly after the measure was implemented and at the end of their inpatient treatment. Only two thirds of patients who had been forcibly medicated

said so in the first interview (42% in the second interview). Conversely, 36% of those who were hospitalized or both hospitalized and restrained said in the first interview that they had also been medicated against their will. Also a study by Poulsen and Engberg [2001] found that patients more frequently reported compulsory measures than was documented in the medical records. The causes of these discrepancies could be both inadequate documentation of the measures used as well as lack of communication and transparency on the part of staff, and psychotic misperceptions of the situation by the patients. The fact that not every compulsory measure is perceived as such, and that the evaluation of a measure as compulsory can change over the period of hospitalization, also suggests that other factors could have an impact on evaluation of the measure.

Multiple studies have investigated the question of whether patients endorse compulsory measures in retrospect, arriving at different results. In the previously cited study by Smolka et al. [1997], the measures were largely rejected by the patients, and this negative attitude was reinforced in the course of the hospital stay. In addition, the patients who had experienced compulsory measures rated the entire treatment and the doctors responsible for it significantly more negatively than did a control group that was not treated with compulsory measures. Otherwise, these differences were not found in the patients who indeed did experience compulsory measures, but did not perceive them as such. Some studies with similar designs yielded rates of retrospective approval of 27 [Haglund et al., 2003], 33 [Lucksted and Coursey, 1995], and 43% [Finzen et al., 1993], while in other studies, higher rates were observed: of 40 patients who were interviewed at the University Hospital in Munich about various compulsory measures, 48% of respondents thought in retrospect that the measures were justified, 30% were ambivalent, and 23% were still opposed to them. The retrospective approval was highest among those who had 'only' received forced medication [Naber et al., 1996]. In summary, it can be stated that retrospective approval of a compulsory measure occurs in at most about 50% of cases; thus the measures are seen as objectionable and avoidable by at least as many.

Studies that investigated what kind of compulsory treatment of patients is preferred, on the other hand, yield quite consistent results. A survey [Veltkamp et al., 2008] of Dutch patients found that about half prefer forced seclusion to forced medication; men especially expressed this preference. Similar results were found by Wynn [2002] in a comparison of restraint and forced medication at a Norwegian psychiatric hospital. In another Dutch study [Georgieva et al., 2012], on the other hand, there was a slight preference for forced medication; seclusion was preferred if it was relatively brief. Finally, a randomized trial [Georgieva et al., 2013] found that the use of forced medication resulted in a slightly lower number of seclusions, although it did not affect the total duration of seclusion. In summary, these studies show that forced medica-

tion is not particularly preferred by patients to seclusion and restraint, nor is it likely to reduce or replace these measures.

Various qualitative studies and substudies of the experience of patients during compulsory treatment and their wishes regarding treatment have found the following trends: patients suffer from the impression that they were not sufficiently informed about and involved in their treatment [Olofsson and Jacobsson, 2001]; that compulsory measures were often administered too early and were not performed correctly [Haglund et al., 2003; Naber et al., 1996]; compulsory treatment is associated with negative feelings such as anger, helplessness, resignation, fear, and shame [Haglund et al., 2003; Lucksted and Coursey, 1995; Naber et al., 1996] and is experienced as humiliating or as punishment [Finzen et al., 1993]. There are also complaints about lack of or insufficient conversations between patients and staff [Andreasson and Skärsäter, 2012; Finzen et al., 1993; Haglund et al., 2003]; treatment is equated with medication and custody, and therefore the desire is expressed for a more integrative approach to treatment and for more psychological care [Katsakou et al., 2011; Olofsson and Jacobsson, 2001]. In addition, it is felt that there is a lack of human contact and of relationships with the staff that could contribute to an increased sense of security [Olofsson and Norberg, 2001]. It is clear from these accounts that compulsory treatments, while they are being administered, can cause extreme negative feelings in those affected, and that patients judge them in the context of how the treatments are communicated, processed, and embedded in the treatment regimen and in therapeutic alliances. However, these studies are subject to the usual problem in qualitative studies of a lack of objectivity of evaluation. To obtain a more objective assessment, further quantitative surveys would be helpful, which include a suitable comparison group and also explore the impact of various contextual factors on the experience of compulsory treatment.

### **Are Compulsory Treatments Effective in the Short and Long Term?**

For various reasons, it is difficult to measure the consequences of compulsory treatment with regard to its immediate success, e.g., in reducing the danger of harming oneself or others, symptom reduction or capacity for insight as well as the longer-term treatment outcome in terms of remission and quality of life. Systematic research in the form of randomized controlled trials requires the informed consent of participants, which in turn means that they must have the capacity for insight; but this is precisely what is lacking in the group targeted by compulsory treatments during an acute crisis.

So with regard to the short-term impact of compulsory treatments, what we have are at best quasi-experimental studies with limited validity. An example is a study by Steinert and Schmid [2004], which investigated the changes in symptoma-

tology and functioning from the beginning to the end of inpatient treatment of 88 patients from the diagnostic spectrum of schizophrenic and affective disorders. Patients who had been exposed to certain compulsory treatments were compared with those without such exposure. It was found that the patients who were given compulsory treatment had more extreme symptoms, more aggressive behavior, and lower functioning at admission than those who were not treated with coercion. However, the groups were comparable with regard to symptom reduction and improvement of functioning during inpatient treatment. The authors concluded that short-term treatment outcome does not depend on whether the treatment was voluntary or not, and evaluated their findings as an ethical justification for compulsory treatment of patients with schizophrenia. However, this conclusion is not justified, because of the systematic differences between the groups before treatment. To find out whether compulsory treatments are effective, the treatment variation would have had to apply to patients for whom compulsory treatment appeared indicated from the psychiatric point of view. Such studies have not been done, however.

It is not surprising, therefore, that the Cochrane Collaboration failed in its attempt to conduct a meta-analysis of studies on the effectiveness of seclusion and restraint for behavior that endangers oneself and others [Sailas and Fenton, 2000]. Of the 35 studies that were initially shortlisted, none satisfied the minimal inclusion criteria. The authors concluded that there was insufficient evidence for the efficacy of these measures. Also, a review of 36 studies on the short-term efficacy of compulsory measures for reducing danger to oneself and others in psychiatric settings, which was conducted as part of the preparation of guidelines for the National Institutes of Health and Clinical Excellence (NICE) in the UK, objected to the inadequate methodological quality of the studies and concluded that there is insufficient evidence for the short-term efficacy of compulsory measures [Nelstrop et al., 2006]. Compulsory measures are not recommended in the NICE guidelines [2005] of the Royal College of Nursing for dealing with aggressive behavior. The S2 treatment recommendations, 'Therapeutic Measures for Aggressive Behavior' [Gaebel and Falkai, 2010] also point out that the listed studies, which demonstrate the efficacy of various antipsychotic substances, are not readily transferable to patients who are in aggressive states of arousal.

Given the sparse data, Steinert and Kallert [2006] suggest to consider the results of American studies that investigated the short- and long-term effectiveness of outpatient compulsory treatment. In a study by Steadman et al. [2001], 142 patients were randomized in either a condition with outpatient compulsory treatment or a control condition without coercion, and compared after 1, 5, and 11 months with regard to psychopathology, frequency of acts of violence, rates of re-hospitalization, arrests, quality of life, and adherence. None of these measures showed any differences between the groups. The North Carolina Study [e.g., Swartz et al., 2001], which

was similarly designed and probably the world's largest study of the efficacy of outpatient forced medication, was evaluated by Steinert and Kallert [2006] as showing a moderate advantage in favor of outpatient compulsory treatment, in terms of quality of life after 1 year. However, a Cochrane review [Kisley et al., 2006], which evaluated the same studies, concluded that there is no convincing evidence for the efficacy of compulsory measures for the outcomes under investigation. This state of the evidence was confirmed by a recent British large-scale randomized controlled trial, which found no differences in re-hospitalization rates between patients who received outpatient compulsory treatment (community treatment orders) and those who did not [Burns et al., 2013]. On the contrary, some studies suggested longer-term negative consequences, such as fear of returning for treatment [Swartz et al., 2003] and, in extreme cases, traumatization or re-traumatization [Frueh et al., 2005].

### Summary Evaluation

The studies show that the frequency of forced medication in Germany varies considerably and that some countries manage with fewer and shorter compulsory measures. It is also clear that compulsory treatments are associated with extremely negative emotions such as fear, anger, shame, and helplessness and can have negative consequences for those affected. Evidence is lacking for the short- and longer-term efficacy of compulsory measures. Although in retrospect, half of the patients thought the forced medication was justified, the other half thought that it was wrong. Finally, the studies contradict the view that forced medication is a more humane alternative to seclusion or restraint in crisis situations, since it is preferred by only about half of patients and also does not seem to contribute to a reduction of seclusion. The view that compulsory treatments immediately or in the longer term enhance the patient's well-being or reduce the danger to others can therefore not be justified based on our existing knowledge, even though this may appear to be so in individual cases during a crisis situation.

Nevertheless, and in line with the case reports of the DGPPN, the studies we evaluated indicate that forced medication is usually used in crisis situations with the more severely disturbed, agitated-impulsive patients, who have less insight into their disorder. These patients and situations present medical practitioners with the challenge of choosing between immediate consequences (e.g., preventing harm to oneself, protection of other patients and staff) and longer-term consequences (e.g., loss of confidence, traumatization of the patient). It is indisputable that there are acute situations in which medication against the patient's will seems to be or is correct. Because of the dubious efficacy and potential harm that is done to the patient through compulsory treatments, however, everything should be done, especially beforehand, to prevent such situations from developing. Although it can

be assumed that no psychiatrist thinks lightly of ordering or performing compulsory treatments, the considerable variation within Germany suggests that in some hospitals there is still room for further reduction of compulsory treatments. Furthermore, the fact that there are countries in Europe with lower prevalence of seclusion and restraint provides indirect evidence that in Germany, the scope for using milder and especially preventive agents has so far not yet been fully exploited. However, in order to verify this conclusion directly, more specifically targeted comparisons of different countries would have to be carried out, taking into consideration their structural and legal conditions and the overall situation of the care they provide.

The fact that some leading psychiatric associations fundamentally believe in the necessity of compulsory treatments, against all the opposition from patients' associations, and are so far not receptive to demands for greater reliance on preventive and alternative treatment approaches, may be related to the biological perspective on psychotic disorders that dominates the field of psychiatry. Antipsychotic medication is still considered by many as the only treatment option or at least as a necessary precondition for any other treatment options. This view is contrary not only to the expressed wishes of those affected for a more integrated treatment that includes psychological therapy and a lesser focus on medication; it is also scientifically hard to justify in light of the at best moderate effectiveness of neuroleptics [Leucht et al., 2009] and the very positive experiences with alternative approaches, such as Soteria [Calton et al., 2008], or recently also with cognitive-behavioral approaches for non-medicated patients [Morrison, 2001; Morrison et al., 2004]. The assertion that the practitioner would be forced to resort to measures such as custody and non-treatment if he or she lacked the option to use medication, even against the patient's will, is thus not sufficiently justified. The hasty adoption of the law therefore actually missed an important opportunity to further test and evaluate practices based on voluntary measures. The statement of the Monitoring Body stresses in this regard that 'even if one sets aside these doubts about the admissibility of the proposed regulation from the human rights standpoint, the better guarantee of the rights of people in psychosocial crises on the basis of voluntary treatment and assisted autonomy is scarcely achieved if all that happens is that a changed legal basis is set in place of the old, and the system of psychiatric care falls back into the old patterns' [Monitoring-Stelle zur UN-BRK, 2013].

## Next Steps

To achieve the goal of reducing and avoiding compulsory measures, the debate initiated by the new legal regulation should now be continued with all parties involved. The next steps in research could be to clarify how the variations in the frequency of compulsory treatment come about, so as to use

this knowledge to make structural changes. Besides the influence of hospital management's attitudes [Martin et al., 2007], it would make sense to consider legal, structural (e.g., the spatial and staffing facilities of the hospital, the health-care system) and conceptual factors (therapeutic concepts, training of staff in de-escalation techniques, relationship work, etc.), and to make adjustments accordingly. Furthermore, the spectrum of 'milder agents' other than coercion (such as soothing conversation, strategies for relationship building, bringing in familiar people, offering a break, a drink or a snack) and also lesser invasive compulsory measures (e.g., holding), for which catalogues of measures already have been introduced [Anderl-Doliwa et al., 2005], should be further developed and their effects systematically researched. The evaluation of de-escalation programs, for example, would be part of this spectrum.

Alternative treatments should also be explored in the future (e.g., cognitive behavioral therapy, Soteria approaches) for patients who refuse drug treatment. Such approaches would also meet the expressed needs of patients for more time and communication with staff. At present, the further exploration of such alternatives is held in check by the dominant dogma of ethics committees, that an effective treatment with an antipsychotic drug cannot be withheld from patients in clinical studies, despite the rather moderate effect sizes.

In addition to such treatment alternatives, the systematic use of jointly developed crisis plans and treatment agreements, as advocated by the BPTK, would be a way to provide patients who show the ability to judge with preventive approaches for the future, as well as to do justice to patients' desire for greater participation in determining their own care. Such agreements usually contain a list of proven measures preferred by patients for crises of varying severity. This includes, for example, how the patients' social milieu and practitioners can assist the patient when the symptoms get worse (e.g., by sick leave, support calls, PRN medication), as well as which measures should be used if a mental crisis gets worse (e.g., a call from friend X, being taken to ward B, a relaxation room and understanding, treatment by Doctor C). Such agreements increase the likelihood of effectively counteracting crises early on, so that they do not reach the point of compulsory treatment. In addition, such agreements can establish whether and under what circumstances compulsory treatment is desired. Thus, they could reduce the frequency of compulsory treatment for those who explicitly reject it when they are capable of judgment. Despite initial evidence of efficacy for these interventions, they are rarely used and have so far not been systematically investigated in Germany [Henderson et al., 2008]. Furthermore, patients who are able to judge could be encouraged to complete an advance directive [Amering et al., 2005], so that the problem of the lack of an advance directive, as a critical starting point for potential compulsory treatment, as the DGPPN presents it in a press release [DGPPN, 2013a], could be reduced with the appropriate involvement of all participants.

Another option, which would also ensure greater relationship stability, is the shift of the care system away from its strong focus on inpatient beds and acute care toward more outreach treatment, as has already been implemented successfully in the USA and UK [Marshall and Lockwood, 2000]. Although Soteria approaches, at least in the short term, are staff- and therefore cost-intensive, and therefore the demand of the DGPPN [DGPPN, 2013a] for an allocation of resources within the field of medicine in favor of psychiatry makes sense, the question of costs should not be made a *conditio sine qua non* for the process of change. This is shown by the concept of integrated care in Hamburg, that achieved a change in the structure of care without increasing the resources. Core elements of this concept are the psychosis outpatient clinic and a mobile specialized team for home care that is available around the clock and that looks after patients directly after inpatient treatment and continuously in case of a relapse, to ensure continuity of treatment [Lambert et al., 2010]. There must, however, be further investigation of to what extent the number of compulsory treatments can be reduced by such concepts.

Finally, we would like to look once again at the case study cited in box 2. Since this was a recurrent disorder, the first thing to ask was whether the hospital had encouraged the patient beforehand, when he was capable of insight, to make his wishes clear in the form of an advance directive. The next thing would be to analyze whether treatment agreements had been concluded, whether the patient had received outpatient psychological treatment in connection with previous treatments, whether the hospital has an outreach treatment concept, and whether there was a practitioner who cared consis-

tently for the patient, noticed the impending crisis, and accompanied the patient. The question would also arise of how the hospital staff had been trained to deal with special crisis situations and what measures were used for de-escalation and milder agents, in line with the recommendations [Anderl-Doliwa et al., 2005].

Although almost all practitioners agree that there are acute situations in which a given treatment is the best possible option, even against the patient's will, those with this attitude have yet to prove that such acute situations are unavoidable. If there is no effort to reform psychiatric care in Germany to prevent coercion, we run the risk of not sufficiently taking human rights into account. Due to the so far rather meager efforts to systematically develop the use of milder agents, preventive measures and treatment alternatives, the question arises whether a complete ban on any compulsory treatment, as demanded by the patient groups and the UN Special Rapporteur, would offer a greater chance of positive change in current practice. Despite various problems that would go along with this, it would increase the pressure to develop preventive and alternative options.

## Disclosure Statement

The authors hereby declare that they have no conflicts of interest with regard to this manuscript.

Translated by Susan Welsh  
welsch\_business@verizon.net

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