



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

OPINION

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CONTENTS

1	INTRODUCTION	7
2	TOPIC OUTLINE ORGANISED AROUND LIFE STAGES AND PROFESSIONS	12
2.1	Children and youth	16
2.2	Adults	18
2.3	The elderly	21
2.4	Topic areas covered in this Opinion	22
3	“BENEVOLENT COERCION” – CONCEPTUAL DEFINITION	25
3.1	Definition of “coercion”	25
3.1.1	Working definition	25
3.1.2	Detailed analysis and delimitation of related concepts	25
3.2	Properties of “benevolent” coercion	28
4	FRAMEWORK FOR NORMATIVE ORIENTATION	33
4.1	Central normative concepts	33
4.1.1	Dignity – autonomy – self-determination.....	33
4.1.2	Care	39
4.1.3	Dependency and the need for others	41
4.1.4	Caring relationships and power	44
4.1.5	Vulnerability	46
4.1.6	Trust in people and institutions	48
4.1.7	Judgment and conscience	49
4.2	Relation to basic rights and human rights	53
4.3	Ethical positions on the justification of benevolent coercion in caring relationships	63
4.4	Applications in the area of professional ethics	75
4.4.1	Caring relationships	75
4.4.2	“Deviant” behaviour and the traditional conception of the dual mandate of social professions	76
4.4.3	Shifts in professional self-conceptions	77
4.4.4	Principles of professional ethics	79
5	FIELDS OF PRACTICE	86
5.1	Benevolent coercion in psychiatry	86
5.1.1	Outline	86
5.1.2	Forms of benevolent coercion	92

5.1.3	Current legal framework	93
5.1.4	Current situation in professional practice	103
5.1.5	Ethical reflection	110
5.2	Benevolent coercion in child and youth services	116
5.2.1	Outline	116
5.2.2	Forms of benevolent coercion	125
5.2.3	Current legal framework	130
5.2.4	Current situation in professional practice	137
5.2.5	Ethical reflection	145
5.3	Benevolent coercion in elderly and disability care	150
5.3.1	Outline	150
5.3.2	Forms of benevolent coercion	157
5.3.3	Current legal framework	161
5.3.4	Current situation in professional practice	165
5.3.5	Ethical reflection	169
6	EXECUTIVE SUMMARY	178
7	PRINCIPLES AND RECOMMENDATIONS	213
	DISSENTING VOTE	227
	REFERENCES	234
	CITED DECISIONS	251
	ABBREVIATIONS	252

1 INTRODUCTION

Coercive measures performed with caring or benevolent intent are widespread in health and social services. However, any and all forms of coercion in professional caring relationships constitute a serious infringement of the care recipient's fundamental rights. Therefore, such measures require particularly strong moral and legal justification. The practice of benevolent coercion in psychiatric wards, institutions for the care of children and adolescents, and care homes for the elderly or disabled has been subject to critical scrutiny to a different extent at different times. So far, these discussions have mostly been confined to individual disciplines and different fields of practice have rarely been brought into connection. The present Opinion engages with this challenging topic from a general perspective and develops a normative framework for guidance and orientation. Based on this framework the Opinion then examines the three above-mentioned fields of practice in which the question of justifying the coercive implementation of measures intended to help the recipient, i.e. justifying (allegedly) "benevolent" coercion, is particularly urgent.

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

It is the view of the German Ethics Council that in the context of professional caring relationships the use of coercion as

a means of helping care recipients should be avoided, if at all possible. If a coercive measure must nonetheless be considered, the context of the act must be designed in such a way that esteem and respect for the individual and his' self-determination are reliably maintained. Allowing recipients of care to participate to the greatest extent possible in all phases and situations of professional care that involve benevolent coercion is an immediate expression of this esteem and respect. The principles and recommendations for the use of benevolent coercion in professional caring relationships developed in this Opinion presuppose that it is being used as a last resort. This has two implications. First, these recommendations are intended to contribute to the development of frameworks, structures, and processes which allow coercion to be avoided whenever possible. Second, it is possible for emergencies to arise in which using coercion against a recipient of care must be considered as a last resort. The Opinion aims to provide orientation regarding situations of this kind as well.

In this Opinion “coercion” denotes the overriding of another person’s will. Coercion is called “benevolent” if it is performed with the intention of preventing the recipient from causing harm² to herself. Another question distinct from the issue of benevolence is whether the use of coercion is morally justified in a given situation. This Opinion is concerned with the welfare of human beings who are subject to coercion; therefore, coercion used to suppress behaviour that harms another person rather than oneself will not be discussed in this Opinion, even though in practice the distinction between harming oneself and harming others can be difficult to draw.

1 In the interest of gender equality this Opinion uses “he”, “she” or plural forms alternately.

2 The notion of harm to the self is used in a broad sense here which encompasses not only physical and psychological harm but also damage to a person’s social relationships if this has an adverse effect on the person’s options for participation.

In many ways “benevolent coercion” is an objectionable notion. Initially the term often meets with repudiation, as the hearings held by the German Ethics Council, among others, have shown. Can a coercive act that overrides another person’s opposition ever be experienced as benevolent by that person, even if it is intended to serve his wellbeing? Isn’t this assumption cynical, and the attribute of “benevolence” just a euphemistic obfuscation? Would it not be more accurate to speak of “coercion preventing self-harm”?

Besides the fact that the expression “coercion preventing self-harm” is cumbersome, the German Ethics Council has chosen to use the term “benevolent coercion” because it highlights an important tension that tends to recur when caring for others. Professional care should of course always promote or at least maintain the welfare of the care recipients. On the other hand, it should respect their self-determination, especially in circumstances in which the decisions a person makes regarding herself are difficult or even impossible for others to understand. Conflicts between these two equally fundamental principles occur whenever respecting someone’s self-determination entails allowing them to put themselves at risk of serious harm. In these circumstances, the question arises whether violating someone’s self-determination by means of coercion can be considered benevolent. By using the expression “benevolent coercion” the German Ethics Council wishes to emphasise the fundamental conflict inherent in these situations and to initiate a professional and societal debate about this topic. It is obvious that coercion can only be recognised as benevolent in hindsight by the individual subject to it, if at all. If the person could experience the benevolent aspect of a coercive measure directly, he would most likely drop his resistance and consent to the measure, thereby divesting it of its coercive character.

The present Opinion examines coercion in the context of the health and social care professions. Thus, the following reflections are solely concerned with professional caring relationships. In this context, benevolent coercion often gets

justified by the claim that the duty to care for the recipient's welfare outweighs her right to self-determination. This justification of benevolent coercion is doubtful given the fundamental shift in orientation towards a focus on the care recipient's perspective that has taken place in the field, along with the corresponding changes in caregivers' professional self-conception. These shifts are variously known as a "person-centred orientation", "focusing on resources rather than deficits", or a "human rights orientation". They are explained in more detail below (see chapter 2 and section 4.2).

This Opinion assumes the above-mentioned shifts, the resulting focus on self-determination, and the ongoing discussions about coercive measures in the different sectors as its starting point and formulates a general normative foundation for the justification of benevolent coercion in professional caring relationships. According to the view proposed here, benevolent coercion is not categorically impermissible but can be justified as a last resort under certain circumstances which are *elaborated* below. Three different constellations should be distinguished:

- a) The recipient of care is expressing particular wishes and needs but is undoubtedly incapable of making a fully responsible decision in the given situation. For this group of people benevolent coercion may be justified under certain conditions.
- b) The recipient of care is making a decision, but there are well-founded doubts regarding her capacity for full responsibility in the given situation. In these kinds of doubtful cases benevolent coercion may already be justified under certain conditions.³
- c) The recipient of care is making a decision which undoubtedly is fully responsible. In this case benevolent coercion

3 These borderline cases are discussed in more detail in sections 3.1.2, 4.1.1, and 4.3.

cannot be justified, even if the person's decision results in serious harm to himself and constitutes an extreme challenge to the professional carers' duty to provide care.

These distinctions have two implications regarding the moral justification of benevolent coercion. First, it is very important to assess whether or not a person's actions are fully responsible. While this assessment is inherently problematic and often exceedingly difficult in practice, it is indispensable. Second, benevolent coercion must only be used under certain conditions and as a last resort, even in the case of individuals who are not capable of acting with full responsibility. The argument for this claim will be spelled out in more detail below.

Professional care is oriented around the person receiving care and his welfare. However, a person's own ideas, wishes, and needs and other people's ideas about what constitutes his welfare and what serves his best interest can differ greatly depending on the care recipient's stage of life and the caregiver's profession. Hence, this Opinion introduces the problem of benevolent coercion in professional caring relationships by illustrating it in the context of the human lifespan and its characteristic stages (see chapter 2). Then a general normative foundation is developed (see chapter 4) and applied more specifically to the three above-mentioned fields of practice – i.e. psychiatry, child and youth services, and elderly and disability care – which are shaped by the different professions on which they are based, each with its own scientific foundations and distinct professional self-conceptions (see chapter 5).

2 TOPIC OUTLINE ORGANISED AROUND LIFE STAGES AND PROFESSIONS

The problem of justifying benevolent coercion arises in all stages of life whenever there are situations in which a person's capacity for self-determination is impaired. These impairments can be due to the person's developmental stage (for example in children), they can be temporary (for example in cases of severe mental illness), permanent (for example permanent cognitive impairments), or progressive (for example dementia).

Making fully responsible decisions places demands on a person's faculty of judgment. One must be able to understand the significance of a particular decision for one's current as well as future situation. Depending on the type and scope of the decision, this requires different cognitive, socio-emotional, and moral skills.

Developmental psychology emphasises the active role every human being plays in shaping his development across the various stages of human life.⁴ Even infants and toddlers contribute to their own development quite competently in multiple ways, for example through their patterns of attention, their use of language, and their play behaviour.⁵ As children's cognitive and moral skills mature and they learn to assess their own abilities realistically, they increasingly face the task of taking responsibility for their own development and for others.⁶ In childhood, developing trust in one's own strengths as well as in one's caregivers is the central axis around which one's experience revolves. In adolescence, the focus shifts to trust in one's personal future and the future of society. During this stage of

4 Concerning the different stages of life, cf. the papers in Wahl/Kruse 2014. For a basic understanding of development across the life span, cf. loc. cit. Kruse/Wahl 2014 and Baltes/Lindenberger/Staudinger 2006.

5 Cf. Siegler et al. 2016.

6 Cf. Haase/Heckhausen 2012.

life, more than during childhood, one actively constructs and shapes one's own personality, especially by categorising oneself as a member of particular social groups, creating developmental perspectives for oneself, and attempting to realise these visions.⁷ Adapting the conception of one's developmental goals and one's ways of pursuing them to the given conditions of development is an especially important aspect of this process.

Processes of maturation as well as cultural norms and values define certain developmental windows within which particular goals can be pursued using a justifiable amount of resources and maintaining sufficient chances of success.⁸ Human beings have to decide at each particular point in time which goals to pursue as primary and which to set aside temporarily or abandon altogether. Also, their efforts to realise their goals can fail. Thus, successful human development presupposes not only formulating and pursuing one's own goals, but also having the flexibility to modify or drop goals in case of failed efforts, diminishing material or immaterial resources, or lack of time.⁹

Adulthood is characterised by the simultaneous experience of gains, stability, and losses as well as continuity and discontinuity in the different areas of development. Furthermore, differences between individuals grow larger over the course of development, and changes are increasingly effected by actively setting and pursuing one's own developmental goals.¹⁰ In old age, the necessity of integrating the different perspectives of potential and vulnerability must be emphasised. These include mental and emotional strengths and communication skills on the one hand and physical and brain physiological weaknesses on the other.¹¹ However, aging is not a biological or genetic "programme" that essentially cannot be influenced in

7 Cf. Kruse/Schmitt 2011.

8 Cf. Heckhausen/Wrosch/Schulz 2010.

9 Cf. Brandtstädter 2007.

10 Cf. Freund/Nikitin 2012.

11 Cf. Kruse 2017.

a positive direction.¹² The modifiability of the process of aging both in the physical and the psychological realms is well-proven even for the advanced stages of old age.¹³ Empirical evidence indicates that the older one gets, the more important it becomes to adapt oneself to one's changed life situation, while in earlier stages of life one's life situation can be altered more proactively in order to make it congruent with one's goals and expectations.¹⁴

At any age discrepancies can arise between recipients of care and those responsible for their welfare with regard to (a) the developmental goals deemed crucial by either party, (b) the possibility of (still) accomplishing specific goals at all, or (c) the means considered commensurate with the pursuit of the goals. Empirical evidence reliably demonstrates that appropriate interventions (which, depending on age, may be educational or rehabilitative) can influence developmental processes quite significantly, that developmental opportunities (for example to improve one's health and productivity) can be seized, and that developmental risks (for example progressive loss of competencies or self-harm) can be avoided.¹⁵ However, if these interventions are not in line with the goals endorsed by the recipient himself, they can turn into benevolent coercion. This renders their use particularly problematic.

There are other forms of benevolent coercion to be distinguished from the above-mentioned cases. Measures that deprive the recipient of liberty, for example committing someone to a hospital or care home, installing bedrails or fixation straps, administering sedatives, or performing medical treatment against her will, all constitute benevolent coercion, provided they aim at promoting the recipient's wellbeing.

Even though these measures may ultimately be intended to serve the recipient's welfare, they can nevertheless cause harm

12 Cf. Kowald/Kirkwood 2015.

13 Cf. Lindenberger 2014.

14 Cf. Brandtstädter 2007.

15 For a comprehensive overview, cf. Kruse 2017.

and thwart some of his possibilities of self-actualisation. Thus, the use of measures of benevolent coercion in professional caring relationships always takes place in the context of inherent tensions between welfare and autonomy. As elaborated in chapter 5, the ways and conditions of applying benevolent coercion are quite different depending on the recipient's stage of life and the given system of professional aid.

In the health and social services the decision to employ coercive measures is often made in a triangular relationship between the recipient of care, her relatives or representatives, and the professional carers. Relatives or representatives and professional caregivers usually have the care recipient's welfare in view; however, sometimes they also pursue their own interests. As indicated at the beginning, ensuring the care recipient's wellbeing is the predominant reason adduced in favour of benevolent coercion, which is consonant with the traditional ethos of care and benevolence endorsed by the health and social care professions. In the past, it was often assumed that if an act of coercion is performed with benevolent intent it is therefore justified. However, in virtue of the shift towards a human rights-focused orientation that is taking place in the health and social care professions, the moral and legal justification of benevolent coercion has come under increasing scrutiny. Thus, the justifiability of using benevolent coercion against individuals whose actions must undoubtedly be considered fully responsible is generally doubtful. Benevolent coercion is only considered legitimate under certain conditions and against individuals whose capacity for full responsibility is impaired or can legitimately be doubted. If one adopts this position – as the present Opinion does – determining whether a person's actions are fully responsible is crucial if one is to justify this kind of coercion.

In recent years, the practice of using coercion in adult and forensic psychiatry has also been questioned after several verdicts at the highest judicial level declared the legal foundation of coercive treatment insufficient. In somatic medicine,

nursing, and different fields of practice within the caring professions, controversial discussions about the use of benevolent coercion have increasingly sprung up as well.

In what follows, typical constellations of benevolent coercion in professional caring relationships pertaining to different stages of life are described.¹⁶

2.1 Children and youth

In adolescent services, educational measures are sometimes enforced against adolescents' will. These measures often take place in the context of restrictive educational approaches characterised by coercion. Examples include imposing sanctions for unruly behaviour in the form of restricting access to TV, the internet, or social media, grounding a person, withholding pocket money, or banning calls to the parents. These privileges then have to be "earned" back by rule-conforming behaviour. Educational approaches of this kind enjoy a certain degree of popularity but have been heavily criticised from the perspective of pedagogical science.

Children and youth with disabilities or severe or chronic illness often need particularly extensive medical care. The required procedures can be extremely frightening, especially for small children and children with cognitive impairments. Intense stress – for example because of examinations or surgical procedures – or pain – for example during physiotherapy – can cause defensive reactions in the child, which can escalate into panic attacks. In these circumstances the necessary examination or treatment is often performed coercively. While this form of benevolent coercion does aim at fostering the child's physical health and wellbeing, it must be kept in mind when formulating possible justifications that it can result in

¹⁶ Benevolent coercion also occurs in private and familial caring relationships, which are not covered in this Opinion.

posttraumatic stress disorder and concomitant negative consequences for the child's personality development, especially in children with disabilities or with severe or chronic illness who may experience coercive treatment that is more intense, performed repeatedly, or even applied on a regular basis.¹⁷ If the progression of a chronic illness in a child or adolescent can be prevented by time-consuming daily therapy, parents often face the dilemma of wanting to avoid trauma by therapies forced upon the minor against his will, while on the other hand forgoing the therapies could be viewed as serious neglect.

In case of behavioural disturbances of children and youth, for example eating disorders, attention disorders, or aggressive behaviour in conflict situations, both child and adolescent services and child and adolescent psychiatry are often called upon. Psychiatrists often resort to psychotropic medication to deal with these problems, for example medications for Attention-Deficit/Hyperactivity Disorder. Professionals within the field disagree whether administering psychotropic drugs in these cases does in fact serve the child's welfare, or whether, on the contrary, it actually has a negative impact on her psychological development.¹⁸ Recently, the focus of attention has also turned to measures involving deprivation of liberty used in child and adolescent psychiatry and other institutions. These used to be performed solely based on the parents' consent but now have to be authorised by a family court (in accordance with Section 1631b BGB).¹⁹ The old situation was problematic mainly because in practice the parents often had to make a decision without full knowledge of what measures were being proposed, and they usually gave their consent under pressure from the institution caring for the child. From

17 Cf. Irblich 2004, 16 ff.

18 Cf. Parens/Johnston 2009.

19 Introduced on 1 October 2017 by the *Gesetz zur Einführung eines familiengerichtlichen Genehmigungsvorbehaltes für freiheitsentziehende Maßnahmen bei Kindern* (Act on the introduction of a requirement of family court approval for measures involving deprivation of liberty in children) of 17 July 2017 (BGBl. I, 2424).

a legal point of view consent given by parents in a dilemma or emergency is questionable; nevertheless, practically speaking the custodians as well as the minors in question often have no alternative. The introduction of the new law, according to which coercive measures of this kind are contingent upon judicial approval, promises to improve the situation somewhat insofar as courts are in fact capable of delivering professionally informed verdicts.

If decisions have to be made about the medical treatment of minors, these are the parents' responsibility in principle. However, children do have the right to participate in any decisions affecting them in the form of having their opinion heard and taken into account. There is an ongoing debate from a legal and ethical point of view about the question to what extent the will of a child or youth should be included, or perhaps even considered decisive, when making decisions about medical treatment.

2.2 Adults

In the case of adults, benevolent coercion is used both in somatic medicine and in psychiatry, as well as in nursing and social work. In somatic medicine, benevolent coercion occurs for instance when a cognitively impaired patient who repeatedly tries to pull out his intravenous line is fixated, or when a patient with severe dementia who refuses to eat is given a tube to be force-fed. In psychiatric care, the use of coercion usually gets justified by the need to avert harm to self or others. This Opinion focuses on the prevention of harm to the self since this is the only scenario in which the person's welfare is directly at stake. Patients subject to benevolent coercion include not only individuals with acute psychotic symptoms who lack all awareness of being ill, but also patients with affective disorders or depression who refuse treatment. In these cases, patients are often committed to a hospital or institution against their will

and coercive treatment is applied (see section 5.1.4). Often, relatives are also affected by the patient's condition and therefore urge that coercive measures be performed. However, coercive interventions intended to serve the patient's welfare can trigger a vicious cycle of coercion and resistance. Many people who have been subject to coercion in psychiatry report traumatic experiences of being completely helpless and at the carers' mercy. Individuals who have undergone such experiences often refuse medical and psychiatric attention point-blank during subsequent bouts of illness. This attitude is illustrated by the fact that organisations for (former) users of mental health services often run initiatives which encourage people to draw up advance directives to address the issue of coercion.²⁰

In the different areas of social work, not only direct but also indirect forms of benevolent coercion play a role. A case in point is substance abuse support for the severely addicted. It is common practice in correctional institutions to withhold replacement therapies in order to increase clients' willingness to participate in withdrawal therapies. This gets justified by reference to their welfare. One must be aware, however, that in those constellations the chances of success of withdrawal therapies are low. This must be taken into account when justifying withholding a desired replacement therapy.

In disability care, acts of help, support, or care that aim at serving the recipient's welfare are often performed coercively. As has been well-known for a long time, care recipients with an extensive need for support are usually subject to structural coercion as well.²¹ Since such measures are not enacted to promote the recipients' welfare but rather due to other necessities, they will not be covered in this Opinion.

Interference in women's fertility via the administration of contraceptives is common practice in disability care. It is not

20 For instance, the (German) campaign PatVerfü advocates for advance directives with the slogan "Geisteskrank? Ihre eigene Entscheidung!" (in English: "Insane? Your own decision!") (<http://www.patverfue.de>).

21 Cf. Goffman 1961.

always clear whether the women concerned have been asked for permission. When making decisions regarding such interventions, concerns about the welfare of women with disabilities and the welfare of their potential children play a role, as does the interest of the woman's parents not to have to care for a grandchild as well as the interests of institutions which are often insufficiently equipped to care for parents with disabilities.

Another highly sensitive area in which benevolent coercion is utilised consists in interventions in the family life of people with disabilities. Sometimes children of mentally disabled parents are given to foster families against the parents' will. Given the more recent studies on this topic and the regulations of the United Nations Convention on the Rights of Persons with Disabilities, many experts now advocate increased restraint with regard to state interventions in this area.²²

Certain educational approaches to handling challenging behaviour – for example using rewards and punishments as suggested by behavioural therapy, physical force in the form of holding or subduing, or social exclusion through “time-outs”²³ – as well as the use of so-called acute medication to avert self-harm are considered indispensable in disability care. Acute medication is often administered in a concealed form. Staff shortages and a lack of training in de-escalation skills tend to abet the use of these medications. There has been a critical debate about whether these interventions are always employed with appropriate caution and whether they do in fact serve the recipients' welfare.

22 Cf. e.g. Pixa-Kettner/Rohmann 2012.

23 “Time-outs” are intended to temporarily remove a child or adolescent who is displaying challenging behaviour from their ordinary social environment and hold them in a place with low levels of stimulation, e.g. in rooms specially fitted out for that purpose.

2.3 The elderly

As people approach old age, the prospect of becoming dependent on care renders the issue of benevolent coercion increasingly significant. Coercion used to suppress deviant or obnoxious behaviour, for example in individuals with dementia who are dependent on care, is often justified by appeal to their welfare and the care required to maintain it. When professional caregivers or relatives who are providing care have to make a decision for or against the self-determination of a nursing patient, they are often worried about incurring guilt for failing to care sufficiently for the patient. In addition, professional caregivers fear being held responsible if, for instance, a nursing patient is injured in a fall which could have been prevented by bedrails. This can drive caregivers to employ measures that involve deprivation of liberty or to enforce acts of care coercively.

Individuals with cognitive impairments or dementia have a particularly high risk of being subjected to benevolent coercion. On the one hand, this includes measures involving deprivation of liberty such as committing someone to a closed ward or installing bedrails, straps or other mechanical fixation devices. On the other hand, it can take the form of acts of care being imposed on a person because one “means well by them”. An example of this is care homes imposing an altered food and drink regime on residents that does not correspond to their habits or needs. Also, elderly patients with dementia often exhibit symptoms which are perceived as challenging by their environment, for example psychomotor agitation, nervous irritation, fidgeting, near-delusional beliefs, sensory hallucinations, aggression, sleep disturbances, depression, despondency, or distrust. In practice, the response to these phenomena often consists in administering medication, for example tranquilisers or neuroleptics, or mechanical devices that deprive the patient of liberty (see section 5.3.4).

2.4 Topic areas covered in this Opinion

Coercive medical treatment, for example coercive dental treatment of persons with mental disabilities or coercive therapeutic measures in the case of somatically based delirium, as well as any measures that involve deprivation of liberty, for example involuntary commitment, bedrails, or straps attached to wheelchairs or beds, must be approved by a guardianship court. Here, the court must weigh respect for the patient's self-determination against their wellbeing. From a professional point of view, it is often contentious what kind of protection is required for the sake of the patient's welfare and how it should be implemented. In general, there has been a shift in the relevant moral and legal precepts in favour of enhanced respect for individuals' self-determination. Carers and guardians increasingly find themselves in the situation of having their petitions for coercive measures declined and having to look for alternatives. This poses both professional and ethical challenges for them.

Since public awareness of the problem of benevolent coercion originated in the field of psychiatry, the present Opinion addresses coercion in psychiatry as representative of the entire field of medical practice (see section 5.1). In terms of the content to be covered, the primary reason for this choice is that several verdicts of the highest German courts have highlighted a significant need for reform both in legislation and in psychiatric practice. On the one hand, this has posed considerable challenges for psychiatric services; on the other, it has initiated dynamic processes of developing alternatives to coercion and of deeper reflection within the field of psychiatry.

So far, educational interventions in the case of deviant, challenging, or undesirable behaviour and rehabilitative measures carried out against the recipient's will have not received the same degree of attention in contemporary ethical and juridical debates. From the point of view of the (professional) ethics of the social professions they were considered fairly

unproblematic until a few years ago. The goal of securing the wellbeing of individuals to whom a reduced capacity for understanding and self-determination is attributed was seen as sufficient to justify coercive interventions. However, this presumed certainty of professional ethics has been vehemently critiqued by the disability rights movement where it is considered as heteronomy and a paternalistic transgression imposed on persons with disabilities. This has been expressed poignantly in the slogan of the international disability rights movement, “Nothing about us without us”.²⁴ The movement has brought about significant changes in disability care. In contrast, when it comes to the care of children and youth more restrictive approaches have been making a comeback after progressive educational ideas were prevalent for a certain period (see section 5.2.1). Since the use of benevolent coercion in the area of education has not been discussed as extensively (even though it clearly raises similar problems to the ones debated in medical care), it is addressed as a topic in its own right in this Opinion (see section 5.2).

Further, the Opinion discusses a third area in which coercion is used, i.e. the care of people with a high or extremely high need for help, support, and care, which comprises individuals with complex special needs and impairments (which often include cognitive ones), and also elderly people dependent on care. These groups of people are often subject not only to measures involving deprivation of liberty, but also to educational or rehabilitative measures intended to activate them that are performed against their will. Another shared attribute of these groups is that they tend to live in care homes where they are subject to structural coercion (see section 5.3).

The three fields of psychiatry, child and youth services, and elderly and disability care are characterised by different professions, each with its own scientific foundations and professional self-conceptions. This Opinion therefore examines the forms

24 Cf. e.g. European Disability Forum (<http://www.edf-feph.org>).

of coercion that occur in these different fields of practice and how each of them gets justified from the perspective of professional ethics. The Opinion enquires how coercive measures can be avoided and how they can be justified from a legal and ethical point of view. Further, it applies the general normative foundation developed here to these three fields and points out the areas within practice and legislation in which further action is required.

3 “BENEVOLENT COERCION” – CONCEPTUAL DEFINITION

3.1 Definition of “coercion”

3.1.1 Working definition

In this Opinion, coercion denotes the overriding of another person’s will. Overriding someone else’s opposition is sufficient to constitute coercion even if this opposition is a manifestation merely of what is juridically known as a person’s “natural will” (see point 1.2 in section 3.1.2).

3.1.2 Detailed analysis and delimitation of related concepts

The core element of the working definition adumbrated above is the idea of “overriding another person’s will”.

(1) The word “will” has two distinct root senses: first, the general ability of human beings to act, and second, the concrete intention of a specific individual to carry out a specific action (volition). In this Opinion “will” in the general sense is defined as a person’s ability to originate their actions autonomously and to consider them their own. In contrast, individual volitional acts relating to specific actions (or omissions) require an additional intentional (“executive”) element in a person’s consciousness that disposes them to physically carry out the action. The most accurate description of this element and the nature of its relationship with the physical movement (or omission of movement) that realises the action are matters of contention in the philosophy of action. Presupposing in the following that such an executive element is indeed required for individual voluntary actions (or omissions), this debate does not need to be resolved here.

(1.1) The degree of self-determination underlying the will can vary depending on a person's external situation, their internal state, or their developmental stage within the human lifespan. Even small children have a will which they can assert over against others. However, the will needs to evolve over the course of human development until it acquires the degree of reflexivity required for fully responsible actions, which alone constitute genuine self-determination. An action is "fully responsible" if the person taking it is able to consent, refuse, or choose between different available options, if she understands what she intends to carry out or refrain from (including both the immediate and secondary consequences foreseeable for her), and if she can place her decision in the context of the vision she has for her life. A person is incapable of acting fully responsibly if she is temporarily incapable, no longer capable, or generally incapable of adequately understanding her life situation and the consequences of her decisions and actions or of acting accordingly. Such an incapacity can be due for example to age, illness, or physical or psychological limitations.

In the case of adults, it should generally be assumed that they are capable of full responsibility. One may only deviate from this rule if it has been ascertained in a concrete situation that the adult in question currently lacks the capacity to act with full responsibility.

(1.2) Being unable to act fully responsibly does not mean, however, that a person has no will. The person can still express his wishes and strivings: he may want to move around, accept or refuse a medical procedure, etc. To distinguish these cases from actions that are genuinely fully responsible in the emphatic sense, legal scholars use the term "natural will". Reflexes and involuntary actions do not constitute manifestations of someone's natural will.

(1.3) All human actions are subject to internal and external constraints. Moreover, they take place within social relationships which may involve hierarchical power relations. When there are doubts regarding a concrete individual in a concrete

situation, the distinction between actions that are fully responsible and those that are not must be determined by third parties. In practice it is indispensable to draw these lines, even though it runs the risk of inviting arbitrariness and abuses of power. In order for these decisions to be morally legitimate the criteria used must be transparent and justified.

(2) Coercion is the attempt to override another person's will. The following cases can be distinguished:

(2.1) First, coercion can take the form of one person using direct and unmediated force on another person's body in order to restrict or eliminate the range of decisions and actions available to them. Coercion in this narrow, primary sense of the term occurs, for instance, when a patient with dementia who is thrashing about and presenting a danger to himself is physically held down or strapped to the bed by a caregiver.

However, coercion encompasses much more than just the direct form of using force on a person's body in order to override her will. Additional kinds mainly fall under the following two categories.

(2.2) Indirect forms of interference can also count as coercion under the working definition given above; for instance, locking the door to the ward or withholding a walking frame from a patient who depends on it in order to restrict her movement.

(2.3) In addition, not only can a person's body be interfered with coercively but also their psychological state. Again, further distinctions are possible.

(2.3.1) The first case comprises direct interference with another person's psychological state via threats of negative consequences intended to overpower or neutralise the other person's opposing will.

(2.3.2) Secondly, the will can also be overridden indirectly by withholding relevant information from a person or misrepresenting the facts to him in order to induce him to take a particular action or decision. This constellation also includes

concealing medical drugs in food or drink because the patient would otherwise refuse to take them.

(2.4) Another category of coercion is structural coercion. Structural coercion occurs for instance when institutions subject residents to fixed daily schedules that hamper or eliminate their ability to exercise self-determination when going about their day. This kind of coercion is not benevolent in the sense of the term used here, but rather derives from institutional and organisational necessities. Even though this category is not covered in this Opinion, it must be emphasised that structural coercion should be subject to critical reflection in its own right as well.

(2.5) “Coercion” (in the sense of the working definition above) and “force” (in the sense of objective physical violence) are not identical. Only some of the above-mentioned coercive measures can be characterised as physical violence. In general, force denotes not only the power to impose something on somebody else by authority, but also – in the colloquial sense of the term – a more or less severe violation of someone else’s physical and/or psychological integrity. This can be manifested either as physical violence or in the form of actions that have a psychological effect, for example threatening gestures. These may escalate into direct manifestations of force. However, the use of force can also persist in a latent form, for example if based on her past experiences a patient expects that physicians or nurses will, or at least could, override her will by force due to their power over her.

3.2 Properties of “benevolent” coercion

The use of coercion against others can have different aims. These span the whole range from enforcing egoistic calculations of personal gain to serving the interests of the person subject to coercion out of altruistic benevolence. Only the latter constellation forms the subject of the present Opinion.

The different forms of coercion used to avert danger to third parties (“averting danger to others”) are not discussed in this Opinion. The category of presenting a danger to others includes not only direct forms of threat to concrete third parties, but also behaviour that disrupts the communal life of an institution (for example care homes for children, youth, the elderly, or people with disabilities) or of a family, neighbourhood, or society as a whole, i.e. behaviour that causes indirect harm to the interests of third parties. This category is distinct from the forms of benevolent coercion used to protect the recipient from the harmful effects of her own actions (“averting danger to self or fundamental interests of the self”). In the practice of medical care, nursing, geriatric care, and education, these two aims – i.e. averting danger to self and others – often intersect. However, in order to arrive at a systematic theory and normative evaluation of coercion, it is important to separate the question of legally and morally justifying benevolent coercion used to protect the recipient from herself from the other categories.

The concrete meaning of the “welfare” coercive measures are intended (and required) to protect and promote is very difficult to specify. Traditionally, the relevant professions adhered to a concept of welfare (of a patient, care recipient, nursing home resident, etc.) based on objective properties, i.e. providing for a person’s basic needs, preserving and fostering fundamental capacities (especially those constituting the prerequisites for a person’s reflective, fully responsible self-determination), honouring fundamental human rights, and preventing harm of different kinds and degrees of severity.

However, defining the notion of welfare by these objective criteria raises multiple problems. For instance, the potential harm to be averted and the hoped-for improvement in the patient’s state, as well as the probability of particular outcomes actually occurring, are often difficult to gauge. Furthermore, many medical interventions are complex and can cause a number of distinct effects, which must be evaluated separately and weighed against one another carefully. For instance, one

fundamental question to consider is whether physical harm weighs more heavily than mental or psychological harm or negative social consequences. Questions that can arise in concrete cases include: Is the potential damage only temporary, i.e. reversible, or is it irreversible? What kinds of risks should be taken by the author of an action that is intended to be benevolent or to prevent harm? And more importantly, what kinds of risks is the recipient herself willing to take?

According to some scholars, many of these questions only have subjective answers, insofar as the notion of “welfare” always depends on an individual’s personal evaluation of their own quality of life and their actual or hoped-for degree of health and wellbeing. The scepticism towards objective requirements often stems from the suspicion that ostensibly neutral and objective standards might in fact conceal very concrete interests of third parties and hence a covert (or latent) paternalism. Yet overcoming this kind of paternalism is precisely the task which a medical ethics committed to the principles of liberty, self-determination and patient autonomy has set itself. It is certain that even objective requirements can only ever reflect a limited state of knowledge, which is subject to historical change and includes not only empirical findings, but also changing cultural influences. Nevertheless, one must not fall into the opposite view of holding an individual’s subjective wishes and preferences to be the absolute criterion and sole reliable indicator of their welfare. Although a person’s subjective evaluation of their own wellbeing must always be taken into account in a material way, their views about their own welfare or the effect a given intervention will have on it may contain ideas or appraisals that are obviously unrealistic, perhaps even absurd, for instance if the person is under the influence of illness. Therefore, one must at least attempt to confront the person with the discrepancies between their own viewpoint and more widely shared notions of wellbeing.

People may adapt the way they lead their lives to conditions that are unjust, opposed to their actual welfare, or in violation

of their human rights in a way that makes this adaptation seem self-determined. In order to prevent this from occurring the social, economic, and cultural circumstances which have a real impact on individuals' volitional processes must be critically scrutinised on an ongoing basis.

The above-mentioned problem of the different conceptions of welfare points to the philosophical controversy about subjective versus objective interpretations of what constitutes a good and successful life. Here, this debate can neither be extensively recapped nor brought to an ultimate resolution.²⁵ For the purposes of this Opinion, taking note of the following considerations should suffice.

First, no definition of welfare could be convincing unless it accords a prominent place to a person's subjective experience of herself, especially in the case of possibly having her occurrent expressions of will overridden by others. Therefore, an individual's welfare should never be determined in the abstract, much less by reference to the interests of third parties, but rather by reference to the individual's own point of view.

Second, it must be assumed that the concept of welfare represents a multi-layered and complex category which comprises not only a person's occurrent subjective wishes and preferences, but also his individual biography (including past preferences, values, and goals) as well as societal and cultural ideals of the good life and basic norms (for example human dignity).

Third, there is sufficient empirical evidence for the claim that an individual's subjective assessment of his wellbeing is not static but rather undergoes a process of change or development, depending on circumstances. Listening to explanations that are appropriate to the topic and situation at hand can influence the degree of reflection of a person's volitional processes in a positive way. The more reflection has gone into the concretisation of someone's will in a situation of conflict, the more significant are the argumentative hurdles any justification of

25 Cf. e.g. Griffin 1986.

coercion purporting to serve the recipient's welfare needs to clear (see section 4.3).

Given these considerations, it is clear that the question under what circumstances coercive measures intended to serve the recipient's welfare are legitimate cannot be answered by reference to a notion of welfare defined in abstract or general terms. Rather, the challenge lies in determining where the line should be drawn between an individual's decisions that must be respected on the one hand, and permissible interference for the sake of her welfare on the other.

4 FRAMEWORK FOR NORMATIVE ORIENTATION

4.1 Central normative concepts

4.1.1 Dignity – autonomy – self-determination

The fact that a professional act of care aims at securing the recipient's welfare does not in and of itself justify the particular means of coercion employed in the act. In order to justify benevolent coercion from a moral and legal point of view, a normative framework for guidance and orientation is required.

The paramount principle in this regard is the inviolability of human dignity. In the tradition of Immanuel Kant – which has been especially influential in the modern understanding of human rights and underpins Article 1 of the German *Grundgesetz* (Basic Law, GG) – human dignity consists in each person existing as an end-in-themselves. According to the contemporary interpretation of this doctrine, this right to being considered an end-in-oneself belongs to all human beings solely in virtue of being human (“inherent dignity”). Being an end-in-oneself generally has two aspects. First, it implies the categorical right to be treated as an end-in-oneself *by others*, i.e. never to be used as a mere means to the realisation of someone else's ends. Second, it undergirds the categorical entitlement to determine one's own actions and the way one lives one's life autonomously.

The term “autonomy” has come to signify the capacity for self-determination. (This is a different notion from the concept of moral autonomy in transcendental philosophy.) The concept of autonomy is usually understood to refer to the ability to conduct one's life according to one's own standards. Different conceptions of so-called “minimal” autonomy have been developed, for instance by Harry Frankfurt whose notion of autonomy applies to the context of one's overall way of life

and to social and political action. These conceptions aim to strip the notion of self-determination of excessive requirements of rationality, conclusiveness, and planning, so that as many people as possible can be classed as autonomous. For example, Frankfurt considers it sufficient for a person to identify with the ends of an action because they represent something important to him. According to Frankfurt, this criterion allows one to distinguish autonomous actions from mindless, spontaneous impulses.²⁶ Tom Beauchamp and James Childress also advocate a notion of autonomy that has been divorced from as many substantial requirements as possible. Their definition relies on the so-called “normal chooser”: autonomous decisions patients make about medical treatment must not be gauged by a stricter standard than other decisions adults make as a matter of course, for example choosing a course of study or buying a house.²⁷

In contrast, more demanding conceptions of autonomy, for example the notion of personal autonomy put forward by Michael Quante, require a person to be able to orient her actions and way of life to the normative foundations she has adopted based on her conviction that they constitute a meaningful vision for her life.²⁸ An even more substantial notion of autonomy is employed in discourse ethics. Here, following the Kantian tradition, the moral legitimacy of a self-determined action depends on the universalisability of the maxim underlying the action, which all persons who are directly or indirectly affected by the maxim, decision, or action must be able to agree with rationally.²⁹

Authors advocating relational approaches to autonomy underline that positive interpersonal relationships are constitutive of the ability of human beings to develop self-esteem, self-confidence, and purposeful wishes and goals in general.

26 Cf. Frankfurt 2001, 65 f., also Dworkin 1988, 20 f.

27 Cf. Beauchamp/Childress 2009, 101 f.

28 Cf. Quante 2011.

29 Cf. Habermas 1983.

They emphasise that autonomy can only be exercised meaningfully within relationships of intersubjective recognition.³⁰ Given the multiplicity of competing conceptions, they consider autonomy a variable phenomenon that can be understood very differently at different times and in different spheres of life.³¹ In this approach, the idea of interpersonal relationships assumes great normative importance. The success of these relationships becomes a goal of acts of care in and of itself (see section 4.1.3). If one accepts this as valid, then there is no conflict in principle between being autonomous and being cared for by others. On the contrary, being cared for would then serve the realisation of autonomy in the wider sense of the term. Care then often appears as a mode of assistance: According to this approach, care is conceived as supporting the exercise of personal autonomy (“assisted autonomy”³²) whenever the requirements for making truly autonomous decisions – which can be demanding at times – are not yet met, not currently met, not met anymore, or not met to a sufficient degree during the whole lifespan. This includes the case of children and youth as well as individuals whose capacity for making self-determined decisions is impaired and who need assistance with exercising their right to self-determination, whatever form that may take. The consideration of these and similar situations characterised by an exceedingly high need for support should not obscure the fact that even in ordinary situations autonomous decisions can often be dependent on (caring) assistance. A typical example of this is so-called “shared decision making” about medical treatment where the treating physician and the patient work together to come to a decision about an intervention. Of course, it must be kept in mind that in shared decision making there is a significant difference between the collaborative process of arriving at a decision and its final declaration in the sense of a

30 Cf. e.g. Anderson/Honneth 2005; Mackenzie/Stoljar 2000.

31 For an overview of different theories of autonomy, cf. Rössler 2011.

32 Cf. Graumann 2011, 198 ff.

definitively binding statement. The latter always remains the personal prerogative of the patient in question.

The concept of relational autonomy touches on the first aspect of the principle of human dignity: In interpersonal interactions, human beings must be able to experience physically, as it were, that they are being acknowledged and related to as an end-in-themselves. This relational dimension of human dignity is connected to the integrity of interpersonal relationships for which recognition is essential.³³ However, this is a reciprocal relation. The enactment of one's autonomous and fully responsible decisions always occurs within a web of existing social relationships. Consequently, one's decisions always have an impact on others whose claim to be considered ends-in-themselves must likewise be acknowledged and respected. Causing harm to oneself often causes harm to others as well. No man is an island unto himself. For instance, a patient's fully responsible decision to refuse a medically indicated procedure often results in significant strain on his relatives. While such decisions must be respected, it must not be forgotten that a person is to be held morally accountable for all fully responsible decisions he makes – accountable to himself, but ultimately to those who are inevitably affected by his actions as well. This, too, is a component of a substantial notion of autonomy: It must not be mistaken for the absence of normative or social attachments. Rather, autonomy consists in the self-determined and responsible shaping of one's life within the context of the significant relationships that allow one to become oneself in the first place. This includes the commitments and responsibilities resulting from these relationships which must be factored into any autonomous decision as relevant moral goods.

These considerations show that the notion of autonomy is assigned a variety of quite different meanings in contemporary ethical debates. These range from concepts derived from the tradition of transcendental philosophy founded by Immanuel

33 Braun 2017, 63–258.

Kant – who views human beings’ rational self-governance as an a priori condition of the possibility of human morality as such and therefore strictly distinguishes it from the actual manifestations of a self-determined way of life – to theories that conceive of autonomy as human beings’ actual capacity for self-determination and hence use “autonomy” and “self-determination” synonymously. In order to avoid misunderstandings, the present Opinion by the German Ethics Council uses the notion of self-determination which serves, among other things, as an umbrella term for the range of possible gradations from small children’s elementary expressions of will to the fully responsible self-determination of adults.³⁴

Self-determination presupposes certain fundamental conditions and abilities which make it possible in the first place. It is these physical and psychological preconditions of living a self-determined life whose core can be jeopardised by a person’s situational decisions, actions, or expressions of will. Often, this is what the risk or even the reality of causing serious harm to oneself consists in. In a paradoxical situation of this kind, the use of benevolent coercion is intended to resolve the acute dilemma by serving as a last resort for protecting and (re-)establishing the essential physical and psychological preconditions of living a self-determined life. The crucial ethical question in this scenario is under what circumstances this objective of benevolent coercion can be justified. This also involves the question whether a person may, or even must, be protected from himself if the risk of harm to the self, including threats to his life, is incurred explicitly and consciously in virtue of a fully responsible decision he has made.

As has been emphasised repeatedly, defining the distinction between fully responsible decisions on the one hand, and voluntary decisions which do not meet the criteria for full responsibility on the other is of paramount ethical (and legal) importance. This distinction constitutes the boundary

34 Cf. Deutscher Ethikrat 2012, 46 ff.; Deutscher Ethikrat 2017, 178 ff.

between soft paternalistic and hard paternalistic interference with someone else's freedom of choice. The remarkable variety of concepts of autonomy and self-determination points to the fact that self-determination is a *vague* notion in the emphatic sense of the term.³⁵ It encompasses states of affairs which in and of themselves cannot be sharply distinguished from other related states of affairs, the demarcation of which must therefore be based on appropriate normative and ethical grounds.

Given these considerations, in this Opinion the German Ethics Council employs a notion of fully responsible action that contains the following elements.

- >> *Knowledge* of the immediate as well as secondary consequences of the intended action/omission;
- >> *Condoning* or *accepting* these consequences based on the background of one's own fundamental options in life;
- >> *Being able to choose* between real alternative courses of action.

Actions which do not satisfy the criteria of fully responsible self-determination can still express essential aspects of the self, at least in a simple sense. In principle, even children and adolescents are capable of simple acts of self-determination, as are adults who are not yet capable, or temporarily or permanently incapable, of making fully responsible decisions. This form of self-determination, too, deserves acknowledgment and respect as an expression of dignity and of being an end-in-oneself, which are qualities of *every* human being. If acknowledgment and respect are withheld, the disregarded person's self-respect and self-esteem quickly suffer, as the phenomenon of secondary vulnerability shows (see section 4.1.5). Even if acts of care involving benevolent coercion pursue a justified purpose, one

35 On the philosophical understanding of vagueness and vague concepts, cf. Keil 2017.

must always seek to minimise danger and the risk of causing this kind of harm as an unintended side effect.

4.1.2 Care

“Care” is a relational notion. Care intuitively connects a person’s “solicitude” (“caring”) about someone or something who or which has come under some kind of threat or misfortune with the personal imperative on the part of the person feeling concern (“carer”) to take responsibility for averting or overcoming the imminent threat or misfortune, i.e. to take care of, protect, and foster the care recipient’s flourishing in life. By caring for and rearing their children, parents take responsibility for their children’s maturation into adults, which does not occur naturally of its own accord. Representatives and volunteer or professional guardians take responsibility for persons who are (temporarily) not capable (anymore) of exercising their will independently in order to shape their life in a fully responsible way, i.e. of caring for themselves effectively. By means of their caring interventions, caregivers also assume responsibility for life situations in which the care recipients’ dignity is particularly vulnerable.

These and other similarly structured caring relationships, which nowadays are often called “interpersonal responsibility”, are expressions of *caring* for the welfare of the people for whom a particular caregiver or institution is responsible. However, the notion of “care” is ambiguous. Martin Heidegger, for instance, pointed out the significant qualitative difference between care which “leaps in and dominates” and care which “leaps forth and liberates”. The first kind of care, which leaps in for the other, as it were displaces the care recipient from the orbit of his usual way of life and renders him “dependent and dominated” – even though “this domination is a tacit one and remains hidden from him”. In contrast, the second type of care strives to provide appropriate support to

enable the care recipient to care for herself (again) in the near future and hence (re)gain the capacity to shape her own life autonomously.³⁶ Nonetheless, this kind of care is not entirely devoid of requirements imposed on the care recipient either, since the objectives as well as the means of “leaping forth”, i.e. the intended goal and the methods employed in the caring interventions, inevitably reflect the anticipations and choices of the caregiver. However, the caregiver’s assumptions do not always coincide with the care recipient’s own wishes and goals by any means. This risk is inherent in all caring relationships. Conversely, it is indisputably necessary to minimise this risk if care is to effectively respect, protect, and foster the care recipient’s capacity to shape her own life.

In order to reliably provide care that “leaps forth and liberates”, formal safety mechanisms and procedures have been established in most fields of practice within health and social services. These significantly exceed the existing practical routines of carers, which may be well-intentioned but are ultimately non-binding. An example of this is the logic governing legal guardians’ decision-making regarding care. A person’s representative or legal guardian must not only respect and enact the care recipient’s current or past expressions of will when engaging in acts of care, but is also primarily obligated to support the care recipient’s own capacity for decision-making as much as possible. The fact that the reality of care often does not come close to meeting these standards does not invalidate the meaningfulness of this normative requirement. It merely reveals the egregious deficits in the provision of care, which regrettably still persist in both formal and informal acts of care.

36 Heidegger 1962, 158 f.

4.1.3 Dependency and the need for others

Caring relationships form part of the essence of human existence. They are a necessary consequence of the well-founded anthropological insight, “We human beings are all in need of and dependent on one another.”³⁷ This principle does not at all negate another characteristic of the self-conception of human beings, however: the idea of human freedom. Even under ideal conditions, freedom in today’s societies is not limited to the absence of external control (“negative freedom”). The life projects to which a person commits herself by dint of her freedom and self-determination constitute options for shaping her life which can only be realised *within* a web of cooperative and communicative relationships in which human beings stand by one another. This “positive freedom”³⁸ gives rise to a spectrum of available options for action and decision-making. The more close-knit and reliable a person’s web of cooperative and communicative relationships, the broader this spectrum becomes. The increase in options available for free choice, especially in modern societies, is inextricably linked with an increase in dependency and need for others. In a highly complex society, manifesting freedom in one’s daily life is only possible on the basis of a highly sophisticated system of divisions of labour and guarantees of support – regardless of whether individuals are conscious of this fact or not.

As a rule, the degree of dependency and need for others as well as the ability to use such relationships productively for one’s own projects in life are distributed quite unevenly. Research on “social inequality” demonstrates the extent to which a high degree of dependency and need for others correlates with emotional strain, especially if the person is also convinced that he no longer has the power to change or shape his own life

37 Kamlah 1973, 95.

38 Cf. also Deutscher Ethikrat 2017, 186 ff.

situation, not even in the long term.³⁹ In these circumstances, available medical and social services are often eschewed.

There are life situations in which dependency and the need for others impact the people involved in the relationship in an extremely one-sided way. Such asymmetries regularly occur in caring relationships in the health and social services. Medical patients, individuals requiring nursing, children and youth, etc. depend on others (physicians, nurses, educators, legal guardians, etc.) in a way that is not reciprocal. This generates a special, normatively and morally significant quality of dependency.

The relationship between a child and her parents represents a basic form of this kind of dependency and need for others. Every new-born child needs comprehensive care from her parents in order to survive. In this caring relationship with the parents, she can gradually develop the ability to care for herself and (later) for others as well. Sometimes, this asymmetry of dependency and need between parents and children can be reversed, for instance when a grown-up child takes responsibility for the welfare of the now elderly parents in the form of guardianship or care. In any of these different stages of life, caring relationships between parents and children may be supported by professional services and institutions and occasionally even replaced by them. Nevertheless, due to their extraordinary emotional and social intensity and significance these caring relationships remain unique, which is why they enjoy special legal protection and social support. This manifests for instance in the primacy of the parents' rights. Like other caring relationships, the relationship between parents and children is subject to certain norms. Parental rights are bound to the child's wellbeing. Parents must guide their actions by the maxim of respecting their children as persons and fostering their physical, psychological, and social development

39 BMAS 2013, 265 ff., 358 ff.

into autonomous and responsible human beings. This includes taking the child's own will into consideration.

In caring relationships that take place in professional settings, these deep and long-standing emotional bonds are missing. Therefore, professional ethical standards and legal regulations must take special care to take into account the asymmetry that exists in these relationships with respect to dependency and the need for others, for instance in the form of professional codes, codes of ethics, etc. Over the last few decades such codes have been established in nearly all areas of health and social services.⁴⁰ Many of these regulations are based on principles derived from the theory of care ethics. Care ethics attempts to formulate an ethics sensitive to gender differences,⁴¹ and its principles can be developed in a general form for instance as an ethics of mindfulness,⁴² and in specific forms tailored to the different areas of practice within health and social services as an "ethic of care"⁴³ or "respectful nursing"⁴⁴. These approaches are centred around the four different aspects and phases of moral commitment that arise between caregivers and care recipients: first, *caring about*, which refers to the carer becoming aware of his concern about the care recipient's precarious life situation or at least her need for support; second, *taking care of*, which means the caregiver explicitly takes personal responsibility for remedying the precarious situation of the other person; third, *care giving*, the phase in which the actual acts of care and support take place; and fourth, *care receiving*, in the course of which the care recipient gives feedback on the appropriateness (or otherwise) of the care she has received.⁴⁵

40 Cf. e.g. the revised "Code of Ethics for Nurses" published by the International Council of Nurses in 2012 (ICN 2012) or the principles of professional ethics of the *Deutscher Berufsverband für Soziale Arbeit* (German Professional Association for Social Work) published in 1997 (DBSH 2009).

41 Cf. e.g. Gilligan 1982.

42 Cf. Conradi 2001.

43 Cf. e.g. Tronto 1993, Lob-Hüdepohl 2013a.

44 Cf. e.g. Gallagher 2007.

45 Cf. Tronto 1993, 106 ff.

4.1.4 Caring relationships and power

The logic of *care receiving* attempts to include the care recipient in any decisions about acts of care and hence to secure their moral legitimacy. At the same time, this logic is not immune to some fundamental flaws: when it comes to the reality of care recipients' precarious life situations some of its presuppositions might be naïve, and it can be blind to possible corruptions of acts of care. First, it is naïve because it presupposes that the care recipient can grasp his own situation and use his power of judgment regarding acts of care to an extent which in many cases cannot (yet) be presupposed (anymore). Second, it is blind because it turns a blind eye to the countless possibilities of wielding power (often covertly) by means of acts of care and thereby harming the care recipient's interests significantly.

The advocates of the different versions of applied care ethics have responded to this objection by putting forward the demand for professional ethics to critically scrutinise the (potentially large) asymmetry in caring relationships in health and social services in a way that explicitly takes into account the impact of social and political factors (e.g. the general framework, structural requirements) on systems of care.⁴⁶ Especially with respect to all the overt and concealed ambitions to exert power and control that can creep into caring relationships, this should prove both necessary and fruitful.

Wielding power in the guise of allegedly altruistic acts of care can be done in different ways and for different aims. Sociologically speaking, following Max Weber power consists in a person's being in a position to "carry out his own will despite resistance" within a social relationship.⁴⁷ However, the way in which power is wielded is crucial – it might not even be noticed by the recipient. An example of this would be manipulating an individual's beliefs and preferences. By providing tendentious

46 Cf. Banks/Gallagher 2009, 105 f.

47 Weber 1978, 53.

or filtered information, the care recipient's initial options can be transformed into options that serve the interests of the person in power or even completely coincide with these interests.⁴⁸ The possibility of exerting power by cleverly manipulating someone's beliefs and preferences is strongly aided and abetted by the significant asymmetries in these relationships and the feelings of extreme powerlessness and overwhelm which often dominate care recipients' experience. In the professional debate about this issue, the serious danger of a professional "expertocracy" which can colonise a care recipient's life world in an unacceptable way has been identified. Due to their origin in authority, the experts' ideas may displace the knowledge and beliefs the care recipient has so far oriented his life around.⁴⁹ The extent of power through manipulation grows even larger when the manipulation aims at subtly reshaping, altering, and hence controlling a care recipient's character.⁵⁰

Of course, power in the form of educational interventions or acts of care can have other goals as well. Using power for subtle manipulation is generally viewed negatively because of the suspicion that the intention is to serve only the carer's egoistic calculations of power at the expense of the care recipient's welfare. However, educational interventions involving the use of power can also pursue the goal of creating or strengthening the capacity for power in the recipient. Here power is used in the sense of the ability to set boundaries and shape circumstances⁵¹ by means of which the care recipient can establish, stabilise, or

48 Cf. Lukes 2005, 25–37.

49 Every professional runs the risk of arrogating power over her client to herself in virtue of her status as a professionally trained expert. This power "deprives the recipient of professional interventions of his own capacity to act and make decisions and turns him into an object rather than into the source of legitimacy of the professional's actions" (Dewe/Otto 2001, 1402). This form of professional action supersedes all knowledge the care recipient has in store for acting and orienting himself in his own self-determined way of life. In this way, his life world is colonised from outside by the professional's expert knowledge (cf. Habermas 1981, 171 ff.; Thiersch/Lob-Hüdepohl 2018, 1038 f.).

50 Cf. Foucault 1976.

51 Cf. Lob-Hüdepohl 2012, 11–17.

restore her capacity for assertiveness and self-determination. The professional social strategies subsumed under the term “empowerment” are one example of an approach that pursues this end. Forms of nursing that encourage patients to be more active are guided by the same fundamental goal, as are therapeutic measures committed to the restoration of mental health where this is understood as re-establishing a way of life that is both autonomous and respected within a community.⁵² These aspects of power are also highly significant when it comes to analysing and evaluating benevolent coercion.

4.1.5 Vulnerability

Professional caring relationships within health and social services involve acts of care performed on people or groups of people whose degree of vulnerability far exceeds that of ordinary human beings. Especially in the case of acts of care that involve benevolent coercion, the recipient’s vulnerability tends to be exceptionally high. Many recipients of care (for example individuals with mental illness, disabilities, dementia, etc.) face serious limitations while simply going about their daily lives and thus are less able than others to look after their own interests. Moreover, their heightened vulnerability also reveals itself in the following fact. Manifold offers of support can indeed improve the objective life situation of such individuals by creating or providing them with material or immaterial resources (for example financial resources, nursing and medical care, establishing social networks, and other services integrated into the recipient’s social environment). However, an improvement in these and other objective factors does not always come with a greater capacity to manage one’s own life. For this, advantageous *subjective* factors are also necessary. The person in question must know about the relevant resources and must

52 Cf. Dörner 2000.

be able to *recognise* their potential to be helpful to himself in his personal life situation (cognitive factor). He must also have an interest in improving his life situation and circumstances in the first place (motivational factor). Lastly, he must possess the necessary willpower and fundamental confidence to translate his motivation, which may be available in principle, into actual, sustainable long-term personal engagement (volitional factor).⁵³

The limitations inherent in someone's primary vulnerability (illnesses etc.) often give rise to further limitations within their life situation, especially with regard to the subjective factors. A form of "secondary vulnerability" reveals itself here which concerns the cognitive, motivational, and especially the volitional factor. This phenomenon is apparent in all acts of care involving benevolent coercion, for coercion not only constitutes a restriction in actual fact of the recipient's freedom to act and make decisions, but is often painfully experienced as such by the recipient as well (see section 4.1.6). The recipient's subjective experience can deviate from the objectively imposed restrictions in different ways. Repeated experiences of coercion can accumulate and engender a more or less pervasive sense of being disrespected in the recipient, no matter how "benevolent" others might consider them. This can turn into open rebellion or social shame⁵⁴ as well as a loss of self-confidence and self-respect. However, the erosion of self-confidence and self-respect jeopardises the experience of one's own dignity as a human being.⁵⁵ This is connected with the experience of a strong feeling of belonging to a community and a society which accepts all its members as equal in rights, duties, and life opportunities. Since any experience of coercion is an experience of powerlessness and defencelessness, it can

53 Cf. Lob-Hüdepohl 2012, 8 f.

54 Cf. Honneth 1992, 212 ff., 219.

55 In his famous work "A Theory of Justice", John Rawls counts the "bases of self-respect" among the (few) primary goods which should be distributed fairly by institutions in a "well-ordered society" (cf. Rawls 1971, 440 ff.).

severely damage this feeling of belonging in connection with a sense of self-respect and self-confidence and can in fact lead to social exclusion. People with chronic mental illness, elderly nursing patients and adolescents in closed institutions run by youth services or child and adolescent psychiatry have all been known to complain of this exclusionary tendency. Therefore, one must be mindful of the dilemma that while acts of care involving benevolent coercion may be intended to remedy a person's primary vulnerability, they can significantly increase the risk of violations of their secondary vulnerability.

4.1.6 Trust in people and institutions

An exceptionally high degree of dependency and need for others/caregivers need not necessarily harm or destroy a person's self-esteem. On the contrary, a care recipient's acceptance of such caring relationships can be an expression of her decision "to calmly acquiesce in the dependency and need for support which her illness has occasioned, or even to experience this as a turning towards the other".⁵⁶ From this perspective, a person could develop an "endorsed vulnerability"⁵⁷ as an expression of intuitive trust, which of course may not always stem from a conscious decision but which the person might feel motivated to accept in virtue of an established social practice.⁵⁸ "Endorsed vulnerability" would then be the expression of a particular attitude towards those to whom a person affected by illness or other factors entrusts herself in her need for support, or to whom she knows herself to be entrusted. In this scenario, the trusting and the trusted person each view themselves as participants in a shared practice governed by shared goals and values.⁵⁹ Now, whether or not a care recipient can and does

56 Akashe-Böhme/Böhme 2005, 88.

57 Cf. e.g. Baier 1986; Steinfath 2016.

58 Cf. Hartmann 2011.

59 Cf. Lahno 2002, 209 f.

actually muster this degree of trust crucially depends on the trustworthiness of the carer and of course on the trustworthiness of the legal institutions and organisations providing the structures within which the caring relationships take place. By investing her trust, the care recipient can also actively give rise to the moral obligation on the part of the caregiver not to disappoint the trust placed in him.

In the professional care of children, youth, medical patients, and other care recipients, a relationship of trust must usually be developed gradually. Regardless of whether or not measures involving benevolent coercion are actually considered or perhaps even utilised in these contexts, more often than not the individuals concerned feel that they are *inevitably coerced into* a relationship of dependency on the professional caregivers. In this context the feeling of powerlessness and defencelessness is enhanced if acts of care are carried out via benevolent coercion. Many organisations providing elderly or disability care as well as residential institutions for children and adolescents face a great deal of mistrust by the public. Therefore, it is all the more important for these institutions to implement structural measures that serve to build trust. One way to accomplish this consists in establishing or promoting different kinds of advance directives.

4.1.7 Judgment and conscience

Professional caring relationships often involve difficult decisions which fall outside caregivers' daily routines and pose special challenges for their judgment. Be it a psychiatric patient's unexpected act of self-harm, challenging behaviour on the part of adolescents in educational contexts, or an elderly nursing patient's or disabled person's sudden change of character – physicians, educators, and carers have to decide, usually under severe time pressure, how to handle the novel situation in a way that does justice not only to the care recipient and his

acute situation, but also to the general standards of their respective professions. The challenge is exacerbated if one takes the following considerations into account.

First, actions that cause harm to the self are often complex in nature, insofar as they can impact several different dimensions of a person, for example their health or physical integrity, social participation, or their future capacity for self-determination. In such circumstances, a ranking must be developed which honours the person's individual personality and assesses which of her physical, mental, and social abilities should be protected preferentially.

Second, these processes of gauging priorities often take place under conditions of limited knowledge of the person's actual personality, her individual value preferences, or the probability and extent of the dreaded harm. The better a professional caregiver knows the personal biography of the person in need of help and the probable consequences of particular interventions, the more easily will he be able to avoid unnecessary strain on the care recipient.

Third, the given institutional context often includes a framework that prevents decisions which have been recognised as appropriate from being enacted, for example due to understaffing, lack of time, or an underdeveloped culture of reflection within the institution. Hence, by force of circumstance individuals may feel compelled to make decisions which they personally would prefer to avoid.

Fourth, professional caregivers are expected not only to respond appropriately to surprising and unpredictable situations, but also to understand the dynamics of situations early on and recognise developments that could cause conflict in future so as to prevent or minimise impending harm by means of targeted preventive measures, if at all possible.

These considerations imply that the capacity of professional carers to arrive at judgments that are adequate to the situation at hand is of paramount practical importance. With respect to this question, ethical theories have long made use of

a distinction between two different levels of reflection. These levels are of high practical importance when it comes to the duty of care of professionals engaged in caring relationships.

The first level concerns the personal (for example intellectual and emotional) preconditions that must be met in order for an individual facing a crisis situation to utilise her knowledge of general rules to arrive at a decision that is adequate to the circumstances at hand. Such decisions cannot simply be deduced from general principles of action or calculated by an algorithm. Rather, specific skills of judgment are required which enable a person to adequately assess whether a specific situation falls within the scope of a general principle of action or not. Ethical theories provide a whole range of conceptual resources for the required mediating function of reason, ranging from reflections on *epieikeia* (*aequitas*, equity)⁶⁰ and *phronesis* (*prudentia*, prudence)⁶¹ in antiquity to the long tradition of so-called casuistry⁶² to Kantian theories of practical judgment⁶³ to the different contemporary contributions on intuition⁶⁴ and moral vision.⁶⁵ What these different traditions have in common is the assumption that the ability to discern the right action in a particular situation presupposes a complex process of reflection which includes not only cognitive skills but also practical experience and emotional implications. A mature capacity for judgment is a virtue that challenges the whole human being and involves a potentially interminable learning process.

The second level, which is based on the first, concerns the theory of conscience, which Immanuel Kant defined as “our self-judging moral understanding”, i.e. a second-order

60 Cf. Aristotle, *Nicomachean Ethics* V, chapter 1–5, 10, 14; Horn 2006.

61 Cf. Aristotle, *Nicomachean Ethics* VI, chapter 5, 8–13; Ricken 2014.

62 Cf. Jonsen/Toulmin 1988.

63 Cf. Kant 1895, 1 ff. (AA IV, 387 ff.); Kant 1879, 226 ff. (AA V, 67 ff.); also Höffe 2014.

64 Cf. Burkard 2012; Raatzsch 2013; Heinrichs 2013.

65 Cf. McNaughton 1988; Trampota 2003.

capacity for judgment.⁶⁶ Professional caregivers' self-experience not only in medical care⁶⁷ but in asymmetrical caring relationships in general shows that given the momentous impact of the decisions they have to make, they (have to) engage in unceasing critical questioning whether, or to what extent, they have fulfilled their duty of care when preparing and executing acts that involve potential harm to the individuals entrusted to them. Sometimes people practicing in the helping professions are afflicted with a *guilty conscience* about not having responded adequately to a challenging situation. However, this should not be prematurely interpreted as a symptom of that particular individual's failure. Rather, it might be a symptom of a problematic constellation the causes of which are to be found on the institutional or systemic levels, which therefore indicates a need for change far exceeding the professional actions of individual caregivers. Especially when dealing with measures involving benevolent coercion a feeling of *moral perplexity* may arise, insofar as all available courses of action are morally problematic. Carers can experience the use of coercion as a violation of the important value of the recipient's self-determination, while refraining from using coercion can seem like a lack of care in the face of the imminent danger of self-harm on the part of the recipient, which can cause the caregiver to feel equally guilty.

Given this conundrum, an important quality standard for care institutions ought to be whether, and to what extent, they encourage a lively culture of reflection in their professional staff. Such a practice ensures that carers continually question their own decisions and routines critically and hence strengthens the necessary level of confidence in their actions, especially in difficult situations.

66 Kant 1838, 251 (AA VI, 186).

67 Cf. Wiesing/Bormann 2014; Schmidt/Schönecker 2014.

4.2 Relation to basic rights and human rights

Current legislation does allow for legitimate uses of benevolent coercion; indeed, it actually calls for them in certain cases and under certain conditions (see sections 5.1.3, 5.2.3, and 5.3.3). However, the very idea of the legitimacy of benevolent coercion has been thrown into doubt from the perspective of fundamental rights and human rights.

As far as German constitutional law is concerned, the *Bundesverfassungsgericht* (Federal Constitutional Court) has developed important standards in recent years. In particular, it has redrawn the constitutional coordinates for the particularly sensitive area of coercion in medical care.

In its leading decision of 23 March 2011 the Federal Constitutional Court has determined that coercive medical treatment, i.e. treatment against someone's natural will, constitutes a serious infringement of their basic right to physical integrity, guaranteed by Article 2 (2) sentence 1 GG.⁶⁸ Nevertheless, the Court has stated, legislative authorities are not prohibited in principle from permitting interferences of this kind under certain conditions if they are in service of the recipient's other fundamental rights and interests protected by the Basic Law.⁶⁹ The fundamental liberties protected by the Basic Law do include the right to use one's freedom in ways that third parties may judge to be contrary to the obvious and objective interests of the person invested with that freedom. This effectively grants each person a "right to illness", which precludes

68 Cf. BVerfGE 128, 282.

69 For instance the recipient's freedom of the person as per Article 2 (2) sentence 2 GG (cf. BVerfGE 128, 282) and the right to life and physical integrity as per Article 2 (2) sentence 1 GG (cf. BVerfGE 142, 313).

the option of using coercive measures against someone's "free will"⁷⁰.⁷¹

However, a person might be temporarily incapable of mustering a fully responsible act of will regarding possible treatments for her illness because that very illness prevents her from grasping the necessity of medically indicated measures or from acting accordingly.⁷² If in this situation there is no conclusive indication that her refusal has indeed arisen from a fully responsible act of will,⁷³ then the state's duty to protect citizens' life and physical integrity becomes the most important priority. In this case, the duty to protect must be invoked because of the person's increased need for protection, insofar as she is unable to understand the concrete necessity of a given medical intervention and would therefore be at risk of life and limb without being able to freely arrange for her own protection.⁷⁴

Rendering this adjudication in terms of constitutional doctrine yields the following. The ordinary constellation of a collision between the state's legal duty to refrain from interfering and the legal duty to protect takes place in a triangular relationship. A person *A* invested with basic rights exercises her civil liberties and in doing so interferes with the constitutionally protected interests of another person *B*, who is also invested with basic rights. Now the state is obligated to provide a minimum amount of effective protection to the "victim" (*B*) of the interference, yet at the same time it must not rein in the "perpetrator" (*A*) excessively. Thus, when performing this kind of "protection through intervention"⁷⁵ the state is doubly bound by the Basic Law: it must observe both the prohibition against falling below the lower threshold of due

70 In juridical contexts it is customary to speak of "free will" rather than "fully responsible will" (cf. e.g. Section 104 no. 2 BGB; Lipp 2000, 44 ff., 60 ff.). In the following, the terminology adopted here will be retained, however.

71 Cf. BVerfGE 142, 313, para. 74.

72 Regarding this formulation, cf. BVerfGE 128, 282, para. 46 ff., 49; as foundation: BVerfGE 58, 208 (225).

73 Cf. BVerfGE 142, 313, para. 80.

74 Cf. *ibid.*, para. 79.

75 Cf. Wahl/Masing 1990, 553 ff.

protection (regarding *B*) as well as the prohibition against exceeding the upper threshold of undue interference (regarding *A*).⁷⁶ In contrast, the problem addressed in this Opinion is defined by the fact that the interests to be protected and the intervention to be performed concern one and the same holder of basic rights: the state protects a person from himself. In this context, the distinction between free will and natural will is significant as the two are associated with different interests protected by the Basic Law. When a person lacks a fully responsible will the state's duty to protect is activated. However, this does not immediately justify the use of just any arbitrary means of protection. When fulfilling its duty to protect, the state remains bound by the duty not to interfere with the subject's occurrent natural will. In accordance with this rule, the Federal Constitutional Court classifies the use of benevolent coercion against a person's natural will as an infringement of their right to self-determination. This right is protected as part of their general right of personality. However, the presence of the natural will does not change the fact that the person has an increased need for protection and help.⁷⁷ For this reason, the Federal Constitutional Court has enjoined legislative authorities to permit coercive medical treatment if severe, imminent damage to someone's health, including the risk of death, can be averted by performing a treatment that is not excessively invasive and that has a high chance of success, provided the recipient refuses the procedure by his natural will solely because his illness has compromised his ability to understand the situation and form appropriate judgments, and provided there is no conclusive evidence showing that the refusal of the treatment does indeed correspond to his fully responsible will.

When there is a collision between the basic rights to self-determination and physical integrity on the one hand and the right to the protection of life and physical intactness from

76 Cf. also *Isensee* 2011, para. 217 ff.

77 Cf. *BVerfGE* 142, 313, para. 76; *BVerfGE* 128, 282, para. 47 ff.

self-inflicted harm on the other, then the conflicting rights must be weighed against one another. According to the Federal Constitutional Court, the result of this process is “obviously predetermined” if the proposed medical treatment does not involve any particular risk and there is no conclusive evidence showing that the refusal of the treatment does indeed correspond to the patient’s fully responsible will. In this case, the state’s duty to protect is paramount. When exercising this duty to protect, states the Court, legislators have some scope of discretion regarding the concrete properties of the means of protection. However, this scope of discretion only applies to the question of how to design a particular protective intervention required by the Basic Law, not to the question of whether or not it is indeed required.⁷⁸

On the other hand, legislators must take the patient’s liberties which are in abeyance into consideration as much as possible. In this regard, the Court calls for “substantial and demanding material as well as attendant procedural requirements, formulated with sufficient precision”.⁷⁹ In particular, legislators must take into account the fact that medical treatment is not only concerned with securing a person’s medical protection according to the standards of objective rationality, but that the person’s fully responsible will must also be respected. This holds true even if their fully responsible will must be ascertained by means of indirect evidence, for example based on statements made in the past or the quality of the occurring natural will. Only if this is impossible, i.e. if there is no conclusive indication showing that the patient’s refusal of the treatment represents her fully responsible will, her opposing natural will may be overridden as a last resort.⁸⁰

Hence, legislation must guarantee that coercive measures required in virtue of a constitutional duty to protect can be

78 Cf. BVerfGE 142, 313, para. 80 f.

79 Ibid., para. 82; cf. also BVerfGE 128, 282, para. 72.

80 Cf. BVerfGE 142, 313, para. 82.

performed, while also ensuring that the relevant liberties are protected. Given the large variety of cases that can occur, the law cannot cover all possible constellations in detail. Therefore, the evidence included in the process of weighing the different rights against each other should mostly be drawn from the area of practical applications to concrete cases. Among other things, the person's natural will may have to be taken into account in a graded manner, which includes assessing how closely the natural will approximates the presumed fully responsible will after the necessary assistance with the volitional process has been provided. Furthermore, legislative authorities have to arrange for sufficient procedural safeguards. They must ensure that coercive medical treatment may only be performed if it is certain that the patient is not in possession of a fully responsible will, if his occurrent natural will has been accommodated as extensively as possible, and if the material preconditions for coercive treatment are demonstrably present.⁸¹

It is the view of the Federal Constitutional Court that respect for an individual's self-determination entails the obligation to ensure ahead of any medical procedure that the patient is sufficiently capable of insight and judgment regarding the proposed measure so that she can determine her will freely and hence bindingly. Here, medical directives or previously stated wishes regarding treatment can be decisive for the person's treatment and life situation. If a patient is incapable of insight and judgment and opposes a proposed measure by her natural will, an attempt to convince her of the necessity and reasonableness of the intervention must first be made before treatment may be administered coercively as a last resort.⁸²

As far as procedural regulations are concerned, the Federal Constitutional Court has prescribed that coercive measures must be ordered by a physician.⁸³ Further, there must be

81 Cf. *ibid.*, para. 83 f.

82 Cf. *ibid.*, para. 86.

83 Cf. BVerfGE 128, 282, para. 66; BVerfGE 142, 313, para. 85.

effective judicial and legal protection,⁸⁴ and all coercive measures taken against the recipient's will must be documented, including the fact that they were indeed coercive, the manner of implementation, the pivotal reasons, and monitoring of the effects. According to the Court, such documentation enhances the effectiveness of legal protections, ensures that interventions are commensurate, and constitutes an indispensable tool of systematic, improvement-focused quality control and evaluation. Only on this basis can it be ensured that actions remain professional and appropriate under the conditions typically encountered in hospitals, i.e. frequent changes of staff members caring for a given patient and treatments carried out over the long-term.⁸⁵

The Federal Constitutional Court has reconfirmed and extended these principles in its verdict of 24 July 2018 regarding so-called five-point and seven-point restraint used in the context of civil commitment.⁸⁶ In its decision, the Court classifies any fixation that is not just temporary⁸⁷ as a deprivation of liberty due to the significant degree of invasiveness of this intervention; as such it is subject to judicial reservation as provided in Article 104 (2) GG.⁸⁸ According to the Court, one of the reasons why this kind of intervention is so invasive is that the more helpless and powerless the recipient feels in the face of events, the more he experiences targeted interferences with his freedom of movement as threatening. In addition, interventions in residential or in-patient facilities are often performed on individuals whose vulnerable psychological state implies that the impact of the disregard for their will is particularly severe.⁸⁹ However, the Federal Constitutional Court even

84 Cf. BVerfGE 128, 282, para. 63; BVerfGE 142, 313, para. 85.

85 Cf. BVerfGE 128, 282, para. 67; BVerfGE 142, 313, para. 85.

86 Cf. BVerfG, NJW 2018, 2619.

87 The Court judges a fixation to no longer count as temporary "if it foreseeably exceeds the duration of half an hour" (*ibid.*, para. 1b).

88 Such measures constitute a distinct deprivation of liberty in and of themselves, apart from the judicial order authorising the involuntary commitment (*cf. ibid.*, para. 67–70).

89 Cf. *ibid.*, para. 71, referencing BVerfGE 128, 282, para. 44.

considers infringements of the freedom of the person (Article 2 (2) sentence 2 GG) as serious as the ones just described justifiable in principle.⁹⁰ Such infringements can be justified for the sake of protecting another person or the person herself if this is indispensable for averting imminent, serious harm to her health.⁹¹ However, the Federal Constitutional Court formulates very strict criteria for such restrictions: legislators are obligated to regulate the preconditions for deprivations of liberty and the corresponding procedures in a predictable, measurable, and controllable way.⁹²

Materially, fixations may only be ordered when less drastic means are not viable (anymore), i.e. as a last resort.⁹³ In line with its decision on coercive treatment⁹⁴ the Court requires various forms of procedural safeguards, including requirements that fixations be ordered by a physician, that documentation of the pivotal reasons for prescribing a fixation, of its implementation, and of the duration and type of monitoring be kept, and that prior judicial approval be obtained. If approval cannot be obtained in advance because the situation is an emergency, a judicial decision must be obtained immediately afterwards.

Regarding the use of benevolent coercion in the triangular constellation between parents, children, and the state, a special model of justification applies. Article 6 (2) GG assigns parents comprehensive responsibility for the life and developmental environment of their child, while also granting them the power to make decisions – in the interest of the child’s welfare.⁹⁵ This prerogative includes the option to consent to measures of benevolent coercion used against their child.

90 Cf. BVerfG, NJW 2018, 2619, para. 72.

91 Cf. *ibid.*, para. 74 f.

92 Cf. *ibid.*, para. 76 ff.

93 Cf. *ibid.*, para. 80.

94 Cf. BVerfGE 128, 282. According to the court, the basic principles developed there are for the most part transferable to the issue of fixation (cf. BVerfG, NJW 2018, 2619, para. 81.).

95 Cf. Höfling 2009, para. 17 ff. (includes further references).

The elements of a constitutional legal standard just adumbrated are supplemented on the level of international law by the relevant human rights conventions. In addition to the European Convention on Human Rights (ECHR)⁹⁶ the following are especially important:

- » The United Nations Convention on the Rights of Persons with Disabilities (CRPD)⁹⁷ with the guarantees of Article 12 (equal recognition before the law), Article 14 (liberty and security of the person), Article 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment), and Article 17 (protecting the integrity of the person);
- » The United Nations Convention on the Rights of the Child (CRC)⁹⁸ with the key clause about the child's participation in Article 12.

Both conventions are characterised by a philosophy oriented towards the subject; they are in service of human rights and emancipation.⁹⁹ With regard to the Convention on the Rights of the Child in particular, it has been questioned whether the inclusion of the child's will mandated by Article 12 CRC has been sufficiently incorporated in German law.¹⁰⁰ Concerning the Convention on the Rights of Persons with Disabilities, there have been controversial debates as well in which the question has been raised to what extent German law and legal practice are compatible with the convention in the areas of involuntary commitment and coercive treatment.¹⁰¹ An important cornerstone of these debates are the reports, guidelines, and recommendations issued by the Committee on the Rights of Persons with Disabilities, instituted in accordance with

96 Formally: Convention for the Protection of Human Rights and Fundamental Freedoms, adopted on 4 November 1950.

97 Adopted on 13 December 2006.

98 Adopted on 20 November 1989.

99 Cf. Schmahl 2016a, 96; Schmahl 2016b.

100 Cf. Schmahl 2016a, 100 ff.

101 Cf. Schmahl 2016b, 47 ff.

Article 34 CRPD, which are intended to interpret the stipulations of the convention.

Nevertheless, the Federal Constitutional Court has rightly emphasised that the Committee's proposals do not constitute binding international law either for international or national courts.¹⁰² The Committee has stated objections to the regulations concerning coercive measures overriding a person's natural will – for example involuntary commitment and other measures involving deprivation of liberty or coercive treatment – that are currently in force in Germany; however, the Court has commented that its critique is unspecific. In particular, it takes no position on the crucial question whether coercive treatment in a medical emergency can be necessary or justifiable if a person completely lacks a fully responsible will.¹⁰³ Nevertheless, the Committee's thoughts on the interpretation of this human rights treatise do carry a lot of weight.¹⁰⁴ In particular, they should serve as an occasion to embark on an in-depth enquiry into the central issues of the concept of a fully responsible will and its distinction from the natural will. Such an enquiry also heightens sensitivity to the danger of using treatments that are degrading or violate human dignity.¹⁰⁵

That said, the actual process of weighing conflicting interests that are constitutionally protected and belong to one and the same person is extremely difficult. Rankings constructed in the abstract, an option the Federal Constitutional Court has alluded to, can serve as a broad orienting signpost at best. Such hierarchies must never preclude qualifications or deviations

¹⁰² Cf. BVerfGE 142, 313, para. 90 (includes further references); reaffirmed in BVerfG, NJW 2018, 2619, para. 90 ff.

¹⁰³ Cf. BVerfGE 142, 313, para. 91 (on coercive treatment); BVerfG, NJW 2018, 2619, para. 92 (on deprivation of liberty) – both stating that the Committee “gives no answer to the question what should happen, according to its understanding of the convention, with human beings who are incapable of forming a free will and who are in a helpless situation”.

¹⁰⁴ Cf. BVerfGE 142, 313, para. 90; BVerfG, NJW 2018, 2619, para. 91.

¹⁰⁵ For instance, the practice of the Federal Constitutional Court of establishing precedents regarding the result of the weighing process in the abstract by has been questioned (cf. Uerpmann-Witzack 2016).

for particular individuals in concrete situations. In particular, the aspect of secondary vulnerability (see section 4.1.5) must be taken into special consideration when overriding someone's natural will. This kind of overriding not only constitutes an infringement of a person's physical integrity (for example in the case of coercive treatment) or the freedom of the person (for example being locked in a room), but can also be a serious interference with or violation of their self-esteem as an essential component of their personal rights. This implies that the general right of personality in accordance with Article 2 (1) in connection with Article 1 (1) GG, which the Federal Constitutional Court has invoked in a substantial way, requires further differentiation. Is it a matter "merely" of self-determination (for example regarding physical integrity) expressed via the natural will, or is the right to self-respect at stake, which is connected particularly closely with the notion of dignity? The priority of the duty to protect must also be scrutinised carefully when someone's natural will is overridden not only in an isolated intervention – potentially carried out on different occasions – but in a way that has a long-term, potentially even irreversible impact on the recipient and his future life.

From a legal point of view, it must also be kept in mind that self-determination is a vague concept (see section 4.1.1). Determining the boundary between fully responsible decisions on the one hand, and expressions of will which do not meet the criteria for being fully responsible on the other, is a somewhat precarious task (see section 3.1.2). If necessary, this distinction should be made separately with respect to each of the different legally protected interests. Given these considerations, a simple dichotomy between free will and natural will seems problematic. This is underlined by the fact that the central concepts of the faculties of knowledge, judgment, and action, currently do not have concrete definitions agreed upon across disciplines; such definitions are yet to be developed.

4.3 Ethical positions on the justification of benevolent coercion in caring relationships

The spectrum of ethical positions on the justification of benevolent coercion in professional caring relationships spans the range of coercion being considered legitimate more or less universally to a categorical rejection of benevolent coercion in all its forms.

Advocates of the former position argue that third parties have a duty of care which requires that a person's welfare must be protected even against their will, if necessary by means of coercion. According to this point of view, care is to be understood as a duty which outweighs the right to self-determination in case of clashes between these values. This position invokes a widespread everyday intuition according to which a person in need must be helped out of a basic sense of humanity, even if the person rejects the help. Occasionally the *right to life* is referenced here as well. The state has a responsibility to guarantee the protection and promotion of this right and must enforce it by bestowing appropriate authorisations upon medical or nursing staff, for example. This justification focuses on physical existence – in general or as the precondition of human action – and hence considers *objective* wellbeing as the dominant factor.

In contrast to this absolute primacy of care, advocates of the contrary position assert the absolute primacy of fully responsible decisions, even to the extent of condoning serious harm or even death happening to the person in case care and self-determination are in conflict. According to this view, the reason for the primacy of self-determination is that leading one's life in a self-determined, fully responsible way should be considered an immediate expression of being an end-in-oneself and hence of human dignity. Thus, third parties' duty of care and the state's duty to protect primarily consist in enabling and promoting people's capacity to live a self-determined, fully responsible

life. Caring for others is subordinated, as it were, to serving their self-determined, fully responsible life.

From an ethical perspective, the use of benevolent coercion can be understood as a form of paternalism. Paternalism denotes actions which, firstly, consciously override someone else's expressions of will, and secondly, are performed with the sole or at least primary intent of protecting the recipient from putting himself or his fundamental interests at serious risk. Tom Beauchamp and James Childress define paternalism as "the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or preventing or mitigating harm to the person whose preferences or actions are overridden".¹⁰⁶

The distinction between "soft" (or "weak") and "hard" (or "strong") paternalism put forward by Joel Feinberg, although not uncontentious,¹⁰⁷ is commonly used. An action is called soft paternalistic if the person performing it can be certain that the recipient would consent to the action were he currently able to make fully responsible decisions or determine his will accordingly.¹⁰⁸ The recipient of paternalistic acts may be capable of a certain degree of self-determination which manifests in specific situations in the form of the natural will. However, depending on the case, their cognitive or volitional capacities may be yet insufficient, globally insufficient, or not sufficient anymore in the given situation to make a decision that is fully responsible in the real sense of the term. Such decisions should still be respected as expressions of self-determination; however, they do not possess the same degree of dignity as genuinely fully responsible decisions. In contrast, an action is called hard paternalistic if it overrides the fully responsible and thus truly self-determined decision of another person.

¹⁰⁶ Beauchamp/Childress 2009, 208.

¹⁰⁷ Cf. Quante 2002, 308–315.

¹⁰⁸ Cf. Feinberg 1986, 26.

A problem common to all kinds of paternalism is that it can be extremely difficult to determine a person's subjective and objective wellbeing and the harm or threat that could potentially occur in a given context. The way one perceives a situation, assesses the potential damage and the other person's welfare is always influenced by personal and sociocultural lenses which can cause distortions "in the eye of the beholder" and result in unintentional patronising behaviour.

This distinction yields different requirements for the possible justification of paternalistic coercive measures. Self-determined decisions can have many gradations. The more closely a decision approaches the criteria for being fully responsible, the more significant are the argumentative hurdles any justification of coercion needs to clear.

In general, three kinds of cases can be distinguished:

- a) The recipient of care is expressing particular wishes and needs, but is undoubtedly incapable of making a fully responsible decision in the given situation.
- b) The recipient of care is making a decision, but there are well-founded doubts regarding her capacity for full responsibility in the given situation.
- c) The recipient of care is making a decision which is undoubtedly fully responsible.

These distinctions define the logic of a tiered criteriology, which is helpful for the ethical evaluation of paternalistic acts. However, they do not at all represent firm demarcations between different groups of people. For instance, adolescents or even children, who one would assume to be incapable of making fully responsible decisions as a rule, can on occasion be capable of it, for instance due to developmental advances specific to their life situation. Conversely, adults may be temporarily or permanently incapable of making fully responsible decisions in particular areas of their life although one generally presupposes that they are capable. Therefore, every individual

case must be assessed carefully with respect to the degree of self-determination present in the recipient of care. It must be ensured consistently that any competencies and resources currently available to the care recipient which she could or wishes to use in her decision-making process are in fact utilised. Indeed, even soft paternalistic acts and decisions by third parties must never simply replace the care recipient's expressions of will just because she is incapable of fully responsible self-determination in the real sense of the term. Rather, such interventions must have the character of assistance which in most cases merely supports – and only in exceptional cases actually substitutes – the care recipient's decisions, so that she can lead her life with as much self-determination as possible. It is the indispensable task of representatives and legal guardians to respect and safeguard this principle. For this reason, soft paternalistic acts should avoid not only all forms of coercion which shame, humiliate, or debase the recipient, but also all measures which gradually incapacitate her, cause lasting damage to the competencies and resources available to her, undermine her self-confidence (for example in children and youth), or hinder the acquisition, use, or restoration of the capacity for self-determination (as rudimentary as it may be in some cases).

The crucial threshold between soft and hard paternalism which distinguishes the first two constellations from the third is the presence of a fully responsible decision. Consequently, one must always examine carefully whether or not the care recipient's determination of will can indeed be classified as fully responsible. If one bears responsibility for a care recipient and strives for his welfare in a professional capacity one must not rashly judge his decision-making process to be complete or consider his refusal of a measure to be fully responsible without a thorough assessment. Initially the care recipient might (spontaneously) reject a planned intervention only to consent to it later once he has had sufficient time to weigh the expected pros and cons. Conversely, the reasons the care recipient puts forward in support of his refusal of the proposed measure

must be identified and honoured. Just as the care recipient may change his views in light of his experiences, the possibility can never be excluded that the professional carer, too, might modify or abandon her intentions for treatment in light of the reasons the care recipient states for refusing.

Keeping in mind the demanding requirements of diligence for professionals providing care, the following typological distinctions are intended to provide helpful guidance by identifying and discussing the criteria relevant to theoretical justifications of paternalistic acts.

Regarding scenario a): The first constellation that figures prominently in the practice of professional caring relationships concerns care recipients who are *undoubtedly not yet capable, temporarily or permanently incapable, or no longer capable of making a fully responsible decision* in a given situation.

There is a broad consensus that under certain conditions soft paternalistic acts can be morally legitimate if a person lacks the capacity for full responsibility. In this case the caregiver carries out “what we would do for ourselves if we were rational”.¹⁰⁹ Since there are different standards for measuring the rationality of a way of life, the person engaged in the paternalistic act has to assume that “with the development or the recovery of his rational powers the individual in question will accept our decision on his behalf and agree with us that we did the best thing for him”.¹¹⁰ In order for this assumption not to remain in the realm of fiction or turn into a fatal error, soft paternalistic acts must meet certain criteria. The necessity, proportionality and effectiveness of the measures undertaken must always be demonstrated. Further, with respect to their invasiveness, duration, and degree of reversibility these measures must be the most gentle means to achieve the aim. Also, the expected benefit to the recipient must significantly outweigh the drawbacks experienced by him. When gauging this ratio,

¹⁰⁹ Rawls 1971, 249.

¹¹⁰ Ibid.

both the current and the future welfare of the recipient must be taken into account; in other words, his present wishes and needs must be considered. This frequently involves difficult judgments and trade-offs. These must incorporate the care recipient's perspective in a material way. Further, one must assess whether there is concrete evidence in the person's biography indicating that he might condone the proposed measures in the foreseeable future.¹¹¹ If this can no longer be expected, for example in the case of people with progressive dementia, then if possible soft paternalistic decisions made on the person's behalf should be based on his previous self-determined decisions that expressed a fully responsible attitude towards living his own life (biographical self-determination¹¹²).

Regarding b): The second constellation described above is particularly important in practice. Professional caregivers are often confronted with people who may be capable of making fully responsible decisions in principle but whose capacity for full responsibility can be reasonably doubted with regard to a particular decision to be made in a particular situation. In these cases, the above criteria must be supplemented by the rule that the person's resources for living a self-determined life, which do exist in principle, should be activated as much as possible in the given situation by giving appropriate assistance, or at least that these resources must not be damaged substantially by the coercive measure. If the uncertainty about the fully responsible nature of the decision cannot be resolved, the evidence for and against must be weighed, and a clear preponderance in favour of the probable absence of full responsibility must be established.

In this context the distinction between "doing good" and "avoiding harm" and the assessment of potential harm are important. If soft paternalistic forms of coercion may only be applied under the above-mentioned conditions, then they

111 Cf. Brumlik 1986, 274 f.

112 Cf. Lob-Hüdepohl 2007, 128 f.

must be limited to interventions intended to avoid (further) harm. Moreover, the harm to be prevented must be significant and of a kind that could have a substantial negative impact on the person concerned. This certainly includes emergencies in which a person's self-harming actions would very likely lead to his death and there is no time to investigate whether his actions are fully responsible. An example of such an emergency would be preventing someone from committing suicide when it is not certain that the decision to commit suicide was made with full responsibility. In these cases, stopping the person by means of suitable coercive measures is not only morally permissible, but actually morally required.

The same verdict applies in cases in which it is not the person's physical existence that is at risk but rather the cognitive, social, and affective capabilities on which his future capacity to produce self-determined decisions and actions depends. In these cases especially, preventing someone from causing harm to herself can turn out to be a blessing for him later on despite the use of coercion. However, if the self-harming actions do not threaten the person's life or his future capacity for self-determination, things look quite different. Suppressing such harmful actions by means of coercion could cause significant harm in and of itself, for example to the recipient's self-respect ("secondary vulnerability", see section 4.1.5).

Regarding c): The same challenge arises in the third constellation in an aggravated form: may coercive measures ever be used to override someone's undoubtedly fully responsible decision for the sake of their welfare? Such measures would be hard paternalistic. In the context of professional caring relationships they cannot be justified. Being an end-in-oneself lies at the core of human dignity. It establishes one's right never to be used as a mere means to someone else's ends and not to be externally controlled in how one acts and leads one's life (see section 4.1.1). The right to self-determination also includes the right to reject help from third parties even if this help turns out to be indispensable for securing and fostering one's own

wellbeing. Therefore, it is morally legitimate for a patient to make a fully responsible decision to refuse a medical procedure even if it is medically indicated and failing to carry it out would put the patient at risk of grave harm or even death. Consequently, third parties are also morally obligated to respect such acts of self-determination.

At the same time, this principle must not obscure the acute moral difficulty of borderline cases which confront people engaged in professional caring relationships time and again. Such borderline situations touch the essence of interpersonal solicitude (see section 4.1.2) and hence the moral core of professionally required care. They are characterised by the fact that the person is making a fully responsible decision that puts himself at risk and threatens to destroy or at least compromise the core of his personhood and his being an end-in-himself. In these borderline cases the question arises whether, and if so under what conditions, there might be rare exceptions where even hard paternalistic measures might be morally permissible or even required.

In what follows, four arguments professional carers might adduce to justify hard paternalistic interventions in exceptional cases will be scrutinised and their soundness evaluated. First, the argument of *a person's moral duty towards herself*. This is a weak argument to justify hard paternalistic measures insofar as the well-known topos of so-called duties towards oneself found in the philosophical tradition might serve to prove the moral impermissibility of self-harming actions to the person herself. However, no matter how much a person neglects such duties in her relationship with herself, this does not imply that third parties have the right to enforce the observance of these duties on her behalf. These duties are duties of virtue in the sense of moral commitments a person makes to herself, but their observance must not be enforced. Thus, they do not constitute a sufficient basis for the legitimacy of third-party interventions in case one fails in one's duties towards oneself.

Therefore, this line of argument does not provide a sufficiently convincing justification of hard paternalistic actions.

Second, there is the argument from *freedom of conscience*: This argument takes the subjective experience of professional carers as its starting point and appeals to their personal freedom of conscience. According to this line of reasoning, conflicts can arise in practice in which the idea of care, which is central to the identity of the helping professions, all but morally requires the care recipient's occurrent will to be overridden in order to best protect his wellbeing, since he would otherwise cause serious harm to himself. In extreme situations, allowing a person to go through with their actions without intervening would be unconscionable and would occasion severe pangs of conscience in the professional caregiver because the caregiver's professionally mandated desire and ability to help conflict with the care recipient's occurrent determination of will. Moreover, the requirements of the law and of morality also diverge in an almost tragic way in these cases. This argument is in need of further differentiation insofar as freedom of conscience is an important moral (and legal) good that allows for two very different interpretations. These must be clearly separated from one another based on their soundness.

On the stronger reading, appealing to the professional helper's freedom of conscience is supposed to give them the right to interfere with someone else's actions if that person's actions or omissions run counter to the helper's fundamental moral convictions. However, this problematic view overlooks the fact that judgments of conscience can only be made in the first person singular, i.e. they only apply to actions the effects of which remain within one's own personal sphere. Hence, such judgments do not provide any justification for intruding into someone else's sphere. According to the weaker reading, freedom of conscience merely constitutes a negative right which protects the core of one's own moral identity and thus represents a definitive barrier against intrusion from others.

Infringements of this boundary can never be justified because this would compromise the individual's personal identity.

This notion of conscience cannot be used to establish permission to interfere coercively with another person's self-determination. Conversely, however, it does define an absolute barrier by establishing the impermissibility of *moral coercion*: nobody may be forced to act contrary to the moral principles that constitute their self-image. Therefore, when interpreted correctly, the essence of freedom of conscience consists in the "freedom from coercive 'deconstruction of the person'".¹¹³ At most, it might be permissible under certain conditions for a professional caregiver to terminate their relationship with a care recipient, i.e. to give up their mandate to care for them (for example a physician's contract) in order to remain true to their moral convictions.

The third argument invokes the *necessary protection of the care recipient's future prospects*. This argument plays an important role especially when responding to severely self-harming or suicidal behaviour. According to this line of reasoning, it is permissible to coercively override another person's occurrent will if this is the only way to protect their medium or long-term survival and life prospects. Despite the intuitive plausibility of this argument, further distinctions must be made. In reality, this argument does not succeed in justifying all coercive measures that would technically serve to secure the care recipient's survival and hence her future physical capacity of leading a self-determined life. If any hard paternalistic actions are justified at all, at most it would be those forms that minimise the risk of secondary harm because their duration is short and their degree of invasiveness into the individual's personality low. Complex, long-lasting coercive medical treatment that interferes with the physical integrity of a patient who is unwilling to cooperate (*non-compliance*) cannot be morally justified even in cases of life-threatening situations. However,

113 Rixen 2014, 79.

individual pin-pointed actions, such as thwarting a suicide attempt by knocking a gun out of someone's hand or physically holding them back from jumping off a height, can be morally legitimate or even required in acute emergencies if there is not enough time to investigate whether the person is acting with full responsibility. Ultimately, this is a matter of acting under uncertainty and hence of constellation b rather than c.

The fourth argument concerns *ways of life adequate to human dignity*. Another important point of reference for possible justifications of hard paternalistic measures is the concept of a way of life adequate to human dignity. Whenever the care recipient's self-harming actions get him into a situation which precludes him from living his life in a dignified way as ordinarily understood, then according to this argument external coercion would generally be justified in order to protect his dignity. Objections to this view include the danger of an inflationary use of justifications based on dignity. Advocates of the argument from dignity would surely agree that the self-harm to be averted must be significant enough to threaten the core of someone's personhood and their being an end-in-themselves. Apart from the disagreements about what constitutes the core of personhood (see section 4.1), self-harming actions of this nature would usually cast reasonable doubt on the person's capacity for full responsibility regarding the chosen way of life. Hence, the corresponding potential scenarios of conflict in the context of professional caring relationships, such as extreme self-neglect or self-enslavement, would not be examples of hard paternalism at all, but rather constellations in which the fully responsible nature of the self-harming actions is in doubt. If those doubts cannot be resolved, these cases would fall under soft paternalism. Of course, in this regard the danger of assuming rashly or even abusively that full responsibility is missing must not be overlooked.

In conclusion, none of the arguments adduced yield sufficient reason for qualifying the principle that benevolent coercion used against fully responsible individuals is impermissible.

If a care recipient causes harm to herself through her fully responsible actions, this must be tolerated. However, the examples given in the four arguments demonstrate that in practice someone's full responsibility can often be doubted. This indicates constellation b, i.e. situations in which the doubts about the care recipient's full responsibility must be made explicit and investigated. If the doubts are confirmed, then the case is not in fact one of hard paternalism; the possible justifications of soft paternalistic actions (constellation a) would therefore apply. If the decision is undoubtedly fully responsible, then hard paternalistic coercion is not morally justifiable in the context of professional caring relationships.

The above-mentioned distinctions between the three constellations result in a *tiered decision-making process* for the ethical evaluation of coercion. The first step is to address the question whether the care recipient is currently capable of determining his will in a fully responsible manner. If this question cannot be answered in the affirmative, this by no means constitutes a blanket approval of the use of coercion. Rather, even in situations of this kind so-called soft paternalistic coercive acts are only legitimate if the following criteria are fulfilled:

- » The coercive measure must aim at developing, fostering, or restoring the recipient's capacity to live a self-determined life in the context of the available possibilities and the physical and psychological preconditions essential to this aim. This holds true even if the capacity to act with full responsibility can no longer be achieved.
- » The coercive measure must be suitable, necessary, and appropriate (i.e. the invasiveness and duration of interference must be commensurate) with respect to these aims.
- » The prevention of a primary harm must not cause another undue or potentially irreversible harm ("secondary vulnerability").

- >> The coercive measure must be the only possible way to prevent the harm in question or achieve the stated aim (last resort).
- >> The measure should be such that the recipient would consent to it were he currently capable of making fully responsible decisions.

4.4 Applications in the area of professional ethics

Acts of care involving benevolent coercion can be embedded in “ordinary” as well as “exceptional” relationships of daily life. Relationships between people who share their daily lives as family members, neighbours, or friends are ordinary. Relationships are exceptional if they are formed in a professional setting in which acts of care involving benevolent coercion are performed by a person with the corresponding professional roles and responsibilities. In such relationships, professional caregivers are responsible for adhering to the code of conduct and the standards of their specific professional discipline. The present Opinion only discusses professional caring relationships. Therefore, the preceding foundational considerations regarding the legitimacy of using benevolent coercion in acts of care will now be elaborated more concretely in an ethics of professional caregiving.

4.4.1 Caring relationships

Benevolent coercion is always embedded in specific caring relationships. It is intended to serve the welfare of the individual for whom the person applying coercion (or the institution in whose name he applies it) is formally or informally responsible. Caring relationships exist between the caregiver(s) and the

care recipient(s). However, especially in institutions in health and social services they tend to be structurally organised, pre-determined in certain ways, and usually also legally regulated. While the concept of coercion mostly carries negative connotations even in its benevolent forms, the idea of caring relationships usually evokes positive associations. However, caring relationships are ambivalent, too. Caregivers can use their influence for the purpose of fostering stabilising feelings of being sheltered and accepted in the care recipient. This can be the foundation on which self-esteem and self-confidence can grow so that independence and the capacity to live a self-determined life can ultimately develop. On the other hand, caring relationships can also be a tool of power or domination used by the caregiver to steer or manipulate the care recipient or to enforce social conformity.

The use of benevolent coercion in professional caring relationships is often characterised not only by mistrust on the part of care recipients, but also by the negatively tinted perceptions and experiences of professional carers. In their view, their feeling of at times having to use coercion against individuals in their care follows – sometimes “necessarily” – from the behaviour of the care recipients, which seems to deviate to such an extent from the ordinary, desired, (still) tolerable expectations or ideas of right and reasonable ways to live that the person’s physical or mental integrity seems seriously threatened.

4.4.2 “Deviant” behaviour and the traditional conception of the dual mandate of social professions

Deviant behaviour is often associated with delinquency in the narrow sense of the term, i.e. with criminality. However, in the context of acts of care involving benevolent coercion this association is misleading. While criminal law aims to protect the legal interests of third parties, acts of care involving benevolent

coercion as understood in this Opinion are intended to protect the recipient from himself. Still, the notion of deviant behaviour has a certain validity in the context of benevolent coercion as well. Identifying self-inflicted harm always implies a background of particular ideas about the *actual* welfare and the corresponding actions of *self-care* in service of that welfare from which the care recipient's current behaviour deviates. For instance, the act of refusing therapy might run counter to the physician's ideas of the patient's wellbeing. Similarly, children or youth can get themselves into dangerous situations through their conduct, in which case intervention appears indicated. With children, youth, and also people with mental illness (for instance those in psychotic states) such self-endangering actions are increasingly referred to as "challenging behaviour", although sometimes it is unclear what exactly the challenge consists in.

In response to these challenges the so-called "dual mandate" has traditionally been invoked, at least in the field of social services, and partly also in healthcare. According to the traditional reading,¹¹⁴ the dual mandate consists in caregivers receiving two independent mandates for action, one from the care recipient and one from general society. There can be significant tensions between these two mandates because the former aims at caring for care recipients, who are called "clients" in these contexts, while the latter aims at controlling them.

4.4.3 Shifts in professional self-conceptions

The professional self-conceptions prevalent in health and social services, and hence the prevalent understanding of the dual mandate, have undergone profound change over the last few decades. The stipulation of the Basic Law that Germany is to be a social federal state and the social legislation further

114 Cf. Lob-Hüdepohl 2013b.

elaborating this constitutional precept definitively place the welfare of each individual at the centre of state-run public health and social services. The fundamental norms of Article 1 (1) and Article 20 (1) GG subordinate all acts of care performed under the aegis of the state to the goal of enabling the recipients to live a life that adequately reflects human dignity. In Section 1 (1) of Book I of the *Sozialgesetzbuch* (Social Code, SGB) this altered objective is expressly elevated to the status of the single paramount principle of social law. This has had a profound impact on the self-conception of the social professions and is also in line with international developments: “Social work”, according to the definition given in the fundamental principles of the International Federation of Social Workers, “is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people.”¹¹⁵

Human rights are the basis not only of economic, social, and cultural rights, but also of personal liberties and rights to political participation which are intended to protect and affirm each person’s right to be the unique author of their own way of life. Therefore, the social professions are obliged to respect the primacy of self-determination as well. Consequently, the legitimacy of acts of care is linked back to the care recipient’s right to self-determination and hence to her consent to the respective interventions, except for interventions that are intended to stop the recipient from perpetrating harm against others.

The social professions are just catching up to the field of medical care in which informed consent has long been an established notion, at least as a general principle and normative precept. In some respects, there are of course significant mismatches in the temporal unfolding of this development, for example nationally between the different professional fields and internationally between the different national legal regulations and/or professional codes.

¹¹⁵ <https://www.ifsw.org/global-definition-of-social-work> [2018-10-15].

In Germany, the relevant laws as well as the corresponding professional codes and codes of ethics of the social professions mostly presuppose the care recipient's willingness to cooperate. His informed consent to a given intervention is tacitly assumed, if it is considered at all, but is rarely obtained explicitly.¹¹⁶ However, in some areas of the social services care recipients' rights of participation have been explicitly codified. For instance, in the area of child and adolescent services measures should be planned in cooperation with the minor(s) concerned and the parents or other guardians who have custody for the minor, and the measures should be set down in a binding agreement, so-called "youth care plans". Interventions contravening the parents' will must be ordered by a family court and are only permissible in case the child's welfare is in jeopardy (Article 6 (2) GG; Section 1666 BGB). The participation of children and adolescents in any measures affecting them derives from the belief that even individuals who are not yet capable of legally binding consent should be included according to their level of maturity. Accordingly, the Convention on the Rights of the Child as well as German family law "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child" so that the views of the child are given "due weight in accordance with the age and maturity of the child" (Article 12 (1) CRC; cf. also Section 159 FamFG).

4.4.4 Principles of professional ethics

Within the ethical code of each particular profession, general ethical principles are elaborated and fine-tuned more concretely, taking into account the responsibilities involved in the specific roles of the professionals concerned. With respect to these responsibilities, the main question is how the professionals in

¹¹⁶ Cf. Albus et al. 2010, 150.

question can enact general ethical principles, as well as specific principles applying to their field, in their professionally defined roles. For example, when it comes to formally initiated acts of care involving benevolent coercion, the question how the above-mentioned criteria justifying soft paternalistic actions (see section 4.3) can be fulfilled in practice and how this can be ensured figures prominently. This question is by no means trivial. While it is clear that paternalistic acts are only ever morally legitimate if the capacity to make fully responsible decisions is absent, it seems far more difficult to determine who is to ascertain this incompetency in concrete cases and how this is supposed to be accomplished in a way that guarantees that the result is sufficiently valid. The answer to this problem determines if and how the care recipient's welfare can be ensured and promoted.

Solving questions of professional ethics – such as the ones just mentioned – becomes even more complicated when taking into account the interaction between three tiers of responsibility¹¹⁷ in which any professional act of care (including acts of benevolent coercion) is always embedded in virtue of being performed under the aegis of an institution (a hospital, a home for the elderly or disabled, child protective services, etc.). On the micro-level, there is the personal responsibility of each professional caregiver in their immediate relationship with a recipient of care. On the meso-level, there is the caregiver's personal responsibility as a member of a team which shapes the caregiving and assumes shared responsibility for it as a *systemic actor*. On the macro-level, there is the responsibility of senior management, which is perceived as corporate in nature.¹¹⁸ This tier is responsible for the implementation of appropriate regulations and especially for the institutional framework within which the members of the organisation fulfil their responsibilities on the micro- and meso-levels. In

117 Cf. Kaufmann 1992, 66–90; Löwisch 1995, 74–83.

118 Cf. Lenk 1993, 132–139; Lob-Hüdepohl 2007, 159 f.

addition, with respect to systemic factors the relevant political players such as the legislative authorities should also be included since they determine the regulatory framework of the healthcare system and make decisions regarding the specific allocation of resources. If the interrelationships between these different tiers are disregarded, the common feeling – frequently complained about by caring professionals – of lacking realistic options for implementation, impotently facing abstract moral imperatives of what ought to be done, and hence ending up “morally trapped”,¹¹⁹ is intensified.

Despite the differences between nursing, child and youth services, and medical care, all three fields of practice have in common that the responsibilities specific to each profession are characterised by a *process-oriented approach*. This approach is intended to ensure that the criteria of legitimacy for benevolent coercion are observed and that the result is therefore morally acceptable. The essence of the process-oriented approach consists in safeguarding the participation of the care recipient and others who are legally responsible for her (for example parents, representatives, legal guardians). In principle, this right to participate extends to all phases of a professional intervention, from the initial assessment of the care recipient's life situation to the consideration of possible courses of action, the decision to choose a particular intervention, its implementation, debriefing, and evaluation. Ensuring that care recipients take part in the process as extensively as possible constitutes a fundamental building block of establishing trust between caregivers and care recipients and can significantly reduce the probability of having to use coercion of any kind.

Any measures involving benevolent coercion must be objectively indicated not only legally but also from the perspective of professional ethics. This concerns both the intervention itself and the coercive mode of execution.

119 Cf. Müller 1987, 40.

Coercive measures must only ever be used as a last resort. Therefore, they always have to be preceded by the attempt to use appropriate explanations and transparency in order to convince the care recipient of the necessity of the proposed intervention and to obtain his informed consent. In this endeavour, considerations of practicability (such as the amount of effort expended, time pressure, etc.) must not play any role. One must take special care to ensure that the attempt to convince does not morph into persuasion, and that the recipient's realistic decision space is not intentionally restricted by dramatising the situation, withholding information about possible alternatives, or similar manoeuvres. Indeed, such actions could be said to meet the definition of benevolent coercion themselves, as described in section 3.1.2. Here professional caregivers have to act highly sensitively, especially in situations in which consent is ultimately given without full conviction but rather after long deliberation, hesitantly, or even reluctantly.¹²⁰

The issue of determining whether or not a patient or care recipient is capable of making fully responsible decisions is similarly sensitive. This determination is both extremely difficult and extremely important because the potential legitimacy of using benevolent coercion hinges on it. For instance, if a 25-year-old person with life-threatening anorexia explicitly and repeatedly refuses all life-saving therapies the question arises whether she really is still capable of making fully responsible decisions or whether her illness has already eliminated this possibility. After all, full responsibility presupposes not only sound mental capacity and competency but also the ability to act according to one's own insight and judgment. These conditions can erode under the influence of severe illness. Therefore, the lack of full responsibility must be ascertained in each individual case, despite the fact that this determination is

¹²⁰ This stratification of degrees of consent is only being discussed sporadically in debates and reflections about professional ethics even though it is extremely significant for the grey area between assent/consent and coercion (cf. Banks/Gallagher 2009, 149 f.).

always prone to the risk of serious misjudgements. Nevertheless, the rule still stands that if a decision is fully responsible, then acts of care employing benevolent coercion are not justifiable. Only when the capacity for self-determination is impaired so severely that full responsibility is not present can soft paternalistic decisions in favour of coercive therapies that aim at averting immediate risks to a person's life be morally justified or perhaps even required. In this and similar situations, all parties involved are responsible for raising their professional decisions about therapy, nursing, etc. in an *ethics consultation* if necessary in order to improve their validity.

Assessing whether a care recipient would consent to a given measure, were he currently able to make fully responsible decisions, is equally important and equally difficult. Advance declarations of will are an important aid here. These documents provide information about the patient's own wishes and objections regarding particular situations (for example in the form of an advance directive). First and foremost, however, the person's representatives (parents or other guardians, representatives acting under power of attorney, or legal guardians) have to examine whether the person would consent to the measure were she able to make fully responsible decisions herself. Thus, they have to take part in the decision-making process about the use of coercive measures. This cooperation can actually provide a certain relief from emotional strain for the professional carers.

Procedural responsibilities can only be fulfilled if the relevant processes are *structurally* secured. Ethical advisory services and assistance with decision-making are already firmly established in many institutions in the healthcare field. In social services they are being introduced more slowly.¹²¹ Structural responsibility has to be exercised by the management of the institutions in question, but also by legislative authorities which have to set down the corresponding regulatory framework.

121 Cf. Lob-Hüdepohl 2017.

Thus, the concrete application of general ethical principles to the area of professional ethics entails several additional criteria for the justification of benevolent coercion which mostly relate to the procedures by which it is carried out.

- » Professional acts of care must meet the quality standards of the relevant discipline, i.e. the act in question must be professionally appropriate. In the case of coercive measures, the execution of the coercive act must also be professionally appropriate. In other words, there must be a twofold justification by reference to professional standards, both of the measure itself and of its coercive implementation.
- » It has to be determined to a sufficient degree of certainty whether or not the recipient of care is capable of making a fully responsible decision *regarding the proposed measure*.
- » The presence of the criteria discussed in section 4.3 – i.e. the person's welfare, including their own subjective assessment; the measure being necessary to restore the capacity to lead a self-determined life; coercion as a last resort; secondary vulnerability; potential consent in hindsight – must be ascertained to a sufficient degree of certainty, and any available scope of discretion must be clarified.
- » The care recipient must be taken seriously as a person and must participate in the preparation, implementation, and aftercare of the measure in question.
- » In the case of children and youth, parents or other guardians must participate in the decisions about the use of coercive measures. In the case of adults, the same holds true for representatives or legal guardians if applicable.
- » The relevant criteria must be implemented and secured through appropriate procedures. This includes for instance a professionally qualified and responsible individual ordering and supervising the coercive intervention, as well as documenting the pivotal reasons for the measure, its implementation, and the type and duration of monitoring of the effects.

Another principle of professional ethics concerns appropriate responses to the moral dilemmas that can arise from the point of view of each professional caregiver, at least subjectively: The use of coercion can sometimes cause moral qualms or even feelings of guilt¹²² even when it is morally (and legally) legitimate or even required as a last resort to avert serious self-harm according to the criteria elaborated above. For in these cases, too, the caregiver assumes responsibility, which can be experienced as a “tragic decision”¹²³: In order to protect an important moral good (in this case physical integrity) other important moral goods have to be compromised, i.e. on the one hand the person’s opposing will, which is not fully responsible in the given situation but is nevertheless an expression of his situationally evident self-determination (natural will), and on the other hand the care recipient’s psychological integrity, because they often suffer permanent trauma from the experience of coercion that lasts after the crisis situation has passed.¹²⁴ Conversely, unconditional respect for the care recipient’s fully responsible, self-determined way of life, even in the case of extreme self-harm, can collide with the normative requirements governing professional caring relationships which aim at securing and promoting the care recipient’s existential wellbeing. Thus, when a caregiver in an extreme situation feels impelled to make the tragic decision of disregarding their fundamental obligation to respect others’ fully responsible decisions and does override another person’s self-determination with the aid of coercion, the moral perplexity that gave rise to this choice should not be dismissed. However, coercive measures of this kind cannot be morally justified (see section 4.3). In addition, caregivers acting in this way are subject to legal sanctions.

122 Cf. Bonhoeffer 1992, 272–283.

123 Cf. Habermas 1982, 86 f.

124 Cf. Längle/Bayer 2007; Katsakou et al. 2012; Bergk/Flammer/Steinert 2010; Bergk et al. 2011; Braun 2017, 51 ff.

5 FIELDS OF PRACTICE

5.1 Benevolent coercion in psychiatry

5.1.1 Outline

The actions of physicians and other members of the health-care professions must be guided not only by concern for the patients' welfare but also by respect for their will. When a sick person refuses to undergo a medically indicated treatment, professional carers may and indeed have to attempt to obtain her consent. Ultimately, however, fully responsible decisions must be respected. If the patient is not capable of making fully responsible decisions, situations can arise – not just in psychiatry but in all medical specialties – in which the patient refuses a measure which appears indispensable to her health and well-being. The question whether or not it can be legitimate in these situations to administer the required intervention coercively has long been the subject of controversy, especially in psychiatry. If a coercive measure is intended to prevent a mentally ill patient from causing harm to herself or from suffering harm by refusing medical treatment, it constitutes “benevolent” coercion in the sense used in this Opinion. This does not include coercive measures employed to protect third parties.

Often these two goals have not been distinguished from each other clearly enough. The history of psychiatry is characterised by an ambivalent, conflict-prone mandate. On the one hand, psychiatry has endeavoured to provide professional help to mentally ill individuals in existentially threatening situations. On the other hand, often it has also assumed the role of protecting the general public from the socially challenging and threatening behaviour of people with mental illness.¹²⁵ For instance, in the past coercive measures used to treat psychological

125 Cf. Roelcke 2002; Shorter 2003; Porter 2002.

agitation not only served the purpose of calming the patient down and protecting him from himself, but also of protecting those around him from harm.¹²⁶ Moreover, in reality some of the interventions masquerading as “help” were serving economic ends or even attempting to “exterminate” psychiatric illness as part of a racist ideology. In the 19th century, the idea that people with mental illness are both in need of and capable of being treated gradually gained acceptance. However, simultaneously eugenic notions were spread which culminated in the forced sterilisation and ultimately the systematic murder of mentally ill and mentally disabled people during the Nazi dictatorship.¹²⁷ The memory of these crimes informs the debate about psychiatric care in Germany to this day.¹²⁸

After 1945, new social psychiatric approaches to the treatment of mental illness gained acceptance. These foreground patients’ subjective experiences and the competencies they have for dealing with their illness. Together with advances in the development of psychotropic medications, this paved the way for more gentle and effective forms of therapy. One of the crucial factors in the development of humane and human rights-oriented psychiatric care in Germany was the “Bericht über die Lage der Psychiatrie in der Bundesrepublik Deutschland” (Report on the state of psychiatry in the Federal Republic of Germany) issued by the Study Commission of the *Deutscher Bundestag* (German Federal Parliament) in 1975.¹²⁹ The Commission was formed in view of a “national crisis”¹³⁰ that had already been highlighted in the 1960’s by concerned psychiatrists. Their criticisms identified “inhumane conditions, often unfit for human beings”.¹³¹ The preliminary report of 1973 pointed out that about 40 percent of the rooms in the

126 Cf. Schott/Tölle 2005, 243 ff.; also Wirth/Schmiedebach 2017.

127 Cf. Schmuhl 1992.

128 Cf. Roelcke 2010; also Rotzoll/Hohendorf/Fuchs 2010.

129 Cf. *Deutscher Bundestag* 1975; also *Deutscher Bundestag* 1973.

130 Cf. Häfner 1965, 118.

131 Finzen 2015, 392.

130 specialist psychiatric clinics in Germany contained more than 10 beds, and that only one social worker and one occupational therapist were available per 750 admissions per year.¹³²

Even though the Study Commission was mainly concerned with developing structural recommendations for psychiatric institutions rather than engaging with the substance of psychiatric therapeutic work, the “demand for regional, community-based psychiatric care”¹³³ delivered by psychiatric wards in general hospitals, day clinics, and ambulant services is still relevant today. The Commission’s report not only engendered extensive structural change but also put in place the preconditions for a more far-reaching reform of psychiatry, transforming it from a custodial into a therapeutic discipline. As a consequence, the accommodation and treatment of people with mental illness improved considerably. Through establishing community-based psychiatric care, it was possible to reduce the duration of in-patient stays of chronically ill patients significantly.¹³⁴

Debates about reforming psychiatry sprang up earlier in the German Democratic Republic (GDR) than in the Federal Republic. In the GDR, the Rodewisch Theses were published in 1963 and the supplementary Brandenburg Theses in 1974.¹³⁵ However, apart from the creation of a few model institutions the impact of these theses on the provision of psychiatric care in the GDR was not as profound as that of the Study Commission in the Federal Republic.¹³⁶ “Traditional institutional psychiatry” in the GDR was mostly reformed only after German reunification.¹³⁷ Thus, in large part the history of German psychiatry can be reconstructed as an evolution away from

132 Cf. Häfner 2016, 126.

133 Finzen 2015, 392.

134 In the West German states before reunification, the number of occupied beds in psychiatric hospitals fell from 115,857 in 1975 to 41,219 in 2011. Over the same period, the average duration of in-patient stays decreased from 226.5 to 22.9 days (cf. Häfner 2016, 139).

135 Cf. Kumbier/Haack/Steinberg 2013.

136 Cf. Kumbier/Steinberg 2018.

137 Cf. Kumbier/Haack/Steinberg 2013.

placing “immature” individuals in heteronomous custody and isolation, towards an “open psychiatry” that operates on the assumption that people’s personalities are dynamic and capable of development and endeavours to secure as much self-determination and quality of life as possible for these patients.¹³⁸

Nevertheless, psychiatry continues to be confronted by the challenge of doing justice to the right of people with mental illness to be treated humanely and to be protected from involuntary self-harming behaviour. Coercion is one of the tools that has been and still is employed to address this issue. Coercive measures range from involuntary commitment to seclusion and fixation to coercive treatments involving drugs or electroconvulsive therapy.¹³⁹ These constitute serious infringements of the person’s self-determination and physical and psychological integrity (see section 4.1.1). Therefore, engaging in professional and critical reflection about the use of coercive measures constitutes an important task for modern psychiatry. This topic also arises regularly in public debates.

Psychiatric illnesses like schizophrenia and severe depression often compromise a patient’s ability to make fully responsible decisions. These conditions can impair perception, thinking, feeling, motivation, and behaviour to such an extent that patients affected by them are incapable of understanding the significance or implications of a given situation, arriving at their own judgment about the situation, or of acting accordingly. From a psychiatric point of view, coercive measures appear necessary when a patient’s perception of reality is distorted due to a disease-induced crisis and he is subject to impulses which put him at high risk of inflicting permanent and serious harm on himself, including suicide. Depression, anxiety disorders, and schizophrenia are correlated with a significantly

138 Cf. Gruber et al. 2018.

139 Cf. Henking/Vollmann 2015; Besse et al. 2017.

higher rate of suicidal behaviour.¹⁴⁰ Under these circumstances, the patient may be unable to control the impulses arising from within by his will, or they may be ephemeral states of consciousness that do not correspond to the declarations of will made by him before and after the illness-induced crisis.

From a professional perspective it follows that in these cases treatment should be administered, if necessary even against the patient's currently expressed natural will, especially if his life is in danger. Thus, psychiatrists maintain that the use of coercive treatment and other coercive measures can be minimised but not completely eliminated.¹⁴¹

The fact that patients can experience coercive measures as intimidating or even traumatising remains problematic, however. Some people feel that such measures are unethical or degrading (see section 5.1.4).¹⁴² In these patients' view the possible long-term benefits in the form of mitigating the symptoms of mental illness do not outweigh the acute psychological damage or the degrading nature of the treatment, not even in hindsight.¹⁴³

A report published on 1 February 2013 by the United Nations Special Rapporteur Juan Méndez has sparked a heated controversy about this issue. The report classifies all forms of coercive treatment in psychiatry as torture and calls for corresponding legal bans in the member states. Insofar as coercive measures in psychiatry inflict severe pain and suffering on patients, the paper claims they violate "the absolute prohibition

140 Cf. Singhal et al. 2014. Reviews have shown that borderline disorders, depression, bipolar disorder, and schizophrenia correlate with a tenfold increase in the risk of suicide (cf. e.g. Chesney/Goodwin/Fazel 2014, 158). Eating disorders can cause irreversible harm to bodily functions due to chronic malnutrition. For instance, the standardised mortality rate of patients with anorexia nervosa is more than five times higher than that of the general population (cf. Fichter/Quadflieg 2016, 398).

141 Cf. DGPPN 2014; ZEKO 2013.

142 When treatment is administered in the setting of the patient's own home it is usually accepted more readily than in-patient treatments, both by the patient and her relatives (cf. Berhe et al. 2005).

143 Cf. Thaler 2016; Lehmann 2013.

of torture and cruel, inhuman and degrading treatment”.¹⁴⁴ Many (former) users of mental health services have since appealed to the report to substantiate their demand for a categorical ban of coercion in psychiatry.¹⁴⁵ In contrast, psychiatric expert bodies deem coercive measures therapeutically useful and under certain circumstances even required to serve the patient’s best interest.¹⁴⁶ They caution against a categorical ban of coercive measures because many patients would then no longer be able to receive treatments that are necessary for them from a psychiatric perspective. This view is supported by verdicts of the Federal Constitutional Court of 26 July 2016¹⁴⁷ and 24 July 2018.¹⁴⁸ According to those decisions, coercive treatments or fixations applied against someone’s occurrent natural will do constitute a serious infringement of the right to self-determination even if the patient is incapable of giving consent. Nevertheless, under very strict conditions the Court considers coercive measures permissible and sometimes even required for the patient’s own protection if she is at risk of life and limb or of serious, irreversible damage to her health (see sections 4.2 and 5.1.3).

This controversy highlights how essential it is to develop nuanced ethical and legal assessments of coercive measures used in the care of psychiatric patients. There is no doubt that the history of psychiatry included human rights violations well into the 1970’s, as already mentioned. These were described and critiqued in the above-mentioned Study Commission. In contrast, contemporary psychiatry endeavours to reliably provide humane care for people with mental illness that conforms to human rights standards. However, the fact that many (former) users of mental health services experience coercive

144 UNHRC 2013, 15.

145 Cf. BPE 2007.

146 Cf. APA/WPA 2013.

147 BVerfGE 142, 313; cf. also the earlier BVerfGE 128, 282 (on coercive treatment).

148 BVerfG, NJW 2018, 2619 (on fixations); cf. also the earlier BVerfGE 58, 208 (on involuntary commitment).

measures as cruel, inhuman or degrading must be taken seriously. These perceptions must be taken into account when developing strategies for the use of coercive measures in service of patients' welfare.

5.1.2 Forms of benevolent coercion

A measure is coercive if it overrides the recipient's directly or indirectly expressed will. Coercion is benevolent if the measures taken are intended to prevent the recipient from causing harm to himself (see chapter 3).

In general, two kinds of coercive measures used in psychiatry can be distinguished: first, measures restricting or depriving someone of liberty, which includes measures restricting or entirely suppressing someone's freedom of movement, for instance by means of fixating them or having them committed, and second, measures that are part of psychiatric treatment and care, such as diagnostic examinations, medication, electroconvulsive therapy, or diets that are administered against the patient's will. The second category is usually called "coercive treatment" in short.

Involuntary commitment denotes the admission of a person to a psychiatric hospital or other institution against her will. The person's freedom of movement is then confined to the space of the institution because she is prevented from leaving the hospital or a specific part of the hospital, for example a ward. This can be accomplished by putting her in a locked room (so-called seclusion) or via technical means such as alarm signals or location systems. The patient's freedom of movement can also be eliminated by other coercive measures that deprive her of liberty, e.g. mechanical devices such as fixation with belts, bedrails etc., physical interventions such as being held down, or the administration of drugs ("drug-mediated deprivation of liberty").

Coercive treatment includes performing diagnostic measures (for example drawing blood), administering drugs (for example depot injections), applying electroconvulsive therapy, or force-feeding the patient. These interventions can have the goal of treating either the given psychiatric illness or another concomitant illness.¹⁴⁹

5.1.3 Current legal framework

The legal basis for using coercion in service of the welfare of the mentally ill is provided by so-called legislation for the protection of adults.¹⁵⁰ First, this encompasses guardianship law, which is part of the *Bürgerliches Gesetzbuch* (Civil Code, BGB), i.e. federal law. Amongst other things care by representatives and legal guardians is regulated here. The sole purpose of guardianship law is to protect the person in question from himself. Thus, its entire focus is on benevolent coercion in the sense used in this Opinion.

Second, there are state laws relating to commitment, mental illness, and psychiatric support which must be taken into account. They originated in police law to serve the protection of third parties, which remains one of their functions today. However, nowadays these state laws form part of public healthcare for the mentally ill and are intended to provide them with help and protection. In other words, protecting the general public from the threats psychiatric patients can pose is no longer their sole aim. Accordingly, regulations in many German states grant persons with mental illness a legal entitlement to medical treatment and permit civil commitment and coercive treatment not only for the protection of third parties, but also for the protection of patients themselves, especially

149 Cf. DGPPN 2014, 1424 ff.; Adorjan et al. 2017, 802 f.

150 Cf. Lipp 2013.

in acute crisis situations.¹⁵¹ Therefore, in what follows state laws are discussed along with federal guardianship law insofar as these regulations address coercion used to protect people with mental illness from causing harm to themselves. The corresponding procedures and legal protections are regulated uniformly for both guardianship law and the relevant state laws in the *Familienverfahrgesetz* (Family Proceedings Act, FamFG)¹⁵².

In recent years, the legal foundations of coercive measures in psychiatry have been challenged from a human rights and fundamental rights perspective (see section 4.2). German legislators have responded by drafting reforms of the relevant federal and state legislation; this process has not yet been completed, however. The implementation of the reforms that have been passed is still in its initial stages as well. Hence, at the present time the legal context is undergoing significant shifts.

Role of basic rights and human rights

In addition to the precepts of the Basic Law, international law in the form of the relevant human rights conventions must be taken into account, in particular the above-mentioned European Convention on Human Rights and the United Nations Convention on the Rights of Persons with Disabilities, as well as the Convention on Human Rights and Biomedicine (CHRB) by the Council of Europe,¹⁵³ the International Covenant on Civil and Political Rights (ICCPR),¹⁵⁴ and the Inter-

151 Cf. Marschner, in: Marschner/Volckart/Lesting 2010, Part A para. 10, Part B para. 1 ff.

152 *Gesetz über das Verfahren in Familiensachen und in den Angelegenheiten der freiwilligen Gerichtsbarkeit* (Act on proceedings in family matters and in matters of non-contentious jurisdiction), introduced through the Act of 17 December 2008 (BGBl. I, 2586, 2587), last amended by Article 7 of the Act of 20 July 2017 (BGBl. I, 2780).

153 Formally: Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, adopted on 4 April 1997.

154 Adopted on 16 December 1966.

national Covenant on Economic, Social and Cultural Rights (ICESCR)¹⁵⁵.

From the perspective of fundamental rights and human rights, involuntary commitment was the first topic to become the focus of attention. Recently, however, different forms of coercive treatment and other measures involving deprivation of liberty have been debated as well.

The Basic Law protects freedom of the person, physical integrity, and the right to free development of the personality as basic rights (Article 2 (2) sentence 2, Article 2 (1) sentence 1, and Article 2 (1) GG, respectively). Deprivation of liberty, i.e. a complete suppression of freedom of movement, whether enacted by the state or by private third parties, is subject to special procedural safeguards (Article 104 (2) GG). The constitutional precepts concerning deprivation of liberty and coercive treatment have been elaborated substantially by the Federal Constitutional Court. Its adjudications focus on the treatment of the mentally ill in particular. According to the Court, deprivations of liberty through commitment or other measures such as fixation, as well as coercive medical treatment that overrides the occurrent natural will of a person incapable of giving consent, constitute serious infringements of the person's right to self-determination. However, they are not categorically impermissible; rather, they can be permissible on very strict conditions. They can even be mandated from the perspective of basic rights or human rights as being in the best interest of the person concerned if they prevent him from seriously harming himself (see section 4.2).

On the European level, Article 5 ECHR permits involuntary commitment, and Article 7 CHRB permits medical treatment of persons suffering from serious psychiatric illness without their consent provided they would otherwise be at risk of suffering severe damage to their health and provided appropriate procedures of supervision, control, and appeal are guaranteed.

¹⁵⁵ Adopted on 16 December 1966.

Since Germany has not ratified the Convention on Human Rights and Biomedicine, coercive treatment is regulated by the statutes of Article 8 ECHR (protection of privacy) and Article 2 ECHR (right to life). The European Court of Human Rights (ECtHR) has explicated these precepts more concretely in its jurisprudence.¹⁵⁶

In contemporary international debates, coercive measures are predominantly discussed in the context of the Convention on the Rights of Persons with Disabilities. This convention specifically covers individuals whose mental illness is chronic and applies to all human beings “who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Article 1 (2) CRPD). According to the purpose of the convention these persons are included in its protection (Article 1 (1) CRPD) and are entitled to “the full and equal enjoyment of all human rights and fundamental freedoms.” In addition, the Convention on the Rights of Persons with Disabilities concretises and supplements the universal declaration of human rights given in the International Covenant on Civil and Political Rights. According to Article 12 (2) CRPD, persons with disabilities possess “legal capacity on an equal basis with others” (cf. Article 16 ICCPR). Countries that have ratified the convention must establish safeguards to ensure “that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to

156 On the human rights precepts regarding medical treatment entailed by the European Convention on Human Rights, cf. ECtHR, *Lambert v. France*, 46043/14, 5 June 2015; *Câmpeanu v. Romania*, 47848/08, 17 July 2014; *Haas v. Switzerland*, 31322/07, 20 January 2011; *Pretty v. United Kingdom*, 2346/02, 29 April 2002; *Arskaya v. Ukraine*, 45076/05, 5 December 2013.

the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests" (Article 12 (4) CRPD). Furthermore, Article 14 CRPD protects freedom of movement (as do Article 9 ICCPR and Article 5 ECHR). This implies specific conditions for the justification of coercive psychiatric measures taken against persons with chronic mental illness.

(Former) users of mental health services who call for a categorical ban of coercive treatment justify this demand primarily by appeal to the prohibition of torture and cruel, inhuman, or degrading treatment or punishment set down in Article 7 ICCPR and other human rights conventions (cf. Article 3 ECHR; Article 15 CRPD; Articles 1 and 2 of the United Nations Convention against Torture¹⁵⁷). Even so, such a ban cannot categorically prohibit all forms of coercion used in the care of psychiatric patients. For instance, people with mental illness sometimes refuse to take medication even though a careful assessment has shown that the treatment is clearly medically indicated even if administered coercively. If, due to her illness, the patient is incapable of understanding or assessing the consequences of refusing the treatment, and if her illness and her refusal represent a serious risk of exclusion and of compromising her long-term ability to lead a self-determined life, then – provided everything has been tried and failed to convince the patient of the necessity of the treatment – coercive treatment does not constitute a cruel, inhumane, or degrading treatment in the sense specified in the prohibition of torture in Article 7 (1) ICCPR, and thus does not violate the patient's human rights.

Further, the right to medical treatment provided in Article 12 (2) lit. d ICESCR and Article 25 CRPD as well as the state's

157 Formally: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted on 10 December 1984.

duty to protect the right to life in Articles 6 (1) ICCPR, Article 10 CRPD and Article 3 ECHR play a role. A universal ban of coercive psychiatric measures would result in the neglect and degradation of human beings who are mentally ill. Thus, states would fail to meet their human rights obligations. The Convention on the Rights of Persons with Disabilities obliges member states to take all effective and appropriate measures necessary to enable disabled people to accomplish the highest possible degree of independence as well as inclusion and participation in all aspects of life (Article 26 CRPD). If a patient is incapable of mustering a fully responsible act of will with regard to his own illness because this illness prevents him from recognising the necessity of a particular treatment or from acting accordingly, then the right to life and health and the right to medical treatment bestowed by the Basic Law and the relevant human rights conventions imply a duty to protect the patient's life and health, as has been affirmed by the Federal Constitutional Court as well as the European Court of Human Rights.¹⁵⁸ Hence, psychiatric care is a duty.

In summary, the situation regarding the basic rights and human rights of persons with mental illness is as follows: Just like other kinds of patients, the mentally ill have the right to appropriate medical care that aims at mitigating their suffering and restoring their health. Psychiatric care satisfying the standards of current state-of-the-art science should be accessible to all without discrimination. For the purpose of reducing suffering or restoring health coercive measures may be indicated if the patient is no longer capable of grasping the necessity of the treatment or of acting accordingly and if there are no other alternatives. However, public authorities are obliged to prevent any and all abuses of coercive measures in psychiatry and to reduce their incidence to the absolute unavoidable minimum by means of protective legal mechanisms. These include

¹⁵⁸ Cf. BVerfGE 142, 313; ECtHR, *Câmpeanu v. Romania*, 47848/08, 17 July 2014; see section 4.2.

keeping documentation of coercive measures, their implementation, the pivotal reasons, and of the monitoring of the effects, and providing effective legal and judicial protection. In addition, other options of medical and social support and self-help should be promoted if they can prevent the necessity of using coercive psychiatric measures and if they help individuals with psycho-social limitations lead a self-determined life connected with the society around them.

Latest reforms in Germany

Regarding the question of involuntary commitment, the legal precepts guaranteeing individuals' basic rights and human rights have been included in guardianship law and the relevant German state laws for some time. With respect to other measures that involve deprivation of liberty, the Federal Constitutional Court has recently called for the corresponding state laws to be amended.¹⁵⁹ This verdict might also necessitate a reworking of the guardianship law regulations contained in Section 1906 (4) BGB covering measures that involve deprivation of liberty.

On the basis of guardianship law, measures that involve deprivation or restriction of liberty are only permissible if the patient's representative or legal guardian has given consent. Such measures presuppose that the recipient is incapable of insight and judgment, that she is in serious danger of causing significant harm to herself, and that the risk cannot be remedied by any other less drastic means. If the patient is to be deprived of freedom by being placed in an institution, or if her freedom is to be restricted in another way on a regular basis or for a significant period of time, then approval from a court based on an expert psychiatric evaluation is required, except in emergencies (Section 1906 BGB). The extent to which the previously stated or presumed will of the patient must be taken into account is contentious. Consideration of the patient's

¹⁵⁹ Cf. BVerfG, NJW 2018, 2619.

will is mandated by the basic norm regulating acts of care performed by legal guardians (Section 1901 (3) BGB), by the corresponding contractual obligation of the patient's representative, and by the legal regulations covering coercive measures performed by physicians (Section 1906a (1) no. 3 BGB).¹⁶⁰

Legislation of the German states relating to involuntary commitment and mental illness permits involuntary commitment of mentally ill persons not only for the protection of others, but also for the protection of the person himself, provided he is putting himself at serious risk and the imminent harm cannot be averted in any other way (crisis intervention). This so-called civil commitment is initiated by the relevant administrative authority and must be approved by a court on the basis of an expert psychiatric evaluation. In addition, there are state laws governing the use of other measures depriving the patient of liberty while committed. The regulations in the different German states differ significantly in some respects, however.

According to general principles, examinations of a patient's state of health, curative treatments, and medical interventions may only be performed if the patient has given appropriate informed consent, or in the absence of her consent with the consent of the patient's representative or legal guardian, or in emergencies based on the patient's presumed will (Section 630d (1) BGB). Physicians are obliged by civil law (Section 630f BGB) and the laws governing their profession (Section 10 MBO-Ä)¹⁶¹ to document all important interventions and results pertaining to the patient's treatment.

Regarding the special case of administering coercive treatment that overrides a patient's natural will, none of the laws in effect at the beginning of the century's second decade fulfilled

160 Cf. Brosey 2009, 135 ff., 149 ff.; Lipp/Güttler 2017, 95.

161 (*Muster-)Berufsordnung für die in Deutschland tätigen Ärztinnen und Ärzte* ((Model) professional code for physicians in Germany) in the version passed at the 121st *Deutscher Ärztetag* (German Medical Assembly), Erfurt, 2018.

the appropriate human rights and constitutional rights standards as determined by the Federal Constitutional Court, the *Bundesgerichtshof* (Federal Court of Justice), and other German courts.¹⁶²

In response to this, federal legislators drafted regulations concerning coercive treatment based on existing guardianship law, which entered into force on 26 February 2013.¹⁶³ This law permits coercive treatment of patients who have been committed, i.e. deprived of liberty, in accordance with guardianship law in order to be treated (Section 1906 (3) BGB (prior version)). The Federal Constitutional Court rejected this condition of having to have been committed¹⁶⁴ because it renders coercive treatment of immobile patients impossible in principle although such patients may be equally in need of it.¹⁶⁵ According to the Court, this constitutes a violation of the state's duty – derived from patients' basic rights and human rights – to protect this group of patients from serious self-harm. Consequently, legislative authorities created provisions for these cases as well.¹⁶⁶ Now coercive treatment no longer presupposes involuntary commitment but rather requires the person to be an in-patient in a hospital, or to have been taken to hospital, so that the necessary medical care including potential aftercare is ensured. During hospitalisation coercive treatment may only be performed if the patient's representative, i.e. an authorised

162 Foundational: BVerfGE 128, 282; BVerfGE 142, 313; BGHZ 193, 337; on regulations in state law cf. e.g. OLG Celle, FamRZ 2012, 1896; OLG Cologne, BtPrax 2012, 256.

163 *Gesetz zur Regelung der betreuungsrechtlichen Einwilligung in eine ärztliche Zwangsmaßnahme* (Act on the approval of coercive medical treatment in accordance with guardianship law) of 18 February 2013 (BGBl. I, 266).

164 Cf. BVerfGE 142, 313.

165 In accordance with Section 1906 (1) BGB, involuntary commitment of immobile patients is not possible (cf. BGH, FamRZ 2015, 1484, para. 25; BVerfGE 142, 313, para. 97 f.).

166 *Gesetz zur Änderung der materiellen Zulässigkeitsvoraussetzungen von ärztlichen Zwangsmaßnahmen und zur Stärkung des Selbstbestimmungsrechts von Betreuten* (Act on amending the material conditions of permissibility of coercive medical treatment and strengthening the right to self-determination of individuals in care) of 17 July 2017 (BGBl. I, 2426), entered into force on 22 July 2017.

agent or guardian, has given consent and a guardianship court has approved the treatment, except in emergencies. This presupposes that the patient is incapable of giving consent, that the physician and the patient's representative have tried in vain to obtain her voluntary consent, that the treatment is medically indicated even if administered coercively, that it is appropriate and does not put undue strain on the patient, and that it corresponds to her previously stated or presumed will (Section 1906a BGB). Maintaining proper documentation of the coercive treatment is a precondition for its legitimacy (Section 323 (2) FamFG).¹⁶⁷ If a patient objects not only to the treatment but also to being taken to hospital, he may be taken there forcibly only if the preconditions for involuntary commitment are met (Section 1906 (1) no. 2, (2) and (3) BGB; Section 1906a (4) BGB). The law does not permit coercive treatment outside a hospital suitable for that purpose, for example in a care home, the patient's own home, or at a physician's practice. The question whether there are sufficient constitutional grounds to enjoin legislators to permit coercive treatment in those circumstances as well has not yet been decided by the Federal Constitutional Court.¹⁶⁸

In some German states the relevant state legislation lacks regulations regarding coercive treatment altogether to this day. However, most states have reformed their laws in this area and have passed legislation not only on deprivation of liberty but also on treatment in the context of civil commitment, including coercive treatment and its documentation. The question whether these new regulations do meet the required fundamental rights and human rights standards is still contentious.¹⁶⁹

167 Cf. BGHZ 201, 324, para. 22; BGH, NJW 2015, 1019, para. 7.

168 Cf. BVerfG, FamRZ 2018, 1021 (judicial referral invalid in accordance with Article 100 GG); BVerfG, Order of 7 August 2018 – 1 BvR 1575/18 (petition for the issuance of an interim order declined).

169 Cf. e.g. Henking/Mittag 2014; Henking 2016 (with further references).

Reforms are also necessary with respect to measures involving deprivation of liberty used against persons who have been committed in accordance with state laws, for example fixations (unless they are used for a short period of time only). These kinds of deprivations of liberty require approval by a court and must be regulated by the legislative authorities of each state in accordance with the constitutional precepts elaborated by the Federal Constitutional Court¹⁷⁰ (see section 4.2). Potentially, federal legislative authorities will have to rework the regulations concerning deprivations of liberty within guardianship law (Section 1906 (4) BGB) in response to the Court's jurisprudence.

5.1.4 Current situation in professional practice

Currently, the majority of psychiatric hospitals in Germany do not record or evaluate coercive measures statistically in a systematic fashion. Insofar as they do record them, they do not distinguish reliably between coercive measures performed to protect the recipient herself ("benevolent coercion") and those performed to protect third parties. Nevertheless, the studies described in the following convey important insights about the practice of coercion, including its benevolent form, in psychiatry.

The first publications about the incidence of fixation appeared in the early 1990's.¹⁷¹ In 1997 two working groups were founded in northern and southern Germany with the aim of preventing and reducing violence and coercion in psychiatry. Many of the studies these working groups conducted were subsequently published. The studies contain cross-sectional data from different hospitals, comparisons across hospitals using quality metrics, and recommendations for the prevention

170 Cf. BVerfG, NJW 2018, 2619.

171 Cf. e.g. Fritz/Mack/Rave-Schwank 1991.

of violence.¹⁷² According to one study, the rate of involuntary commitment (number of involuntary commitments per capita) was 175 involuntary commitments per 100,000 residents in 1999. The ratio of involuntary commitment (percentage of involuntary commitment of all in-patient treatment incidents) was 17.7 percent in 1998.¹⁷³ Another study from the early 2000's found the percentage of psychiatric in-patients affected by coercive measures (fixation, seclusion, and coercive administration of medication) to be approximately 10 percent.¹⁷⁴ A 2004 pilot study conducted in eight hospitals examined 31,536 cases treated over the span of one year and found that coercive measures were used in approximately 9 percent of cases (corresponding to 3,337 cases in absolute terms).¹⁷⁵

In comparison with more recent studies a small decrease in the tendency to use coercion can be observed.¹⁷⁶ A 2017 study examined 6,544 in-patients from eight different psychiatric and psychotherapeutic hospitals in five German states. The results showed that coercive measures were used against only 8 percent of patients. About two thirds of those patients received a single coercive measure and one quarter received two. At 61.1 percent restriction of freedom of movement was the most common coercive tool, followed by confinement via commitment to a closed ward (43.5 percent). Coercive administration of medication was used in 5.5 percent of cases, force-feeding in 1 percent, and coercive diagnostic measures in only 0.4 percent of cases.¹⁷⁷ The frequency of coercive measures also varied depending on the type of psychiatric illness. Patients with schizophrenia, schizotypal or delusional disorders had the highest incidence of coercive measures (classified as F2 according to ICD-10; total of 161 coercive measures), followed by patients

172 Cf. Steinert et al. 2015; Steinert et al. 2002; Ketelsen et al. 2001. Regarding forensic psychiatry cf. also Jakovljevic/Wiesemann 2016.

173 Cf. Dreßing/Salize 2004, 36.

174 Cf. Steinert et al. 2001, 155.

175 Cf. Steinert/Baur 2004, 20.

176 Cf. e.g. Bruns/Henking 2015, 21.

177 Cf. Adorjan et al. 2017, 804 ff.

with addiction disorders (ICD-10: F1; total of 147 coercive measures) and organic mental disorders (ICD-10: F0; total of 106 coercive measures).¹⁷⁸ When mapping the different types of coercive measures to the different diagnoses, it emerges that direct restrictions of freedom of movement were used most frequently against patients who had both F1 and F2. Coercive administration of medication was used most frequently in the F2 group.¹⁷⁹

In the state of Baden-Württemberg coercive administration of medication to persons with acute mental illness was categorically prohibited between June 2012 and February 2013 after several verdicts had declared both the relevant state legislation and the statutes of federal guardianship law inadequate (see section 5.1.3). A study provided evidence for the effects of abandoning coercive medication on the use of other coercive measures applied to patients with psychotic disorders and on the duration of in-patient stays. The temporary ban of coercive medication led to a significant increase of 39.8 percent (pooled cross-sectional analysis) of other coercive measures, such as fixation and seclusion, compared to the previous year. For the group of patients admitted as in-patients before that time, the increase was even larger at 124.4 percent (longitudinal analysis). However, the ratio of patients subject to coercive measures remained the same. Contrary to expectations, the duration of in-patient stays decreased slightly.¹⁸⁰

Comparisons of the frequency of involuntary commitment and the structure of psychiatric procedures in different countries of the EU yields a heterogeneous picture. A study conducted in 15 EU countries showed that the presence of risk to self or others is not a requirement for involuntary commitment in all countries. Countries in which it is mandatory to involve legal counsel during the procedures resulting in involuntary

178 Cf. *ibid.*, 804.

179 Cf. *ibid.*, 805.

180 Cf. Flammer/Steinert 2015.

commitment naturally have significantly lower rates of commitment. Different legal regulations, different structures of the relevant procedures, and different criteria for involuntary commitment result in divergent rates and ratios of involuntary commitment. For instance, in Portugal the ratio of involuntary commitment was 3.2 percent in 2000, in Germany it was 17.7 percent (1998), and in Sweden 30 percent (1997). Similar differences appear with respect to the rate of involuntary commitment, which was 6 per 100,000 residents in Portugal (2000), 175 in Germany (1999), and 114 in Sweden (1998).¹⁸¹ In Germany judicial statistics show that the number of court procedures has been rising continuously since the 1990's.¹⁸² This must not be rashly interpreted as a *de facto* increase in the use of coercive measures in psychiatric practice, however. Conversely, for example, the number of civil commitments is not tracked on a federal level at all.

In addition to the above-mentioned statistics on psychiatric practice, another central factor in the normative evaluation of coercive measures is the way patients perceive and experience them subjectively (see sections 5.1.3 and 5.1.5). Different studies have demonstrated that involuntary commitment, coercive administration of medication, and fixation constitute severe stressors for the recipient and tend to cause negative feelings of fear, humiliation, and powerlessness.¹⁸³ One study investigated patients' subjective impressions three weeks after having been subject to coercion. The patients stated retrospectively that the most common feelings they had had while committed, but also during coercive measures like fixation and medication, were helplessness, rage, and anger. Patients who were more clinically stable evaluated the measures more negatively than patients who were more severely ill.¹⁸⁴ The same study showed that three quarters of those surveyed were satisfied with the

181 Cf. Dreßing/Salize 2004, 36.

182 Cf. Bruns/Henking 2015.

183 Cf. Frajo-Apor/Stippler/Meise 2011; Längle/Bayer 2007.

184 Cf. Armgart et al. 2013, 278.

therapy they had received, and that 74.2 percent of patients would return to the same hospital in case of further need for treatment.¹⁸⁵ In another study patients assessed their experience as somewhat less serious after a certain amount of time had passed.¹⁸⁶

Another study yielded similar results. This study illustrates the experience of patients who have experienced coercion by recounting their opinions in their own words. Patients view these measures as humiliating (“I think that nothing more humiliating could possibly happen to you in a psych ward”; “It’s humiliating and there really aren’t any words for that feeling, being at the mercy of others and just being nothing anymore. You are nothing in that moment”), inhuman (“You are almost a third-rate, fourth-rate human being”), traumatising (“What doesn’t kill you makes you stronger – once you have experienced that you really appreciate freedom”), and degrading (“It started right away with the nurse’s degrading behaviour in the bathroom where I had to get undressed and it was a man. That was discrimination against me. It was awful”).¹⁸⁷

The question which forms of coercion are experienced as the most stressful cannot be answered definitively yet. A randomised study did not find any significant differences between fixation and seclusion with regard to their impact on patients.¹⁸⁸ After a period of one year, however, fixation was assessed as more stressful.¹⁸⁹

In public debates carers are often accused of using coercion to wield power and punish recalcitrant patients. The statements made by patients in some studies seem to corroborate these allegations. A closer look at the relevant research reveals a less clear picture of caregivers’ goals and motives, however. In one study, hospital staff judged coercive measures to be

185 Cf. *ibid.*, 281.

186 Cf. Katsakou et al. 2011.

187 Frajo-Apor/Stippler/Meise 2011, 296.

188 Cf. Bergk et al. 2011.

189 Cf. Steinert et al. 2013.

violations of integrity and a cause of damage to the relationship between therapist and patient. Further, they stated that such interventions trigger fear and discomfort in patients. The study subjects named violence and threats by patients as well as self-harm as reasons for using fixation and seclusion.¹⁹⁰ In another study, staff of an emergency ward viewed coercive measures as part of treatment but also as a means of averting attacks by patients in order to ensure everyone's protection, safety, and security.¹⁹¹

In intercultural treatment situations, there are often language and cultural barriers which can cause problems. This has been known in psychiatric practice for a long time and some research into the topic has been conducted, particularly since the development of transcultural psychiatry in the 1990's.¹⁹² However, the current state of research into the impact of multiculturalism on the use of coercion in psychiatry is unsatisfactory. In a public hearing held by the German Ethics Council, some experts underlined the fact that language barriers increase the risk of coercion significantly. One of the reasons for this is that German hospitals have too few interpreters, so that when crisis situations occur conversations that might serve to deescalate, provide comfort and security, and clear up misunderstandings take place with delays or too late. Furthermore, accessing appropriate psychiatric or psychotherapeutic treatment and care is more difficult for foreign-language patients because there are not enough therapists that speak their language. This increases the likelihood of crisis situations in which coercive measures may become necessary.¹⁹³

In psychiatric practice, the guidelines published by the relevant expert bodies are of great significance. They are

190 Cf. Wynn 2003.

191 Cf. Husum/Finset/Ruud 2008.

192 Cf. Heise 2005; Hegemann/Salman 2010.

193 Cf. the online documentation of the hearing titled "'Wohltätiger Zwang' in der Psychiatrie" (Benevolent coercion in psychiatry), held by the German Ethics Council on 23 February 2017, available at <https://www.ethikrat.org/anhoeerungen/wohlttaetiger-zwang-in-der-psiychiatrie> [2018-08-15].

formulated based on the most up-to-date scientific knowledge and aim to provide security and orientation to the professionals administering care. While physicians themselves remain crucial to identifying the most suitable treatment in each individual case and taking responsibility for their choices, the guidelines are widely accepted by medical professionals and thus form an important contribution to the realisation of good clinical practice.

In September 2018 the *Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde* (German Association for Psychiatry, Psychotherapy and Psychosomatics) issued the S3 guideline “Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen” (Avoiding coercion: prevention and therapy of aggressive behaviour in adults).¹⁹⁴ This guideline contains scientifically based recommendations for the diagnosis and therapy of aggressive behaviour; however, it explicitly does not cover coercive measures used to suppress auto-aggressive behaviour. Nonetheless, many of the recommendations given there should also be heeded when it comes to utilising coercion to prevent self-harming behaviour. For instance, the guideline emphasises the importance of documentation and evaluation as well as independent external counsel and supervision of coercive measures.¹⁹⁵ A publication by the same organisation titled “Achtung der Selbstbestimmung und Anwendung von Zwang bei der Behandlung psychisch erkrankter Menschen” (Respect for self-determination and use of coercion in the treatment of mentally ill persons) focuses on the justification of coercive measures in particular and details corresponding recommendations.¹⁹⁶

194 S3 designates the most methodologically rigorous class of guidelines. In contrast to guidelines of type S2, which are merely evidence-based or consensus-based, S3 guidelines are both evidence and consensus-based. The previous version of the new guideline first published in 2010 was classified as S2.

195 Cf. DGPPN 2018.

196 Cf. DGPPN 2014.

Another important document concerning coercion in psychiatry is the statement issued by the *Deutsche Fachgesellschaft Psychiatrische Pflege* (German Association for Psychiatric Nursing) regarding the use of measures that deprive patients of liberty in acute in-patient psychiatric care.¹⁹⁷ In this statement, measures that involve deprivation of liberty are deemed to be infringements of patients' personal rights. They are understood to be measures of last resort in the day-to-day work of psychiatric care "when all methods and structural options for resolving acute crisis situations have been exhausted and there is no other alternative".¹⁹⁸ The statement includes definitions of the role of psychiatric nurses when implementing measures that deprive patients of liberty and providing after-care in psychiatric emergency wards.

5.1.5 Ethical reflection

The ethical evaluation of benevolent coercion specific to psychiatry resumes the fundamental ethical principles elaborated in chapter 4. The analysis must take into account that first, psychiatry is characterised by complex structures of responsibilities which include not only the level of individual professionals but also that of the relevant institutions and their operators. Second, it is not enough to consider individual actions or courses of action in isolation. Rather, the personal attitudes and opinions underpinning the actions as well as the concrete decision-making procedures and communication processes must also be taken into account. Third, each person's specific situation should be considered when evaluating particular measures. Fourth, the preconditions for benevolent coercion to be morally legitimate cannot be defined in abstract or general terms, but rather are the result of concrete lines drawn by

¹⁹⁷ Cf. DFPP 2016.

¹⁹⁸ *Ibid.*, 1.

individuals who need to justify their decisions. Therefore, the use of benevolent coercion must be subject to a procedure of scrutiny involving multiple steps and criteria.

First of all, it should be pointed out that the precise meaning of the concept of a psychological (mental, emotional, psychical) illness has long been the subject of controversial debates all over the world in fields such as psychiatry, psychology, neurology, philosophy, ethics, and also in the field of law, for instance with respect to questions of mental competence, decision-making capacity, and culpability.¹⁹⁹ Currently, no consensus on the definition of mental illness exists. This is not simply due to a historically contingent inadequacy of empirical knowledge or the current state of science. Rather, the multiplicity of proposed definitions and models arises from a number of normative, social, and metaphysical background problems which do not have generally accepted solutions, for example the problem of the relationship between mind and brain (mind-body problem), of distinguishing what is normal from what is deviant, irrationality from reason, self-determination from helplessness, and last but not least the relationship between medicine and society. Anyone responsible for making medical diagnoses must be conscious of the highly complex necessity of making *decisions* which is involved in recognising many psychopathological conditions. Such decisions are unavoidable, at least in the borderline area between normalcy and relevant deviance. Even if a decision appears highly irrational from an external point of view, this does not constitute a sufficient reason to override it – for example by means of coercion – if this decision is in harmony with the person's inner convictions, beliefs, normative orientations, and values. Furthermore, norms about the general social appropriateness of particular forms of behaviour must be used with an abundance of caution. A person might be stubbornly oppositional and exhibit behaviour that does not fall into any ordinary set

199 Cf. Schramme 2013; Feuerstein/Schramme 2015.

of expectations about socially appropriate behaviour, but that does not mean in and of itself that the person is mentally ill.

From a normative point of view, it is necessary to distinguish between a care recipient's right to the restoration of his mental health and assuaging of his mental suffering and his rights to self-determination, humane treatment, and equal participation in society.²⁰⁰ Based on these distinctions coercion may be indicated as part of appropriate psychiatric care if there is good reason to assume that it can avert the danger of a patient causing serious harm to himself while lacking a fully responsible will and that it can restore his mental health. Here, the benevolence of the measures taken must be assessed, firstly, in terms of mitigating the patient's current subjective and objective suffering and, secondly, with a view to preserving his interest in a life free from mental illness, his options for leading a self-determined life and participating equitably in society.

Since every person has the right to decide if and how her illness, including any mental illness, should be treated ("right to illness"), benevolent coercion in psychiatry can only ever be justified if the person's capacity for self-determination is impaired so that she can no longer make fully responsible decisions in the given situation or act accordingly, or at least if there is no conclusive indication that her refusal to be treated corresponds to her fully responsible will. Otherwise, coercive measures cannot be morally justified, even if they are intended to serve her welfare.

Consequently, assessing the patient's capacity for self-determination and ascertaining that she is incapable of originating fully responsible decisions or actions in the given situation because her capacity for self-determination is impaired is a necessary precondition for coercive measures to be legitimate. However, neither the mere fact of a psychiatric diagnosis nor the possibility or necessity of treating it as determined from the

200 For an ethical perspective on this, cf. Schramme 2013; Gather et al. 2017; for a legal perspective see section 5.1.3.

point of view of psychiatry in and of themselves imply that a person's capacity for self-determination is impaired. Similarly, refusing medical treatment should not instantly be interpreted as a sign of an impaired or absent capacity for self-determination. Rather, it must be determined in each individual case, based on the given situation and the problem to be addressed, whether or not someone's capacity for self-determination is compromised. Furthermore, a specific justification must be given for why this prevents the care recipient from producing fully responsible decisions or actions in the given concrete situation.

The question of coercion arises whenever a person's will is discernibly opposed to a proposed measure. There are a number of ethical reasons why such expressions of will are relevant to the decision-making process. On the one hand, respect for the person as such implies that even though a particular expression of will may not be fully responsible, it still should not simply be dismissed. Moreover, coercion used against someone whose will is evidently opposed can be experienced as traumatic, even if the action is judged to be benevolent by the standards of third parties. These individual responses to coercion must be factored into the overall evaluation of the benevolent aims that can realistically be accomplished because they can counteract the intended purpose of the measure and undermine the patient's trust in the medical field and/or his social environment. This is especially important in the case of patients with chronic mental illness where the goal of restoring their health becomes less and less relevant because it is probably unachievable. Instead, individuals in this category should be given the opportunity to lead a life that is acceptable to them, including full participation in society, despite having a more or less debilitating mental disability.

It follows that coercion in the service of a mentally ill person's welfare is only acceptable under certain additional, limited conditions. As in the other fields of practice, coercive measures must only ever be used as a last resort, and they must be

performed under conditions that approximate the recipient's will as closely as possible. Coercive measures must pursue the primary goal of restoring the person's full capacity for self-determination. They must only be performed if the person herself would condone them were she currently capable of making a fully responsible decision, or if she would judge them to be right and necessary in hindsight.

An important means of ascertaining a patient's wishes is an advance declaration of will (for example an advance medical directive). From a medical and ethical point of view, the patient should receive appropriate counselling from a physician and then make a joint decision about the future course of action to be taken in case of illness or loss of the capacity to give consent. These wishes should be set down in a medical directive. Drawing up such a directive also serves as an expression of a cooperative relationship between physician and patient and of mutual respect. It can form a suitable basis for conversations between physician and patient in future crisis situations and can thereby help to prevent or reduce the use of coercive measures.²⁰¹ A treatment directive usually states the goal of treatment as well as concrete preferences regarding future treatments to be performed. It contains a medical directive or another type of advance declaration of will detailing the patient's wishes regarding future treatment. If they have not already done so, patients can also name a trusted person in the treatment directive to support them if necessary. That person can be given power of attorney, or a directive can be submitted to a guardianship court nominating her as legal guardian. The *Bundesärztekammer* (German Medical Association) and its *Zentrale Ethikkommission* (Central Ethics Committee) rightly recommend this since it provides the patient with a representative who can speak for him and assert his will in the treatment process.²⁰²

201 Cf. Radenbach/Simon 2016.

202 Cf. BÄK/ZEKO 2013, A1581 f.

One of the primary goals of treating psychiatric illnesses is to enable patients to handle their illness and any conflicts or crises that may occur in such a way that they can master their affairs and their daily lives according to their own standards. Therefore, a therapeutic approach beholden to human dignity is geared towards the patient as a person; the patient must always be included in the treatment process as an active participant. Using coercion to treat the mentally ill inherently conflicts with this requirement. Moreover, even if coercion is justified in a specific exceptional situation, this does not mean that it may be used again in subsequent crisis situations without a thorough assessment. Rather, the use of coercion presupposes in every single case that the temporary restriction of freedom which it involves is undertaken with the realistic expectation of overcoming crises that might lead to self-harm, resolving conflicts, restoring the patient's control over her actions, and especially promoting – or preserving, if necessary – her capacity for self-determination and participation in society in the long term. The realisation of this objective can be promoted through new learning experiences, new experiences of social communication, broadening someone's range of possible behaviours, and facilitating other positive experiences.²⁰³ Studies on the efficacy of such measures demonstrate that even severe affective disorders can be mitigated significantly through a combination of psychotropic medication, psychotherapy, and social work.²⁰⁴ In the realisation of such a person-centred approach coercive measures can only ever be acceptable temporarily. At any rate, it is necessary to convey the long-term perspective to the patient from the beginning, and to examine jointly in hindsight whether the use of coercion did indeed contribute to the patient's self-determination and participation and was therefore justified.

203 Cf. Cox/Hetrick 2017.

204 Cf. Gartlehner et al. 2017; Cox et al. 2014.

5.2 Benevolent coercion in child and youth services

5.2.1 Outline

State-run child and youth services have undergone fundamental change over the last few decades.²⁰⁵ Nowadays child and youth support services encompass a broad spectrum of types of social work, spanning general support for children, youth, and their families (for example day-care centres, services and activities for youth, and family education), specific help with child rearing in special circumstances (for example if the parents' child-rearing skills are limited), and so-called intensive educational measures, which in especially dramatic crisis situations include committing adolescents displaying extremely challenging behaviour to a closed ward. Each of these measures is regulated comprehensively by legal norms, in particular those contained in SGB VIII (Child and Youth Services Act).²⁰⁶ The paramount principles informing the structure of child and youth services are (a) *preventing* the development of precarious biographies in children and youth, (b) *integrating* the individuals concerned into society while preserving their "unique life situation and perspectives",²⁰⁷ and especially (c) allowing children, youth, and their parents or families to *participate* in the planning and execution of professional help. The welfare of children and youth lies at the centre of child and youth services. It must be secured and promoted through targeted educational interventions, for instance by facilitating the unfolding of an individual's developmental potential.

205 Cf. the overview in Böllert 2018; Schröder/Struck/Wolff 2016.

206 *Gesetz zur Neuordnung des Kinder- und Jugendhilferechts* (Act on the revision of child and youth services law) of 26 June 1990 (BGBl. I, 1163), new version published on 11 September 2012 (BGBl. I, 2022), last amended by Article 10 (10) of the Act of 30 October 2017 (BGBl. I, 3618).

207 Faltermeier/Wiesner 2017, 496.

Until the 1980's, the dominant approach in the field was focused on deficits, so that "difficult" children and youth were usually viewed as neglected, evading work, or delinquent. It was believed that these challenges had to be remedied by strict corrective training. The resulting "coercive education" tended to be disciplinarian and stigmatising: "difficult" children and adolescents were proof of their parents' failure to rear them properly. This "failure of the family", as Hans Thiersch has described the deficit-oriented approach to these children and youth, "was attributed to the children in the form of neglect and then moralised. They [children and adolescents] were bad and were seen as bad from the beginning. One had to be harsh towards them [...]".²⁰⁸ In light of this attitude it is no wonder that institutionalised educational support in particular was characterised by systematic harshness and coercion.²⁰⁹ This did not seem problematic at a time in which corporeal punishment and bullying counted as suitable educational methods for children and youth, both in families and in public educational institutions, and (still) met with broad acceptance.

From today's point of view, such educational approaches engender outrageous educational practices. Over the last few decades, the pain and injustice done to children, for instance in public care homes and charitable homes run by the church, has been extensively covered in the media. It has also been taken up by the Petitions Committee of the *Bundestag*.²¹⁰ On the Committee's recommendation the *Bundestag* established a round-table called "Heimerziehung in den 50er und 60er Jahren" (Education in care homes of the 1950's and 60's), which submitted its final report in December 2010.²¹¹ The report details a broad range of abusive educational practices: Children and

208 Thiersch 2012, 8.

209 Cf. Kunstreich 2007, 11.

210 It stands to reason that the many cases of sexual abuse that have been documented in recent times grew out of an educational system dominated by violence in which children experienced themselves as relatively devoid of rights.

211 Cf. AGJ 2010.

youth were often brought to these homes against their guardians' (parents') will and taking them into care was justified by appeal to abstract and vague notions like "neglect" or "being at risk". Consequently, "in practice any behaviour defined as 'deviant' could result in a child or adolescent being placed in an institution".²¹² Former residents of such institutions report "massive violence on the part of educators and staff, beatings, rigid and inhumane punishments, arrests, humiliations, being barred from contact with others, censorship of letters, religious coercion, and forced labour".²¹³ The report reveals that children and youth were also subject to psychological violence in the form of insults and degradation, sexual abuse as well as peer violence (i.e. violence by fellow "inmates") due to collective punishments.²¹⁴

However, child and youth services have seen a crucial shift which began to gather force as early as the 1980's. The coercive nature of the "total institution"²¹⁵ of the care home was scrutinised critically, and alternatives based on progressive educational ideas started springing up, for example alternative child care centres, shared houses for adolescents, and other forms of individual care situated in the recipients' ordinary life circumstances.²¹⁶ Approaches of conforming education to the attributes and needs of children gained increasing acceptance. The pedagogical tools based on these ideas build on the existing skills and developmental potential of the child or youth – however rudimentary these appear to be initially – and take special care to honour their right to self-determination and participation in decision-making processes in an age-appropriate way. The chief purpose of these reforms was the restoration of the essential core of all educational interventions: to establish relationships between educators and children or youth that are

212 Ibid., 10.

213 Ibid., 13.

214 Cf. Hafenegger 2017, 13.

215 Cf. Goffman 1961.

216 Cf. Kunstreich 2007, 11.

characterised by mindfulness and trust and are therefore sustainable. Interventions are always embedded in an interactive relationship between an educational professional and the individuals in his care.

Like punishments, the coercive elements of an educational intervention often form the sobering climax of an escalation, inevitable as they may appear in an acute crisis. In addition to their antecedents, such interventions have an aftermath that threatens to negate their intended effect. Coercion can damage or destroy the educational relationship, which depends on mindfulness and trust, because it often leaves children and youth experiencing themselves as the mere object of devaluing or humiliating treatment. If care recipients respond with severe opposition, professional caregivers are often overwhelmed, especially if there are not enough staff in a given situation to provide individual responses to the problems at hand. This increases the danger of further escalation. Hence, coercive measures often have the opposite effect of how they were intended; they don't succeed at diminishing challenging behaviour and calming the situation down.

As a consequence, the reforms of child and youth services instituted in the 1970's aimed at establishing a fundamentally different framework for educational constellations which would foreground the interactive and processual character of educational interventions and would thus interrupt the vicious cycle of coercion and opposition as early as possible.²¹⁷ This "educational turn" manifested itself in the *Dritter Jugendbericht* (Third Youth Report, 1972),²¹⁸ in "Grundlegende Vorstellungen über Inhalt und Begriff moderner Jugendhilfe" (Reflections on the conception and objectives of modern adolescent services, 1974)²¹⁹ both published by the Federal Ministry for Youth, Family and Health, and finally in the *Achter*

217 Cf. Thiersch 2012, 12.

218 Cf. BMJFG 1972.

219 Cf. BMJFG 1974.

Jugendbericht (Eighth Youth Report, 1990)²²⁰. Legislation regarding child and youth services was amended in 1990 to reflect those changes. The structural principles of prevention, integration, and participation are now enshrined in law, and child and youth services are founded on the principle of “educating children and adolescents to become responsible and community-oriented personalities” (Section 1 SGB VIII).

However, despite this overall objective it must not be forgotten that professional relationships, just like everyday educational relationships (for example between a child and her parents), are often confronted with a “pedagogical paradox”:²²¹ Aiming to promote a sense of responsibility and self-determination in children and youth over the course of their development sometimes necessitates educational interventions that override the child’s current level of self-determination and thus seem to counteract the original goal.²²² Such measures definitely include all forms of coercion. However, entirely forgoing such measures equally detracts from the aim of educational interventions, i.e. promoting children’s and adolescents’ development into autonomous and responsible personalities. This aim presupposes being sensitive to their specific experiential world. At the same time, it often requires changing their daily routines. Developmental processes have to be instigated, sometimes against the child’s or youth’s opposition. Thus, modern child and youth services should follow the objective of being sensitive to their clients’ experiential worlds while at the same time “being conscious of their own temporary intrusiveness and placing appropriate limits on the required orientation towards clients’ experiential worlds”.²²³

The new approach of the “educational turn” informs child and youth services to this day, both in practice and in the relevant legal regulations. Unfortunately, this has not been

220 Cf. BMJFFG 1990.

221 Cf. Brachel 1985; Giesinger 2011.

222 Cf. Giesinger 2011.

223 Faltermeier/Wiesner 2017, 496.

sufficient to prevent repressive forms of interventions from persisting in some areas. Recently, these have even become more wide-spread again,²²⁴ especially in the context of more or less closed institutions to which children and adolescents are committed. Therefore, this area deserves particular attention, despite constituting only a small section of the broad spectrum of child and youth services.

Abusive educational practices in several residential institutions have recently been revealed to the public, for example in the *Friesenhof-Mädchenheime* (Friesenhof Homes for Girls, founded in 1999) in the German state of Schleswig-Holstein and in the three homes run by the Haasenburg GmbH (founded in 2002) in the state of Brandenburg. After complaints about these conditions were made public, an independent commission of enquiry instated by the relevant state minister carried out an enquiry into the approaches and practices used at the Haasenburg institutions for intensive therapy. Their final report, published in 2013, makes it clear that corporeal punishment, emotional abuse, and humiliation of children and adolescents was commonplace.²²⁵ Children and adolescents were not granted any privacy. Further, a pedagogical approach of so-called token and level systems was used: Residents had to obey very strict rules in order to gain some personal liberties, which they could lose again at any time.²²⁶ The chief purpose seemed to be to “break the young people’s will”.²²⁷ In December 2013, the state ministry in charge revoked the operating license of Haasenburg GmbH. The company’s lawsuits against the closure were unsuccessful.

224 Cf. Kappeler 2017.

225 Cf. MBSJ 2013.

226 Adolescents had different privileges depending on the level they were put in (red, amber, green). Everybody had to start at the red level. Red meant: isolation from other adolescents in a room that had only a mattress and a table, no schooling, sometimes also locked or taped-over windows. The committee’s final report mentions the case of a boy who was at the red level for over a year. Cf. *ibid.*, 45.

227 *Ibid.*, 59.

The excesses disclosed in the Haasenburg homes may be exceptions;²²⁸ at least there is no sufficiently reliable data about the incidence of such practices in residential homes.²²⁹ Still, according to the Brandenburg investigative committee the intensive educational approach enacted in the Haasenburg homes is by no means uncommon.²³⁰ A corresponding tendency in child and youth services has been registered, at least with respect to the increased frequency of utilising closed residential institutions. In expert debates this is thought to be connected to an increasing public focus on security, which has been observed for some time, and the increasing scandalisation of adolescent delinquency.²³¹ Apparently, this tendency is magnified by budget constraints and requirements of efficiency and efficacy.²³² Conversely, fees for places in residential institutions are comparatively high, creating incentives for the institutions' operators to establish such services. Such (large) homes are still the exception, however. Nowadays complex mixed set-ups of ambulant and (partly) residential care are common, as are wards or homes that are open in principle but closed on an individual or optional basis.²³³ Yet even in these forms of care, restrictions of liberty and coercion can occur, for example so-called time-out rooms,²³⁴ body searches or room searches, obligations to provide urine samples as part of drug screenings, children being taken to school against their will etc. In many institutions these and other infringements of individuals' basic rights (which also includes video surveillance) happen without any explicit written mandate, without being reported to the relevant state authorities, without being discussed in a

228 Similar excesses have also been discovered and penalised in other states, e.g. at the Friesenhof homes for girls (cf. Schleswig-Holsteinischer Landtag 2017, especially 500 ff.) and at several residential institutions for children and adolescents with disabilities in Bavaria (cf. BStMASFI 2016).

229 Research into this question is urgently needed.

230 Cf. MBS 2013, 38.

231 Cf. Spiess 2012.

232 Cf. Peters 2016, 177.

233 Cf. Krause 2016, 79 f.; Lutz 2015, 303 ff.

234 See footnote 23.

meeting devoted to the support roadmap as specified in Section 36 SGB VIII, and without documentation or evaluation.²³⁵

Decisions to remove a child or adolescent from their family or hand over their care to child protective services have a particularly severe impact. Due to understaffing at child and youth protective services, children and adolescents are not always allowed to participate in these decisions appropriately, their wishes about their preferred place to live and desired living arrangements are not always taken into account, and siblings are sometimes separated against their will. Children and adolescents tend to experience this as coercion. This jeopardises the success of the support measures and often has negative ramifications in the course of the person's life.²³⁶

Child and youth services are not only confronted with the pedagogical paradox time and time again, but sometimes also with contradictions inherent in the "schemes of knowledge and action"²³⁷ specific to their profession. Such conflicts often occur in the context of involuntary commitment of children and youth to support institutions. Here child and adolescent psychiatrists play an important role alongside the educational experts. The former evaluate the individuals to be committed and are responsible for any supportive treatment that may be necessary during their stay. However, educational and psychiatric expert bodies differ in their assessment of the necessity of this kind of commitment. From the point of view of child and adolescent psychiatrists, even medium and long-term measures that deprive the recipients of liberty often turn out to be necessary and useful, at least for children and adolescents who have "a very unstructured social environment, high emotional lability, a history of failure in different youth institutions, on-going substance abuse, or other behaviours that clearly put the person at risk or that are inappropriate for their age,

235 Cf. Peters 2016, 176.

236 On the staffing situation at child and youth protective services and the resulting consequences cf. Beckmann/Ehltling/Klaes 2018.

237 IGFH 2015, 7.

for example drug-related crime or prostitution”, and who “do not seem to be responsive (anymore) to ordinary youth services”.²³⁸ Educational experts do not always share this view, however. They tend to highlight novel methods for dealing with “difficult” children and youth based on cooperation and respect, which in their view are successful, and defend children and youth against “attempts to intimidate, control, psychologise, and ‘therapise’, potentially even involving medication”.²³⁹

Certainly both psychiatric and educational child and youth services are oriented around the child’s or adolescent’s welfare.²⁴⁰ However, for professional reasons they approach their work differently. Child and adolescent psychiatrists mainly operate in acute crisis situations in which urgent help is needed. (This is why they are actually called in for help by educational professionals quite frequently.) Hence, they obviously concentrate on psychopathological disturbances and mainly employ scientifically validated *therapeutic* interventions. On the other hand, child and youth services based on *social pedagogy* focus on the long-term care and support of children and youth in difficult life situations, as well as the sustainable development and promotion of the care recipients’ own resources in order to help them shape and master their lives successfully.²⁴¹ Consequently, the professional outlook of child and youth services following a social pedagogical approach demands that they take their clients’ entire life situation into account. For instance, this manifests in the fact that interventions are embedded in an extensive framework of implementing a support roadmap, which is actually legally required (Section 36 SGB VIII) and is supposed to ensure that care recipients and their guardians

238 DGKJP et al. 2014, 3 f.

239 Krause 2016, 82.

240 These services take into account the principle of developmental psychology that developmental processes neither depend solely on organismic maturation nor solely on environmental conditions of socialisation, but on the interplay between the two (interactions between the individual and the environment).

241 Cf. Böhnisch 2005.

participate in the process according to their own resources and that they do so voluntarily if possible.²⁴²

Both perspectives are professionally valid. The tensions that tend to arise between them must not be resolved in favour of one of the two poles. Problems in this area usually occur because a collaboration based on mutual understanding could not be established and the accomplishment of the fundamental goals is being made more difficult or even impossible by interventions from the other “camp”. One example of a problematic practice is the long-term coercive administration of medically indicated psychotropic drugs. This can put a severe strain on the relationship between the educational professional and the child or youth in question. Thus, it can render successful educational work more difficult or even impossible. On the other hand, this practice often occurs in cases in which the child or youth presents a risk not only to themselves but also to others, for example the professional carers or other residents at their institution. In these circumstances, weighing the different interests at stake and reconciling them with the child’s or youth’s need for a sustainable educational relationship can be extremely difficult.

5.2.2 Forms of benevolent coercion

The constellation just described is by no means unusual. It illustrates how in child and youth services, like in other fields of practice, coercion (such as the involuntary administration of psychotropic drugs) performed in the context of professional care often occurs in situations in which the distinction between preventing harm to the self and preventing harm to others is difficult to draw. Thus, in many cases it is not clear whether such cases of coercion can be classified as benevolent, let alone exclusively so. In addition, in virtue of the specific triangular

242 Cf. Denner 2016 (includes further references).

relationship between the child or youth, her legal representatives (usually the parents), and the state authorities exercising their duty to protect the child, the different forms of coercion in the context of child and youth services have one feature in common. Due to the primacy of parental custody, any intervention affecting the child or youth requires the (parental) guardians' consent. This can result in problematic constellations: In order to divest a benevolent professional intervention of its coercive nature, (age-appropriate) consent from the child or youth as well as the parents' consent are required. If both are lacking, then the measure is as it were doubly coercive: it is coercive towards the child or youth whose wellbeing is at stake and towards the parents, who are equally bound to care for and serve the child's welfare. Even if the guardians consent to the measure out of their own free will, their consent does not negate the coercive nature of the measure since it still overrides the will of the child or youth in question.

That said, in the institutionalised education of children (a) individual coercive incidents can be distinguished from (b) coercive elements in pedagogical approaches and (c) coercive contexts in which (educational) support is offered. All three forms of coercion also play a role in the day-to-day work of bringing up children and adolescents. Such day-to-day upbringing is provided by parents, siblings and other relatives, the social environment in the form of neighbours and friends as well as institutions like day care centres and schools. Coercion in day-to-day upbringing serves the same purpose as upbringing as such, namely to avert potential dangers and promote the development of children and youth into responsible and community-oriented personalities.

Of course, pedagogical interventions in the context of professional child and youth services cannot simply be equated with those taking place in ordinary child-rearing. The family is a lived social and experiential domain that is fundamentally protected from interference by the state. It is subject to different standards than the temporally limited connection a

child or youth has to a support institution; the latter kind of relationships are not necessarily based on trust. In contrast to the more or less naturally arising relationship of trust between parents and children, trust between educational professionals and children or adolescents has to be (painstakingly) built, and always remains fragile. Therefore, the danger of coercive interventions having a counterproductive effect is significant, especially with respect to the constitutively significant educational relationship. In the context of professional support services, the following forms of benevolent coercion can be distinguished.

Physical coercion

Forms of physical coercion cover the spectrum of holding someone down to prevent them from harming themselves or other children or adolescents, to physically subduing someone, for instance in order to take them to or remove them from a particular place. Even though these forms of coercion occur frequently in the daily routine of educational care, they are rarely discussed, even in the professional community, apart from a few obviously inappropriate and abusive cases, which then become known as “care home scandals”. The extent to which physical coercion affects the wellbeing of children and youth and puts a strain on them depends on the context and urgency of the situation as well as the individual’s age. Physically subduing someone may appear unavoidable at times. Nevertheless, such actions can be misused by educational professionals for the purpose of demonstrating power. Furthermore, educators tend to experience situations in which they apply physical coercion to a child or youth as highly emotionally charged and stressful. This can aid and abet aggressive or even brutally violent behaviour on their part.²⁴³

243 Cf. Schwabe 2010.

Restriction and deprivation of liberty

In contrast to the more spontaneous actions of physical subduing, measures involving restriction or deprivation of liberty tend to be planned, systematic forms of limiting a person's freedom of movement. One particularly drastic form of deprivation of liberty is fixation with belts or straps, which predominantly occurs in child and adolescent psychiatry and in homes for disabled children and adolescents. Fixation is used to prevent danger to self and others.²⁴⁴ Since it is usually carried out with the guardians' consent but without the child's or adolescent's consent, it counts as coercion. Restriction of liberty includes having children or youth taken into care against their will. In emergency situations, if children or adolescents need to be protected from abuse or neglect within their family of origin or from harm in their extrafamilial environment ("street children"), authorities can move them to a home, another residential institution, or a foster family either temporarily or permanently. In residential care, there are open and closed forms of accommodation. Distinguishing precisely between open and closed forms has become difficult, however, since the "boundaries between 'open', 'partly open', 'closed on an individual basis', and 'closed' forms of care" have nowadays become blurred.²⁴⁵ In the case of closed residential care the person is subject not only to restrictions but also to deprivation of liberty. The latter is defined as follows: "(1) an individual's personal freedom is restricted against their will; (2) the duration and intensity of restriction exceed age-appropriate limitations; (3) the child or adolescent is being confined to a limited space; and (4) their stay is (constantly) being monitored and contact with persons outside the closed space is prohibited".²⁴⁶ The practice of committing individuals to closed wards or institutions to prevent them from harming themselves and others is

244 Cf. Igel 2010.

245 Wölfel/Redmann/Löffler 2016, 117.

246 Peters 2016, 172.

part of child and adolescent psychiatry, but also of child and youth services.²⁴⁷

Intensive educational approaches involving coercive elements

Professional educational approaches can involve coercive elements that are based on the principles of behavioural therapy. The use of such methods then gets justified by appeal to the child's or adolescent's welfare. These approaches are often part of a firmly established and, more importantly, easy-to-understand system of privileges enacted in residential youth institutions to modify behaviour.²⁴⁸ There are two kinds of systems of privileges: point and level systems. In a point system, the child or youth "earns" points for specific kinds of behaviour, which are added up over time and can then be exchanged for desired things or activities. In a level system, rule-conforming behaviour is rewarded by advancing to another level that offers more privileges, while rule violations are punished by getting relegated to a lower level with fewer privileges.²⁴⁹ Another intensive educational measure that is coercive in nature is the use of time-out rooms. These so-called "crisis rooms", "calm-down spaces", "isolation rooms", or even "reflection chambers" are used to isolate a child or youth for a certain amount of time in order to calm them down and terminate their challenging behaviour.

Coercive treatment

The administration of behaviour-altering medication can be classed as coercion in two ways. First, these drugs are sometimes administered as coercive treatment in the narrow sense of the term, i.e. against the natural will of the person concerned. Nowadays there are comprehensive legal regulations detailing

247 Cf. Igel 2010.

248 Cf. Tischler 2009.

249 Cf. *ibid.*; for a critique cf. Kunstreich/Lutz 2015.

the necessary preconditions for performing coercive medical treatment on adults (see section 5.1.3); this is not the case for minors, however, for whom no explicit legislation exists. Children or adolescents who have a mental illness or disorder and whose capacity for understanding and judgment is therefore impaired are probably the most likely to meet the preconditions for coercive medical treatment.²⁵⁰ Second, behaviour-altering pharmacotherapy can be subjectively experienced as a form of coercion that has negative physical, intellectual, and emotional consequences since the medication is intended to modify the recipient's behaviour – which she perceives as “normal” or “natural” (for example in the case of obsessive-compulsive disorder, psychosis, etc.) – to bring it more in line with the social system of norms. Situated in the contentious intersection of pedagogy and psychiatry, psychopharmacotherapy for children and adolescents raises numerous specific legal and ethical questions, which in part differ quite significantly from those concerning adults.

5.2.3 Current legal framework

The welfare of children is the central concern of the (legal) regulations governing acts of care involving benevolent coercion in child and youth services. Apart from averting all forms of danger to life and limb, this concern manifests itself especially as “fostering the child's development” and “educating children and adolescents to become responsible and community-oriented personalities” (Section 1 SGB VIII).

The welfare of children as central concern

The framework for securing and promoting the child's welfare mainly rests on the following basic presuppositions: the substantial requirements to respect the child's subjectivity and

²⁵⁰ Cf. Irblich 2004.

individuality as well as his right to be raised non-violently, and the structural requirements set down in the relevant human rights legislation, articles of the Basic Law, and sub-constitutional legal regulations which establish the primacy of parental custody and the state's mandate of watching over the children.

The United Nations Convention on the Rights of the Child, the European Convention on Human Rights, and Article 6 GG guarantee each child's right to have his or her individual welfare taken into account. This includes honouring the child's individual needs and wishes (within the framework of the constitutional order and the structures of family life). Accordingly, the child has a right to be included and to participate in all decisions relevant to their welfare. This is explicitly enshrined in Article 12 CRC ("in accordance with the age and maturity of the child"). Article 8 ECHR and Article 6 GG have the same implication, as demonstrated in the relevant jurisprudence (of the European Court of Human Rights and the German Federal Constitutional Court). Further, Article 6 (2) GG establishes children's right to be brought up by their parents. The state is obliged to observe and support this right.²⁵¹

On a sub-constitutional level the child's inclusion and participation are mandated in Section 1626 (2) BGB and Section 1618a BGB in the context of parental custody, also in Section 1793 (1) sentence 2 BGB for legal guardians, and in Sections 8, 5 SGB VIII for child and youth services.²⁵² According to these regulations, parents and guardians must allow the child to participate in any decisions affecting him in a manner that is appropriate to his age and maturity, and the child's consent should be obtained whenever possible. With regard to education and choice of profession they must take the child's

²⁵¹ Cf. BVerfGE 121, 69, para. 75.

²⁵² This is also relevant in other areas in which the child's will plays an important role, e.g. in judicial arrangements for child custody, when dealing with the other parent, or when securing the child's position in legal procedures by granting the right to be heard or even proper procedural rights, or providing a guardian ad litem.

particular abilities and inclinations into consideration (Section 1631a BGB).²⁵³

Children and youth must be included as participants in any intervention undertaken by public child and youth services in accordance with their current level of maturity (Section 8 (1) SGB VIII). They have their own right to receive counsel (Section 8 (3) SGB VIII), to be taken into care (Section 42 (1) no. 1 SGB VIII), and – provided they are entitled to services (for example Section 8 (3), Section 24 and Section 42 (1) no. 1 SGB VIII) – the right to express wishes and make choices (Section 5 SGB VIII). If support with child-rearing and integration into society is needed, children and youth should receive counselling and participate in the development of a roadmap for the interventions (Section 36 SGB VIII).

Right to be raised non-violently

One of the essential elements of the welfare of children is their legally protected right to be raised non-violently (Section 1631 (2) BGB). When bringing up children one must encourage them to respect others; therefore one obviously must not engage in degrading treatment towards the child oneself. The notion of violence at play here is broader than the one used in criminal law. It encompasses not only corporeal or physical violence but also psychological violence. Legislators have not formulated a concrete distinction between permissible and impermissible coercion in this regard. On the spectrum of possible forms of violence, the use of any violence at all – even mild forms – to sanction children’s behaviour (punishment) or to subdue and influence their will (“anticipatory beatings”) is proscribed by Section 1631 (1) BGB. However, direct and potentially vigorous physical interventions intended to protect the child (for example preventing her from falling off the

²⁵³ There are a number of additional regulations that shield the child’s will from external control and protect her welfare irrespective of the question of child custody etc., e.g. the strict prohibition of sterilisation (Section 1631c BGB).

changing table) or to carry out or enforce parental acts of care (for example taking the child out of a sandbox, washing her hair) remain permitted. In these circumstances the requirements of suitability, necessity, and appropriateness have to be observed.²⁵⁴

Non-violent forms of coercion used to enforce parental commands and prohibitions are only permitted within the limits defined in Section 1631 (2) sentence 2 BGB, i.e. on the condition that they do not involve emotional wounding or degrading treatment. Other limits that are no less obvious (for example the prohibition of all interventions involving torture) are not explicitly stated in the above law but are easily inferred from the principles of necessity and proportionality which are applicable here as well. A legal guardian is bound in the same way (although the applicable sanctions are different) when exercising their right of custody, as are third parties entrusted with custody by the parents, for example boarding school staff or grandparents. In any case, external persons do not possess more extensive authority over a child than they do over other adults. They neither fulfil educational functions nor do they have any other right to impose themselves on the child. They must respect his physical integrity, self-determination, and dignity in the same way as with adults.

When it comes to state authorities, the dictate of non-violence and the principle of respect for the child are even more obligatory, especially in adolescent services (either statutory ones or private ones commissioned by state authorities). However, state authorities can only take action if and to the extent to which the child herself, her guardians, or a court order has instructed them.

Parental custody

In accordance with Article 6 (2) GG, parents have the right as well as the duty to care for their child. They are responsible for

²⁵⁴ Cf. Coester 2005, 756.

the child's welfare. This includes both care of property and custody. The latter essentially encompasses care, education and supervision, the right to determine the child's whereabouts and the child's contact with third parties.

Therefore, acts of care involving benevolent coercion may be used in child and youth services only at the parents' request and within the scope of their authority (i.e. heeding Section 1631 (2) BGB in particular). If an act of care that involves benevolent coercion is opposed to the parents' will, it is only permissible if and to the extent to which interference with the parents' primacy of care is authorised by the state's duty to watch over the children. Consequently, parental custody fundamentally serves as a protective shield for the child, even if the proposed measures are, or are meant to be, benevolent. The parents' authority over the child's life extends up to the threshold of jeopardising the child's welfare and is legally restricted only in very few cases (for example Sections 1630, 1631b, 1631c, 1632 (4) BGB). On the one hand, this authority obligates the parents to promote the child's welfare and hence her self-determination and self-esteem. On the other hand, their authority is guaranteed and cannot be blocked by the child's will (again, up to the point of jeopardising the child's welfare). The scope of liberty and authority granted to the parents is justified by the assumption that as a rule parents are willing to care for their children and are best placed to recognise and realise the wishes and welfare of the child. The primacy of parental custody serves as a protection against interference by the state and external control of child-rearing practices by institutions outside the family, as happens in totalitarian systems. This authority cannot be granted to other people (legal guardians, other persons who have custody of the child) or to organisations running child and youth services to the same extent.

The state becomes involved in its function of watching over the family (Article 6 (2) sentence 2 GG) when the child's welfare is in jeopardy (Section 1666 BGB) or if either the parents or the child request an intervention. The primary duty of the

state consists in enhancing the parents' competence as caregivers, for instance by offering child-rearing support. The state only has the right to intervene in parental custody if support measures are unlikely to succeed and the child's welfare would otherwise be endangered. SGB VIII details in the fourth section of the second chapter the regulations concerning the specific type of assistance called child-rearing support measures. These measures reflect the ongoing shift in child and youth services away from enacting authoritarian interventions towards providing a social pedagogical service. Child-rearing support measures are not intended to compete with or even take over the parents' child-rearing role, but rather aim at supporting the parents in performing their role successfully. Thus, according to the approach of the Child and Youth Services Act, it is actually the parents who are the recipients of child-rearing support measures. Further, they participate in a cooperative process of counselling, clarification, planning, and implementation of suitable and necessary support measures (on planning support measures see Section 36 SGB VIII).²⁵⁵ The type and extent of support is determined by the educational needs of each particular case (cf. Section 27 (2) sentence 2 SGB VIII). The law enumerates a number of common examples of the type of support described in Sections 28–35 SGB VIII, i.e. child-raising counselling, social group work, educational support and care assistance, social pedagogical family support, child care groups, foster care, residential care or other forms of supported housing, and finally intensive social pedagogical personal care.

The interventions governed by juvenile criminal law and those governed by juvenile welfare law are not sufficiently integrated at the present time. Judges at juvenile courts can order adolescents to accept educational support in the form

255 Cf. e.g. the overview given by Schmid-Obkirchner, in: Wiesner 2015, before Sections 27–41 para. 15 ff.

of educational counsel (cf. Section 12 no. 1 JGG)²⁵⁶, day-time or overnight institutionalisation, or another form of residential care (cf. Section 12 no. 2 JGG). The question then arises whether in these situations coercion applied against a child's or adolescent's will can be justified as benevolent in the sense used here. If the conditions stated in Section 1631 (1) BGB are not met, then it is definitely not justified.

Preventing risk of harm to the child's welfare

If the child's welfare is at risk in his family of origin, different instruments of support and intervention are available. As in the case described above, the parents' primacy of preventing harm must first be taken into account. Subsequently the following interventions may be used:

- » Having the child taken into care (Section 42 SGB VIII); in the case of "self-reporting" either with or against the will of the persons who have custody of the child (potentially involving a judicial reservation); temporally limited;
- » Restriction or deprivation of liberty in an open, partly closed, or closed residential institution;
- » Planning support measures, allowing for the participation of the child/youth in question and the legal guardians.

Regarding (residential) institutions run by child and youth services, harm to children is prevented by means of documenting interventions/measures and by processes of approval, control, and supervision of such institutions (Sections 45 ff. SGB VIII). Incidentally, such institutions are usually instruments of benevolent coercion in and of themselves insofar as children and youth stay there against their will. Therefore, they must be subject to strict criteria and procedures of control.

²⁵⁶ *Jugendgerichtsgesetz* (Youth Courts Act) of 11 December 1974 (BGBl. I, 3427), last amended by Article 1 of the Act of 9 December 2019 (BGBl. I, 2146).

5.2.4 Current situation in professional practice

Research on the use of benevolent coercion in child and youth services is sparse, both with respect to statistical data or quantitative studies and qualitative studies. There are very few systematic investigations into the way children and youth experience benevolent coercion in the context of child and youth services and into its psychological impact. However, narrative descriptions that have been published suggest that coercive interventions and situations are often experienced as hurtful and humiliating.²⁵⁷ The *15. Kinder- und Jugendbericht* (Fifteenth Youth Report) states “that the current debate about mistreatment in educational institutions rarely considers the perspective of the adolescents and young adults themselves, and little is known about the way adolescents experience either violence or counselling services”.²⁵⁸ Further research into these questions is urgently needed.

Physical coercion

Data on the use of physical coercion in professional caring relationships predominantly stems from research interviews conducted with former care home residents from the 1950’s and 60’s. These individuals experienced physical coercion as having a severe impact.²⁵⁹ Nowadays this is no longer the case for care home residents, probably because the use of violence is widely condemned and legally prohibited. Regarding the current situation, Carsten Höhler reports that many adolescents judge physical coercion and physical subduing to be necessary or helpful in hindsight.²⁶⁰ Despite these differing evaluations over time it must be kept in mind that “for all forms of physically based coercion the possibility of re-traumatisation and

257 Cf. Redmann/Gintzel 2017.

258 BMFSFJ 2017, 440.

259 Cf. Kuhlmann 2008, 41 f.

260 Cf. Höhler 2009.

injury cannot be excluded".²⁶¹ Höhler points out that establishing a relationship with an educational professional is crucially important to children and youth who are in care. For this reason psychological coercion in the form of withholding affection is experienced as particularly severe.

Residential care

Studying the incidence of restriction and deprivation of liberty in the residential care of children and youth empirically is difficult because the boundaries between open and closed forms of care have become blurred (see section 5.2.2).

In response to a minor interpellation by the parliamentary group of *Bündnis 90/Die Grünen* (Alliance 90/The Greens) the federal government has disclosed that in 2015 German family courts processed a total of 14,304 legal procedures regarding involuntary commitment in accordance with Section 1631b BGB.²⁶² In addition, there were 1,469 ongoing cases of educational support measures in which judicial approval of deprivation of liberty in accordance with Section 1631b BGB had been granted.²⁶³ Data by the *Statistisches Bundesamt* (Federal Statistical Office) show that the number of cases of partial or total removal of parental custody over children or adolescents that were processed by German courts rose from 7,505 in the year 2000 to over 12,771 in 2010, and to 17,168 in 2016, representing a significant increase.²⁶⁴ These numbers only reflect how many cases were heard in a court, however, and do not include information about what decisions were ultimately made or implemented.

The statistics on child and youth support do not capture interventions involving restriction or deprivation of liberty (for example commitment to a home) as such. Despite this lack of data, Birger Antholz has attempted to derive concrete figures

²⁶¹ Ibid., 93.

²⁶² Cf. Deutscher Bundestag 2017, 3 (Table 1).

²⁶³ Cf. ibid., 4 (Table 2).

²⁶⁴ Cf. Statistisches Bundesamt 2017a, 8 (for 2016), 14 (for 2000 and 2010).

concerning the actual occupancy of available places in closed wards and institutions, using data from youth support statistics, a study conducted by the *Deutsches Jugendinstitut* (German Youth Institute) in 2013, and a request for information submitted by himself to the relevant state ministries. While the results were contradictory, a decrease in the incidence of involuntary commitment can be identified. According to Antholz, his own investigations reveal that in 2016 there were 351 children and adolescents (not including children with physical or mental disabilities) living in 25 care homes in Germany that used measures involving deprivation of liberty. Of these children 167 boys and 86 girls were living in gender-segregated accommodation and 78 children were living in co-ed facilities. The average age was 14.5 years and the average length of stay was 11.4 months, not including brief stays that were cut short.²⁶⁵ However, when evaluating the validity of these data the above-mentioned vague boundaries between open and closed forms of care must be taken into account, which renders a definite assessment more difficult.

In a study that claims to include the most extensive data set to date on the assessment of the impact of educational support measures, the findings for residential care programmes were quite positive. Based on a partial sample of 2,160 complete cycles of support, 58 percent of adolescents in residential homes showed significant improvement in at least one of the three developmental dimensions examined (the psychosocial dimension, learning and achievement, and personal responsibility).²⁶⁶ It is still contentious, however, whether or not and under what conditions closed forms of residential care are effective and pedagogically appropriate at all.²⁶⁷ In one study, children and adolescents associated locked doors and secure windows with “jail” and “psychiatry”.²⁶⁸ Most importantly,

265 Cf. Antholz 2017.

266 Cf. Tornow 2008, 34.

267 Cf. e.g. Hansbauer 2016.

268 Cf. Schwabe/Evers 2008.

apparently no sufficient empirical evidence has yet been found for the assumption that closed residential care has a long-term positive impact on the life of the individuals who undergo that experience.²⁶⁹

Intensive educational approaches

Intensive educational approaches that involve coercive elements, for example phase or level models or time-out rooms, are motivated by principles of behavioural therapy. They are based on results of behaviouristic research obtained through observation and experiments and can involve conditioning of certain behaviours. However, experts disagree on whether such approaches actually contribute to a person's ability to lead an autonomous life in a sustainable way.²⁷⁰ In order to substantiate such a claim scientifically, a complex set of causative factors and contexts of action must be taken into consideration.²⁷¹ Phase and level systems run the risk of creating vicious cycles of punishment: the more rules are put in place the more rule violations occur, which then get punished in turn. Fabian Kessl has pointed out that behavioural approaches can be applied abusively if aspects of functionality dominate educational practices.²⁷²

Time-out rooms allow highly aggressive children and youth to remain in a social group of other children or youth more easily and for longer periods of time. This benefits not only the other members of the group but especially the individual in question. Of course, the motive for temporarily isolating someone in a time-out room is not always obvious to the person subjected to this treatment, especially in the case of persons with mental disabilities. When a child does not grasp the purpose of a given intervention, she tends to experience it as sheer bullying. In addition, there is the danger of merely

269 Cf. e.g. Wölfel/Redmann/Löffler 2016; Lindenberg 2011.

270 Cf. e.g. Doll 2016; Kunstreich 2016.

271 Cf. e.g. Albus et al. 2010.

272 Cf. Kessl 2015.

suppressing the symptoms of the challenging behaviour rather than addressing the causes or shedding light on the individual's own subjective view of the situation. Therefore, invasive interventions of this kind can retraumatise the child or youth concerned.²⁷³

In the academic debates in the field of education, such restrictive or confrontational educational approaches tend to meet with reservations. At present the available research only allows for initial speculations. The few existing empirical studies about coercion, disciplinary measures, and sanctions in child and youth services raise doubts about whether these tools are actually used for the primary purpose of ensuring the recipients' welfare. Apparently, a significant proportion of professionals in this field not only tend to enforce rules, but also use such measures as punishments although the severity of the challenge presenting itself does not really justify the extent of the readiness to punish.²⁷⁴ Sometimes mistrust predominates, so that "negotiating about how to address misbehaviour"²⁷⁵ based on mutual understanding and forgiveness is impossible. Moreover, coercion is often applied even though a relationship characterised by empathy and trust between the child or adolescent and the educational professional has not been established. This implies that these forms of coercion differ fundamentally from those typically occurring in day-to-day care in the family. In the context of the family there is a mixture of attachment, gratification of needs, choices as well as coercive elements, which allows those elements to actually succeed in their aim of supporting the wellbeing of the child or youth.²⁷⁶

The expert delegates from adolescent services heard by the German Ethics Council take a very critical view of coercive

273 Cf. MBJS 2013, 77 f.

274 Cf. Mohr/Ritter/Ziegler 2017, 21 f.

275 Clark/Schwerthelm 2017, 17.

276 Cf. Schwabe/Vust 2008, 75 f.

tools in education.²⁷⁷ They assert that while some children show “an ostensible improvement in the short-term”, this is soon followed by a “house-of-cards effect”, and long-term sustainability is lacking.²⁷⁸ Further, they point out that there are no long-term studies on restrictive or confrontational educational approaches in child and youth services. However, research on child-rearing has established that “rigid and punitive educational practices can increase the experience of heteronomy, reduce self-confidence and empathy, and generally close off developmental options as well as aggravate problematic developments”.²⁷⁹

Coercive treatment

Sedating someone with the aid of drugs is generally viewed as a sign of failed educational efforts towards children or youth who for example have a decreased attention span or inadequate impulse control or suffer from obsessions and the resulting actions, etc. In addition to physical symptoms, such as epileptic seizures or disturbances of sight or hearing, children and youth with mental disabilities oftentimes display behavioural problems as well. There are indications that the long-term administration of psychotropic drugs to treat different kinds of behavioural conditions has become more frequent in recent years, not only in the United States but also in Western Europe. However, this increase depends on the type of substance, age, gender, and the specific country.²⁸⁰ Looking at Germany

277 Cf. the online documentation of the hearing titled “‘Wohltätiger Zwang’ in der Kinder- und Jugendhilfe” (Benevolent coercion in child and youth services), held by the German Ethics Council on 18 May 2017, available at <https://www.ethikrat.org/anhörungen/wohltaetiger-zwang-in-der-kinder-und-jugendhilfe> [2018-08-15].

278 Ibid. This is the reply Hubert Schwizler and Daniel Götte gave in the hearing to the question how, in their experience, children and adolescents respond to coercion in the short, medium, and long term.

279 Ibid. This is the reply Holger Ziegler gave in the hearing to the question what immediate and long-term consequences of coercion have been identified.

280 Cf. Chien et al. 2013; Hsia/Maclennan 2009; Meng/D’Arcy/Tempier 2014; Olfson et al. 2012; Zito et al. 2008.

in particular, in the 2000's there was a significant increase in the number of prescriptions for stimulants to treat attention disorders and disturbances of impulse control. In contrast, the 2010's saw a noticeable rise in prescriptions for antipsychotic medication for boys and antidepressants for girls between the ages of 14 to 17.²⁸¹ Reports from professional practice also indicate that children both with and without disabilities may experience problematic uses of long-term medication that are neither questioned nor reassessed regularly. Unfortunately, there is no reliable systematic research on this topic in Germany as yet.

Due to frequent or regular medical treatment and the intensive educational support measures children with disabilities have to undergo, they are subject to benevolent coercion more frequently than children who do not have a disability. This can lead to the development of post-traumatic stress disorder, especially in small children and children or adolescents with mental disabilities who might struggle to comprehend their experiences adequately.²⁸²

Participation and complaints procedures

If possible, the conflicts that frequently occur in child and youth services should be solved in ways that are suitable for children and youth and do not involve coercion. Processes of participation and complaints procedures can play an important part in this.²⁸³ It has been empirically demonstrated that participation not only helps to avoid coercion but also constitutes an essential causative factor facilitating the success of interventions performed by child and youth services with respect to the subsequent course of the recipient's life.²⁸⁴

In the above-mentioned support roadmap procedure participation is mandatory. The concrete form it takes can vary,

281 Cf. Abbas et al. 2016.

282 Cf. Irblich 2004.

283 Cf. the contributions in Equit/Flößler/Witzel 2017.

284 Cf. Albus et al. 2010.

however. A recent study has shown that most staff working in child and youth protective services consider participation extremely important throughout the duration of the support process; however, a large case load often prevents them from following through on this commitment.²⁸⁵

Possible forms of participatory processes within institutions include group councils, advisory councils, or institutional “parliaments”. Internal complaints procedures are handled by elected educational professionals or external persons of trust. Internal processes for participation and complaints have now become widespread in smaller institutions that utilise democratic educational approaches. In contrast, larger organisations that have “very clear hierarchies and little by way of a dialogical organisational structure or culture” are struggling to establish such procedures.²⁸⁶

Ombudspersons are external complaints bodies which provide low-threshold support services for children, adolescents, and parents. The ombudsperson’s task consists in strengthening the position of care recipients vis-à-vis service operators and service providers, promoting the success of support measures via participation, and facilitating negotiations and mediation. These forms of assistance contribute materially to the prevention of coercion.²⁸⁷ In order for ombudspersons to support their clients effectively in asserting their point of view and their wishes when engaging with child and youth services, the following minimum conditions should be met: independence, a clear mandate and extensive authority, directly contactable by children and adolescents, cooperation with other organisations, and accountability (including to adolescents).²⁸⁸ Such

285 Most professionals in general social services have to cover far more than the 35 cases recommended by the *Bundesarbeitsgemeinschaft Allgemeiner Sozialer Dienst/Kommunaler Sozialer Dienst* (Federal working group on general social services/communal social services) (cf. Beckmann/Ehltling/Klaes 2018, 119).

286 Knuth/Stork 2014, 248.

287 Cf. Arnegger 2018.

288 Cf. Hansbauer/Stork 2017.

ombudspersons organisations have become increasingly professionalised. Over the past 15 years they have been established in most German states. There is no legal framework for them as yet, however.²⁸⁹

5.2.5 Ethical reflection

Coercive measures are often experienced as humiliating by the children or adolescents subject to them. Furthermore, far too little is known about the long-term effects of using coercion in child and youth services. However, presenting convincing empirical evidence would be a necessary, albeit not a sufficient condition for the moral justification of restrictions or deprivations of liberty and of restrictive and confrontational educational approaches based on coercion in the field of child and youth services.

Education intends to assist and enable children and youth to develop into mature personalities capable of leading autonomous and responsible lives. Throughout this process they are dependent on the support of adults. The development of children and adolescents is influenced not only by genes and environment, i.e. by biological, social, and more idiosyncratic factors, but is the outcome of a process partly shaped by the unique needs and preferences of each child or adolescent themselves. As described at the beginning of chapter 2, even infants and toddlers actively participate in and shape human interactions. As a consequence, the child as the agent of her own life lies at the centre of contemporary research on childhood. Thus, education must be oriented towards the child *qua* person and her subjective wishes and goals. The child should be able to rely on the fact that she will be treated as an agent in her own right and taken seriously by the persons and institutions providing care. Developing full responsibility, the ability

²⁸⁹ Cf. DIMR 2016.

to take initiative and try new things, the feeling of being recognised as a person, the ability to integrate one's experiences and roles into one coherent identity – all these skills presuppose that the child's self-efficacy and self-confidence have been encouraged and trust in other people and institutions has been fostered.²⁹⁰

Education should be oriented towards the child's or adolescent's development into a fully responsible personality; at the same time, it must take their current needs and interests into consideration in order to achieve that goal. This includes taking the child seriously as a being with moral sentiments. In the past, it was believed that children lack the capacity for independent, non-heteronomous moral feelings, i.e. feelings that are not exclusively conveyed by adults.²⁹¹ This blunted people's sensitivity to the moral injuries done to children by an overly authoritarian upbringing. However, over the last few years research in developmental psychology has collected important empirical evidence that fundamentally undermines those outdated beliefs. In contrast to the views of Jean Piaget and Lawrence Kohlberg, nowadays developmental psychologists no longer consider children (even toddlers) to be amoral or completely in thrall to authority, but rather capable of their own moral sentiments which are meaningful to them even though they might not be very nuanced, much less rationally deliberated.²⁹²

Children and youth have the right to have their moral sentiments acknowledged and respected. They should be treated as persons with dignity at any age and should never be subjected to degrading or humiliating treatment.²⁹³ As a unique stage of the human lifespan childhood has intrinsic value;²⁹⁴ it should not be seen merely as a temporary, deficient phase

290 Cf. Erikson 1997.

291 Cf. Garz 2008.

292 Cf. Gopnik 2009, 17.

293 Cf. Baumann/Bleisch 2015; Stoecker 2013.

294 Cf. Macleod 2015; Bagattini 2016.

of human development.²⁹⁵ Paternalistic decisions taken in the context of care must be oriented around the child as a person and his wishes and needs and equally towards the adult he will one day become. Both the current and future welfare of the child must be considered. When assessing the child's current welfare, subjective aspects, especially his expressions of will, must be included as a substantial component.²⁹⁶ However, expressions of will must be distinguished from reflexive actions, which occur spontaneously and bear no relationship to the child's personal values and beliefs.

Assessing the child's welfare, including her subjective well-being, is first and foremost the duty of the people who have a close personal relationship with the child. As a rule, this will be the parents or guardians. In virtue of their intimate familiarity with the child they are usually best placed to understand her needs, interpret them appropriately, and make decisions to meet them.²⁹⁷ Their personal relationship with the child and their extensive personal knowledge of her imply their right to parental custody. Nevertheless, they, too, are obligated to allow the child to participate in their decisions as much as possible.

Further, the participation rights set down in Article 12 CRC obligate state institutions and authorities in particular to grant children the right to be heard and to participate in any affairs concerning them.²⁹⁸

In order to mature into a fully responsible person, self-confidence and self-esteem are essential. Both of these prerequisites only develop in relationships characterised by respect. Thus, the child's participation in all decisions affecting him also possesses an instrumental value, since it is the respect for the child as a person manifested in this practice that creates the indispensable preconditions for the child's future

295 Thus, Tamar Schapiro's position that adults have a duty "to help children work their way out of childhood" (Schapiro 1999, 735) must be rejected.

296 Cf. Wiesemann 2014; Wiesemann 2016.

297 Cf. Schickhardt 2012, 261 f.

298 Cf. Krappmann 2010; Krappmann 2013.

development. For instance, when a child refuses to go to school, it might be necessary to force her to go to facilitate her development into a fully responsible person in the future. Still, if the child is to develop a sustainable motivation to go to school, the reasons for her behaviour must not be ignored and the question must be considered how the child as a human being with her own wishes and needs can be included in the choice of possible courses of action and whether the measures considered are at all degrading. The latter is definitely the case if the child experiences them as humiliating or traumatising. Using coercive tools that attempt to produce rule-conforming behaviour through conditioning and hence promoting heteronomous behaviour is also a form of disregard for the child's personality. Such strategies are therefore unjustifiable. Instead, educational support measures must be chosen which respect and promote self-determined behaviour even in children, seek out the child's cooperation, and foster the child's trust in the educational attachment figures in the long term.²⁹⁹

Thus, the specific problem with justifying coercion in child and youth services consists in acknowledging the legitimate and indeed imperative goal of helping the child or adolescent develop into a fully responsible person, while on the other hand not treating him as an instrument in service of that goal in concrete situations, which would violate his dignity. This holds for all the forms of benevolent coercion in professional educational constellations described above, i.e. physical coercion, restriction or deprivation of liberty, intensive educational approaches involving coercive elements as well as coercive therapeutic interventions.

With respect to the justification of closed residential programmes one must take into account the fact that they "constitute a massive and highly risky intervention into the life world

299 Cf. Redmann 2017.

and biography of the young person concerned, the long-term efficacy of which has not yet been reliably established”.³⁰⁰

Regarding intensive educational approaches, if “coercion and obedience [...] do not result in self-empowerment”, “only lead to a prolongation of the experience of powerlessness” on the part of the child or youth, “and hence accomplish resignation and external compliance at best”,³⁰¹ then these approaches counteract the original benevolent intent and are therefore unjustifiable.

It has to be ascertained in each individual case and context whether a given child or adolescent is capable of making fully responsible decisions, bearing in mind that this capacity may already exist in minors. A general rule based on age ranges, while set down in law in relation to third parties for good reason, is not appropriate for ethical evaluations because it does not do justice to the child’s or adolescent’s individuality.

Only if the child or youth is not (yet) capable of full responsibility can benevolent coercion ever be justified. Determining the extent to which the capacity for responsibility is present is therefore crucial. This can often be difficult, however, especially in the case of adolescents. Nonetheless, it must be assessed all the more carefully and conscientiously, and the reasons for the assessment must be made transparent.

In order for any proposed measure to be legitimate, the parents’ or other guardians’ consent must usually be obtained. Without their consent a coercive intervention may only be performed in emergencies in which the parents cannot be reached in time, or if the parents themselves pose a substantial danger to the child’s welfare.

300 Wölfel/Redmann/Löffler 2016, 117.

301 *Ibid.*, 120.

5.3 Benevolent coercion in elderly and disability care

5.3.1 Outline

Elderly care

Institutions providing elderly care: At the end of 2015, about 783,000 people in Germany were living in full-time residential care homes.³⁰² Care homes for the elderly as separate social institutions have only existed in Germany since the 1950's. Originally, they were conceived as continuations of the poorhouses and sick houses of the 19th century in which individuals who did not have any family or sufficient financial means (anymore) would live out their days. In accordance with this conception, providing accommodation to the people living there was seen as their primary purpose. In the late 1960's and 1970's, residential homes for people dependent on care followed a hospital model. It was not until the 1980's that the residential aspect started being foregrounded, in connection with the idea that elderly care should not be focused exclusively on the deficits of people in need of care, but should also promote the personal resources still available to them. In the 1990's demands for institutions to be opened up more extensively started to arise, in the sense of establishing smaller units and enacting approaches based on residential communities.

Professional elderly care: As residential care for people requiring care has changed over the years, the set of qualifications nursing professionals need has changed as well. Elderly care was long viewed as a uniquely female skill that did not require any vocational training, additional skills, or continuing education. Initiatives to establish appropriate training first arose in the late 1950's. The *Heimpersonalverordnung* (Ordinance on the personnel requirements for care homes) passed in 1993 and the nursing care insurance scheme introduced in

302 Cf. Statistisches Bundesamt 2017b, 7.

1995 have contributed significantly to the goal of raising training in elderly care to the same standards as medical nursing across Germany. On the nursing care insurance scheme, staff caring for the elderly are only recognised as professional carers if they can provide proof of at least three years of training. In 2020 the *Pflegeberufegesetz* (Caring Professions Act) will enter into force which unifies training for general medical nursing, medical nursing of children, and elderly care. In other words, elderly care is a relatively new profession the evolution of which is not yet complete.

Fundamental conceptions of old age in the context of elderly care – from the deficit to the competency perspective: In addition to the changes in care institutions and in the training of caregivers, there have been corresponding shifts in the perspectives on old age and nursing that underpin provision and care. The shift from a deficit-focused to a competency-focused orientation has now prevailed in most institutions providing elderly care and increasingly shapes caregivers' professional identity.³⁰³ However, this change of perspective can sometimes cause conflicts if staff or relatives are leaning towards the competency-based approach to old age while residents (or patients) hold the deficit view. Caregivers might try to enforce particular exercises or activities for training and rehabilitation against an elderly person's will because from a professional point of view they are convinced that those measures will foster competencies effectively. However, many elderly people reject such activities based on the belief that positive change in the areas of self-determination, participation, and quality of life is not possible in old age. In other words, in this scenario the external perspective conflicts with the care recipient's subjective experience.³⁰⁴

The development away from a deficit orientation towards a competency orientation must not be interpreted such that

303 Cf. Güther 2015.

304 Cf. Frühwald 2012; Remmers 2000; Riedel 2013.

one assumes all elderly people to have a perspective focused on competencies and resources, which would burden them with expectations which they cannot possibly fulfil.³⁰⁵ In advanced old age (or in the fourth stage of life) especially, i.e. from the middle of the ninth decade of life, a decrease in plasticity (neural, physical, cognitive adaptability) and resilience (psychological endurance) can be observed in many elderly people. In persons with chronic or progressive illnesses and associated losses of function this decrease can be very large.³⁰⁶ In this case one must be cautious not to overtax the person, and any requests on their part to desist from enforcing exercises, training, and rehabilitation should be taken very seriously. Once again benevolent coercion emerges as a related theme, insofar as interventions performed against the recipient's will might at first seem to benefit her, while a closer analysis shows that they might actually do more harm than good. In other words, whenever an intervention is being carried out the elderly person should be allowed to communicate her subjective perspective at length, and her views should be taken into consideration.

A second shift in perspective which is central to contemporary conceptions of provision and care is characterised by the integration of vulnerability and potential.³⁰⁷ This integration is often found to be both necessary and fruitful even for elderly people who require extensive care or are suffering from dementia. One line of argument regarding old age – which is frequently put forward despite being highly problematic – posits that there are “competent” individuals on the one hand, who have to be distinguished from elderly people who are “decrepit”, “dependent” or “affected by dementia” on the other. The integration of the perspectives of vulnerability and potential should be seen as an empirically based alternative to

305 Cf. Remmers/Walter 2012.

306 Cf. Fried et al. 2001; Murray et al. 2005.

307 Cf. Kruse 2017; Kuhlmeier/Blüher 2011.

this conception of old age.³⁰⁸ It provides the foundation for capturing *different types of loss-gain relations varying across individuals*. Moreover, it brings into focus processes of change *within a single individual*: Even people dependent on care or suffering from dementia have a large spectrum of possible states, i.e. significant variation even over short periods of time, with respect to their physical and cognitive performance and their emotional wellbeing. Furthermore, it must be kept in mind that dependency on care is not synonymous with a loss of self-determination or the capacity to make decisions. On the contrary, many people dependent on some level of care are capable of making fully responsible decisions and hence experience the externally imposed limitations on their right to self-determination as one of the biggest psychological burdens of their situation.³⁰⁹

However, the integration of the perspectives of vulnerability and potential must not be understood to imply that potentials should be foregrounded in a one-sided way while vulnerabilities are disregarded. Especially in advanced old age, it is to be expected that phases of physical or emotional exhaustion will occur more frequently. In these circumstances the implementation of interventions is no longer justified because they are more likely to decrease rather than increase the recipient's quality of life and wellbeing. This holds true especially when a chronic or progressive illness has begun to reveal a person's final physical, cognitive, and emotional limits and is gradually bringing about a penultimate or ultimate condition.³¹⁰

Elderly people in disability care

Institutions providing disability care: Around the middle of the 19th century numerous care homes and sanatoriums came into existence. They were usually run by the church and were

³⁰⁸ Cf. BMFSFJ 2016, 21.

³⁰⁹ Cf. Kojer/Gutenthaler 2016, 29; Kruse 2010.

³¹⁰ Cf. Eckart 2012; Kruse 2018; Remmers/Kruse 2014; also the contributions in Bormann 2017.

conceived and structured like psychiatric asylums. In these institutions people with special needs or mental impairments lived in “a world of their own”, separated from their family and community. The exclusion and concentration of persons with disabilities in these institutions aided and abetted the euthanasia campaigns carried out during the Nazi era which claimed the lives of a large number of victims with physical, mental, and emotional disabilities. After the war, homes for the disabled initially continued on as before using the same approach, although the number of residents had been significantly reduced. The philosophy of special needs education had been developed much earlier – i.e. in the second half of the 19th century – and had been implemented successfully in some countries; however, in Germany it was not until the 1970’s that it began to replace the approach of “provision and care”. When the “principle of normalisation” was adopted from Scandinavia, long hallways and large dormitories began to disappear and residential units with single rooms and living and kitchen areas were built. Residents usually live in these disability homes their entire lives.

Professions providing special needs education: The concept of special needs education was introduced in the second half of the 19th century. The holistic approach to care that is considered the foundation of this discipline manifests itself in the particular emphasis placed on educational therapeutic offerings. These measures are oriented towards autonomy and participation and aim at responding to cognitive and physical impairments and behavioural disturbances in a responsible manner, both on an individual and a social level. Further, they are particularly concerned with identifying and utilising individuals’ physical, cognitive, and emotional resources. This is also reflected in the vocational training of special needs educators. It is a prerequisite for acceptance into the vocational training programme, which lasts between 18 and 24 months, to possess a state-approved certification as an educational professional, adolescent and care home worker or social care

worker. This entry requirement underlines the educational and therapeutic orientation of this profession.

Fundamental conceptions of old age and disability in the context of disability care – from the loss to the facilitation perspective: On the whole, there is no good evidence for the assumption that the aging process of persons with disabilities is fundamentally different from that of people who do not have any impairments. Differences found in some cases are mainly due to limitations *specific to a given impairment*. In addition, people with disabilities may have led their lives in conditions which are not conducive to developing or preserving competencies, self-determination, and participation. In this case, the observable differences to people without disabilities are to some extent caused by institutions. The ability of elderly people to learn new things and adapt successfully to altered requirements and tasks is generally underestimated. In the case of people with disabilities, indications of *plasticity* are overlooked even more frequently due to a lack of knowledge and unfounded stereotypes. People with special needs face a significantly higher risk of discrimination based on negative conceptions of old age.³¹¹ To the extent to which such ideas of old age are abandoned and special needs support is offered to the elderly, positive developments regarding self-determination and participation can be observed in people with disabilities even during the later stages of life.³¹² This holds true for many different kinds of impairments.³¹³

Consequences for elderly and disability care

In elderly and disability care, residents suffering from physical or mental decline pose significant professional challenges to carers when it comes to preserving their self-determination, participation, and quality of life. Conflicts between elderly

311 Cf. Ding-Greiner/Kruse 2010.

312 Cf. Wacker 2001.

313 Cf. Ding-Greiner/Kruse 2010; Herr/Weber 1999.

people on the one hand and relatives or staff on the other often arise owing to divergent interpretations of the concepts of self-determination, participation, and quality of life and disagreements about how to realise those objectives. Frequently, the potential for change and development in old age is viewed differently, too. Finally, especially when the degree of dependency or the given impairment involve severe cognitive decline, the patient's capacity to understand the potential benefit of measures of therapy, rehabilitation, rehabilitative nursing, and activation may be noticeably diminished. For cognitive or emotional reasons the care recipient may have difficulty understanding explanations or assessments of interventions which are possible or indicated from a professional perspective; hence they might respond with resistance and defensiveness. Due to this lack of insight and the fact that such measures can involve effort (sometimes a significant amount), the resident might refuse to undergo the corresponding interventions or does not really participate in them actively. This gives rise to a conflict: From a *professional* point of view therapy, rehabilitation, activating care, and social work are deemed necessary in order to utilise existing physical, cognitive, and emotional resources and social communication skills and thus help foster self-determination, participation, and quality of life in order to preserve these qualities for as long as possible. However, if the patient cannot be convinced and refuses to accept particular offerings or participate actively in nursing or therapeutic, rehabilitative, or educational interventions, then may these measures be applied against the person's will?

With regard to the activation of elderly people in disability care, one challenging issue ought to be mentioned which can make the implementation of exercises and training considerably more difficult. The biographies of elderly people with disabilities often include comprehensive care but little or no encouragement to develop independent initiative and self-determination. Often such persons were even considered "uneducable". The reason for this is that until well into the 1990's,

many institutions providing disability care were following an approach of “provision and care” rather than one of fostering resources. As a consequence, certain forms of dependency such patients exhibit were (and still are) the result of institutional practices. In particular, elderly people with special needs do not always receive the degree of activation that would be functionally appropriate given their potential for plasticity.

5.3.2 Forms of benevolent coercion

In residential care for the elderly and disabled, coercive measures are used in different ways. They are regularly justified by appeal to the recipient’s welfare (for example preventing falls or controlling challenging behaviour, motor agitation, or restlessness in order to carry out intended acts of care) and therefore constitute benevolent coercion in the sense used in this Opinion.

Measures restricting freedom: At least with regards to residential care for the elderly, data from several empirical studies demonstrates that mechanical measures restricting freedom are used on a regular basis, and sedatives are used frequently. A “physical restraint” is any action or procedure, including mechanical ones, “that prevents a person’s free body movement to a position of choice and/or normal access to his/her body by the use of any method, attached or adjacent to a person’s body that he/she cannot control or remove easily.”³¹⁴ Any such restraint constitutes a restriction of freedom. Two kinds of measures can be distinguished: they can be either “adjacent to” or “remote from” the body. Measures adjacent to the body include for instance bedrails on both sides of the bed or fixation straps attached to a bed or chair which the person cannot unfasten, fixed tray tables attached to a chair or wheelchair, and the wheelchair itself if it is placed in a position that prevents

314 Bleijlevens et al. 2016, 2309.

the person from getting up. Measures remote from the body limit the person's freedom of movement in an indirect way. Examples include locking doors to rooms or apartments.

Sedatives are also called "pharmacological restraint". Antipsychotic medication, tranquilisers, and other psychotropic medications can hamper a patient's self-determined movements and make him listless and sleepy. Psychotropic medication in particular is sometimes administered in a concealed way via food or drink.³¹⁵

Other coercive measures used in nursing: Other forms of benevolent coercion practiced in elderly and disability care include force-feeding or drinking, withholding walking aids, isolating people who display challenging behaviour, withholding information about communal activities, or installing timers on TV sets.

Performing rehabilitative educational measures against residents' will: In the practice of residential elderly and disability care, staff are frequently confronted with situations in which residents decline to participate in measures for activation which from a professional point of view are empirically proven to contribute to the promotion and preservation of competencies, self-determination, participation, and quality of life. Often residents refuse even when these measures have been explained to them at length and their usefulness has been demonstrated. The reasons for this refusal can be found firstly in residents' cognitive decline, which renders insight into possible benefits difficult or even impossible, and secondly in high emotional tension which prevents residents from concentrating on explanations and instructions or from following them. To this is often added a lack of willingness to undergo the physical and cognitive effort required to participate in such activating measures. This lack of willingness can be due for instance to a subjective experience of physical and emotional

315 Cf. Kirkevold/Engedal 2005; Haw/Stubbs 2010.

exhaustion (often described as “fatigue”) which has a negative effect on the individual’s motivation to take part.

However, it is not just intensive educational measures (in the sense of interventions) like these which can trigger a defensive stance in the recipient. Even cautiously confrontational endeavours, such as recommending or encouraging a person to eat food of their own accord or get dressed autonomously, can meet with dismissal or even refusal on the part of residents, even though following the recommendation or encouragement would constitute one of the preconditions for promoting and preserving self-determination and independent initiative. Here staff in residential institutions providing elderly or disability care are faced with the question to what extent they should exert gentle pressure in order to instigate and maintain behaviours which from a professional point of view help to foster and preserve self-determination, participation, and quality of life. If the concrete implementation of such measures for activation involves overriding the recipient’s occurrent will, then it constitutes coercion according to the above-mentioned definition. This is true even in cases in which the motivation to participate in an intervention is initially lacking but subsequently begins to emerge and develop self-sustaining force. In this case the measure might gradually lose its coercive character.

Residential care: Structural coercion involved in care performed in a residential setting should also be mentioned as a possible form of benevolent coercion. As in the case of restrictions of liberty and administration of sedatives, in this scenario, too, coercion is purportedly justified by its consequences, regardless of its objective contribution to the recipients’ wellbeing. In particular, daily routines and a structured life are supposed to have a beneficial long-term effect. To the extent to which this is the case, it represents a moderate form of coercion with benevolent intent. In these circumstances the elderly person’s subjective experience of coercion can be minimised if she herself, as well as the members of her familial and

professional support systems, proactively reflect on her future physical and mental-emotional development as well as her social integration and participation, and formulate an honest answer to the question what kind of living arrangement would be ideal during phases of high physical or perhaps mental and emotional vulnerability.

Regarding living situations in advanced old age, especially for elderly people who need care or suffer from dementia, moving into a residential facility can become an important concern. One example of this would be a severe stroke causing lasting impairments of the person's mobility. In this situation, patients treated in hospital during the acute phase of their illness are often discharged with the message that from a medical and nursing point of view, returning to their own apartment is no longer feasible and hence moving to a nursing home is the only remaining option. This happens especially when the person's family does not have sufficient resources to care for them at home (anymore). Elderly people often experience such a move as being forced on them against their will.

Another example is the growing physical and psychological exhaustion relatives experience due to the demands of providing and caring for a family member who requires intensive nursing or is in the advanced stages of dementia. In these circumstances, relatives may see no other way of solving the situation than to move the family member to a nursing home. Again, such a move can easily be experienced as coercive by the elderly person in question. This problematic constellation cannot be solved merely by expanding the range of ambulant and part-residential types of care. In addition, families – which includes not just elderly but also middle-aged family members, who will usually be the first to assume caring responsibilities – must consider the question how the care of elderly family members should be handled in good time and determine what kind of arrangement they prefer. Those considerations can then be used as the basis for making concrete preparations. In this way abrupt changes of a person's situation, which are

typically experienced as particularly coercive, can be avoided. In addition, provided the necessary financial resources are available this approach allows for a lot more freedom of choice, which in turn materially strengthens the belief in being able to shape one's own life situation rather than being urged or forced to make particular decisions. The way relationships and communication are handled by the different family members is of primary importance in this regard.³¹⁶

5.3.3 Current legal framework

In principle, the legal regulations governing professional acts of care involving benevolent coercion in the context of elderly and disability care and in the treatment of the mentally ill are the same. Besides the German Basic Law, international law in the form of the relevant human rights conventions is applicable, in particular the European Convention on Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the United Nations Convention on the Rights of Persons with Disabilities. More concrete legal regulations concerning benevolent coercion in elderly and disability care are mainly found in guardianship law as detailed in the German Civil Code. Procedural regulations and legal protections are covered in the Family Proceedings Act. The framework provided by constitutional and human rights law as well as the relevant guardianship law regulations have already been adumbrated (see section 5.1.3). With regard to elderly and disability care in particular, the following can be stated.

The basic rights and human rights of people who need care entail their right to appropriate nursing and medical care aimed at mitigating their suffering and restoring their health. Medical care and nursing satisfying the standards of current

³¹⁶ Cf. Engel 2008; Engel et al. 2012; George/George 2003.

state-of-the-art science should be accessible to all without discrimination. Coercive measures might be indicated in this context if the patient is no longer capable of grasping the necessity of a particular treatment or of acting accordingly, and if no other alternatives are available. Nevertheless, state authorities are obliged to prevent any and all abuses of coercive tools by means of protective legal mechanisms, and to reduce their use to the absolute unavoidable minimum. This includes keeping documentation of coercive measures, their implementation, the pivotal reasons, and of how the effects were monitored, as well as providing effective legal and judicial protections. In addition, other options of medical and social support and nursing should be promoted if they can prevent coercion from becoming necessary and if they help nursing patients lead a self-determined life connected with the society around them.

With respect to interventions carried out by physicians, guardianship law provides the following: examinations of the patient's state of health, curative treatments, or other interventions performed by physicians in service of the patient's welfare are only permissible with the patient's consent, or else with the consent of a legal guardian (representative) or authorised agent holding power of attorney, except in emergencies. Further, coercive measures applied by physicians must be approved by a guardianship court and may only be performed on in-patients in an appropriate hospital setting. Any such measure presupposes that the patient is incapable of giving consent, that both the physician and the representative have tried in vain to obtain their voluntary consent, that the measure is medically indicated and necessary even if administered coercively, and finally that it does not put undue strain on the patient. Further, it must correspond with her previously stated or presumed will and must be documented (Section 1906a BGB). If a patient not only refuses treatment but also refuses to be taken to hospital, she may be taken there forcibly only if the preconditions for involuntary commitment are met (Section 1906 (1) no. 2, (2) and (3) BGB; Section 1906a (4) BGB).

Measures involving restriction or deprivation of liberty are only permissible with the representative's consent. They presuppose that the recipient is incapable of giving consent, that he is presenting a serious danger to himself, and that this danger cannot be averted by any less drastic means. If the patient is to be deprived of freedom by being placed in an institution, or if his freedom is to be restricted in another way on a regular basis or for a significant period of time, then approval from a court based on an expert psychiatric evaluation is required, except in emergencies (Section 1906 BGB; Section 321 Fam-FG). It is still contentious to what extent the patient's previously stated or presumed will is to be taken into account in these circumstances, as mandated by the basic norm in Section 1901 (3) BGB governing acts of care performed by legal guardians, by the corresponding contractual precept for agents holding power of attorney, and by the legal regulations concerning coercion used by physicians in Section 1906a (1) no. 3 BGB.³¹⁷ It is possible that the regulations concerning deprivation of liberty within guardianship law (Section 1906 (4) BGB) will have to be revised as the Federal Constitutional Court has recently called for the regulations governing deprivation of liberty in the relevant state legislation on mental illness to be amended.³¹⁸

With respect to medication the following distinction must be made: If medication is administered in order to treat an illness, then it is subject to the requirements applying to (coercive) measures performed by physicians. If a drug is used to limit the patient's movement, then the laws regarding deprivation of liberty must be observed. Thus, the legal requirements depend on the purpose for which the medication is used.

The legal framework regulating nursing is also relevant to benevolent coercion. The *Heimgesetz* (Care Home Act) was passed as early as 1974. It protects residents whose mental or

317 Cf. Brosey 2009, 135 ff., 149 ff.; Lipp/Güttler 2017, 95.

318 Cf. BVerfG, NJW 2018, 2619.

physical flexibility is limited and who are dependent on assistance. The objectives of the Care Home Act were extended in 1990 when the aspect of securing independence and self-determination was added. The principle of respecting residents' dignity followed in 2001. In 2006, the first reform of the federal system devolved legislative powers regarding the regulation of care homes to individual German states. Today's laws on care homes are characterised by the shift in perspective from a focus on institutions to a focus on individuals and their right to social participation.³¹⁹

Furthermore, the nursing care insurance scheme is inter-related with developments in care and nursing.³²⁰ It was the introduction of this programme that guaranteed the right of care recipients to demand a certain standard of care and to choose their preferred institution freely. The ongoing debates and critiques of the professional situation and of nursing care legislation, including many roundtables, have yielded continual change and evolution. For instance, a care charter has been drawn up which stipulates the rights of care recipients, i.e. the right to self-determination, physical and psychological integrity, privacy, nursing, care and solicitude, information and education, communication and participation, religion and culture, and palliative care.³²¹

General principles of medical and professional law (cf. Sections 630 f. BGB; Section 10 MBO-Ä) already provide that coercive measures must be documented. Due to the special procedural regulations of Section 323 (2) FamFG, this is actually a requirement if they are to be legitimate.³²² However, measures involving deprivation of liberty are not covered by specific legal regulations in this regard. State laws for the most part only contain a general obligation to document care. More specific

319 Cf. Wiedersberg, in: Dickmann 2014, Part C I., in particular para. 10.

320 Cf. Igl/Welti 2018, Section 38.

321 Charter of the Rights of Persons dependent on Care and Support (<https://www.pflege-charta.de>).

322 Cf. BGHZ 201, 324, para. 22; BGH, NJW 2015, 1019, para. 7.

requirements are set down in corresponding contracts by care insurance companies and care operators in accordance with Section 113 (1) SGB XI.

5.3.4 Current situation in professional practice

There is abundant literature describing that carers, relatives, and physicians regularly cite the care recipient's welfare as the chief motive for using measures that restrict freedom, sedatives, and other forms of coercion. In particular, avoiding falls and injuries stemming from falls, facilitating medical or therapeutic interventions, and preventing other forms of risk in order to ensure the care recipient's protection are often named.³²³

Currently, the use of coercion in residential nursing is not documented systematically. The nursing quality reports issued by the *Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen* (Medical Advisory Service of the National Association of Statutory Health Insurance Funds) suggest that the incidence of measures that involve restrictions of care home residents' freedom has been declining in recent years. While the third quality report showed that 20 percent of the individuals in the sample had been subject to restrictions of freedom,³²⁴ in the fourth report the number had fallen to 12.5 percent,³²⁵ and in the latest report to 8.9 percent.³²⁶ These nursing quality reports do not justify inferences about differences between particular care homes or geographical regions, but they do illustrate the above-mentioned trend.

A study of about 2,400 residents in 30 care homes in Hamburg found that on the day of data collection, 26.2 percent of residents had experienced at least one measure involving

323 Cf. Köpke/Meyer 2015.

324 Cf. MDS 2012, 18.

325 Cf. MDS 2014, 10.

326 Cf. MDS 2017, 10.

restriction of liberty.³²⁷ Bedrails was the most commonly used tool. Belts, fixed tray tables and other measures were recorded for only 2–3 percent of residents, respectively. At the end of a 12-month period, 39.8 percent of residents had been subject to at least one measure involving restriction of liberty. For about one in ten residents a belt or fixed table was used at least once in a 12-month period. There were significant differences across the 30 institutions. In the care home with the lowest rate of measures involving deprivation of liberty, less than 5 percent of residents were found to have experienced such measures on the day of data collection, whereas at the facility with the highest rate it was about 60 percent.³²⁸

Deprivation of liberty is associated with negative effects on health and wellbeing. These include for instance immobility, stiff joints and even serious injuries, for example if a patient falls while attempting to climb over bedrails. Associations with decubitus, deteriorating bladder function, stress, and aggressive behaviour have been described in the literature as well.³²⁹ If measures involving deprivation of liberty are performed in an unprofessional manner, they can cause serious injuries, including ones resulting in death.³³⁰

In an expert hearing held by the German Ethics Council, it was emphasised that in senior care medications that effectively restrict freedom are usually administered without judicial approval.³³¹

Studies have shown that when it comes to the use of psychotropic medications there is significant variation among care homes in Germany. Frequencies between less than 30 percent and more than 80 percent of residents having at least one

327 This included measures to which the residents had consented.

328 Cf. Meyer et al. 2009, 985 f.

329 Cf. e.g. Köpke/Meyer 2015, 42.

330 Cf. Berzlanovich/Schöpfer/Keil 2012.

331 Cf. the online documentation of the hearing titled “‘Wohltätiger Zwang’ in der Pflege und Behindertenhilfe” (Benevolent coercion in elderly and disability care) held by the German Ethics Council on 19 May 2017, available at <https://www.ethikrat.org/anhoeerungen/wohlttaetiger-zwang-in-der-pflege-und-behindertenhilfe> [2018-08-15].

prescription have been documented.³³² These differences could not be explained by properties specific to particular residents or care homes. Rather, they can be put down to the “organisational culture” of the relevant institutions which very likely influences the practices of administering medication prevalent there.³³³

The above-mentioned hearing by the German Ethics Council also covered other forms of coercion used in nursing homes, for example isolating residents who engage in challenging behaviour, withholding information about communal activities, and installing timers on TV sets. No information is available about the extent of such practices and whether they get justified by appeal to the recipients’ welfare.

The decision to exert gentle pressure in order to implement measures that preserve and foster competencies, self-determination, participation, and quality of life if these measures are deemed necessary from a professional point of view is often a conflicted one, as was demonstrated as early as the 1990’s in a comprehensive study on situations of conflict and stress in care homes and nursing homes.³³⁴ In this study residents, their relatives, and staff members were interviewed at length about possible causes of conflict and different behaviours in conflict situations. In addition, their behaviour in conflict-laden situations was observed (participant observation). The mere act of offering activating measures was a central factor that was often sufficient to spark conflicts. Implementing them against a person’s will did so even more of course, for instance in the case of (playfully executed) memory tasks, behavioural training (with systematic reinforcement), or exercises relating to daily practices (also with systematic reinforcement). An analysis of the development of conflicts conducted over longer stretches of time and interviews with staff members from different

332 Cf. Meyer et al. 2009, 986.

333 Cf. Richter et al. 2012.

334 Cf. Kruse et al. 1992.

institutions showed that whenever exercises and training could be integrated into residents' daily lives *gradually, carefully, and sometimes even without them noticing*, residents' interest in the objectives of these practices was gradually awakened. The crucial reason for this increase in involvement was the significant improvement residents experienced in their perceived self-efficacy, i.e. the belief that they had skills and abilities at their disposal which could contribute to mastering specific situational challenges successfully.

One comprehensive study about the possibilities and limitations of preserving and fostering self-determination and participation in care homes for the disabled implemented an approach to caring interventions based on Margret Baltes' ideas of promoting autonomy and reducing dependency.³³⁵ This approach aims at fostering autonomy and independent initiative in people of advanced old age who are affected by mental impairments. The study was subsequently extended to elderly individuals with emotional impairments.³³⁶ Like other studies in the past, this study (and its component studies) showed that one part of the residents adamantly *refused* to participate in any measures activating or promoting autonomy and independent initiative at all. This could go as far as residents refusing to get up in time in the morning or to get dressed without help. These individuals were used to being dressed in the morning and undressed again in the evening. The study first presented an approach focused on promoting autonomy and independent initiative to staff, along with basic information about cognitive and behavioural plasticity. In the second step, interactions between residents and staff were recorded on video; the recordings were then analysed and discussed in reflective conversations. It became clear that before the intervention some staff members had given up their efforts to activate residents whenever they met with resistance or refusal. If they succeeded

335 Cf. Baltes 1995; Baltes 1996.

336 Cf. Ding-Greiner/Kruse 2010.

in carrying out interventions designed to promote autonomy and independent initiative in an *unforced way, using incentives and reinforcement* and integrating them into the behavioural repertoire of the mentally impaired elderly people in their care, residents' motivation to participate in the exercises and training increased significantly. Furthermore, in the institutions in the intervention group (but not in those in the control group) a highly significant increase in behaviour based on autonomy and independent initiative was observed, correlating with an equally significant improvement in wellbeing.

The task of carrying out the work of nursing and care in a way that serves the recipients' wellbeing encounters limitations not only in dependent patients' resistance to particular allegedly benevolent acts, but also in the caring professionals themselves. Their working conditions, especially in elderly care, are characterised by a high workload, understaffing, dissatisfaction with how the work is valued, low pay, and a lack of career opportunities. Professionals in this field describe themselves as overstretched and emotionally exhausted.³³⁷ Of course, this state of affairs has an impact on care recipients, too. In a survey conducted by Thomas Goergen, 70 percent of elderly care nurses stated that they had engaged in actions or omissions that could be seen as problematic, including restrictions of residents' liberty, or that they had observed such behaviours in other carers.³³⁸

5.3.5 Ethical reflection

An ethically informed approach to the manifold phenomena of benevolent coercion in the care of elderly and disabled people must meet at least the following four general criteria.

337 Cf. Goergen 2004.

338 Cf. *ibid.*, 17.

First, professional carers should determine carefully in each individual situation which of the above-mentioned constellations (see section 4.3) best describes the quality of self-determination articulated by a care recipient, i.e. whether it positively falls below the threshold of a fully responsible volitional process, whether there is well-founded reason to doubt their full responsibility due to specific impairments of their health or cognitive functions, or whether a patient's will is fully responsible beyond reasonable doubt, at least in the given context of action. Coercive measures intended to avert self-harm can only ever be justified if the recipient is incapable of making fully responsible decisions or if there are at least well-founded doubts about his capacity. Even when this has been ascertained, the following conditions must be fulfilled in order for coercive measures to be legitimate: The measure must be necessary with respect to its aim, it must be professionally indicated in order to prevent harm even if administered coercively, it must be commensurate and the duration and degree of invasiveness must be appropriate with respect to this aim, it must involve the least possible risk of traumatising and loss of trust in the caring relationship, and there must not be any less invasive options available. Moreover, all relevant aspects of the measure must be carefully documented. The necessity of protecting the resources for making self-determined decisions that are still available to elderly or disabled care recipients implies not only the general demand to minimise coercion, but also to justify it all the more carefully (whenever it does appear inevitable) the more closely the care recipient approaches the threshold of a fully responsible determination of will.

Second, it must be kept in mind that institutions providing elderly or disability care often have *complex structures of responsibilities*. These include not only the tier comprising individual agents but also those of institutional care home operators and the framework of social legislation. In principle this legislation can be changed via political means but it nonetheless limits the scope of action on the individual and institutional levels

significantly. Thus, in order to prevent responsibility for existing shortcomings from being rashly attributed to a single individual, or alternatively to the operator of the institution or to the care system as a whole by overgeneralisation, it is necessary to conduct a detailed analysis of the coercive acts in question in order to identify their actual causes, which are often multi-layered.

Third, even with respect to the practices of individuals it is not enough to consider individual *actions* in isolation. Rather, the *personal attitudes and opinions* underpinning the actions as well as the *concrete decision-making procedures* and *communication processes* which form the background of individual problematic decisions and undesirable routines must be taken into account.

Fourth, it must be ensured that the *specific life situation* of the person in question is taken into consideration in an adequate way when evaluating particular measures taken. This includes not only the special *vulnerabilities* and *developmental potentials* of elderly or disabled people dependent on care, but also the characteristic *volatility* of these individuals' processes of *determining and articulating their own will*. Their will can exhibit different degrees of autonomy and determinacy at different times. Hence, manifold *ambivalences*, *ambiguities*, and *gradations* are to be expected.

That said, in the following some especially important desiderata of an ethically considerate approach to coercion in the practice of elderly and disability care will be described. First, it is necessary to critically examine the unquestioned ideas and preconceptions that tacitly guide people's actions. Second, low-level forms of coercion should be used intentionally in order to stimulate care recipients – whose motivation may initially be lacking – to participate in measures of activation. Third, the use of mechanical means of restricting freedom should be avoided. Fourth, the use of psychotropic medications should be avoided if at all possible. Fifth, professionals should consciously reflect on the uncertainty they experience

with regard to their actions in situations of conflict and doubt. Sixth, the immense importance for institutions of a culture of communication that facilitates emotional unburdening must be recognised.

Re (1): Avoiding unjustified coercive measures in the context of elderly and disability care requires not only honing one's *perceptual abilities* (in the sense of moral perception) and *sensitivity* to the manifold forms of overt and covert coercion that occur in the daily practice of care, but also the *willingness to critically examine* one's own fundamental attitudes towards the elderly and disabled as well as the specific value-laden preconceptions, ideas, and approaches guiding one's actions. Coercion always begins in the mind of the person who feels entitled, or even obligated, to perform particular coercive acts. Especially if professional caregivers have a one-sided, deficit-focused view of old age and disability, they tend to overlook or underestimate the resources that are in fact available to the care recipient to determine and articulate her will independently. For the same reason, they can inadvertently strengthen existing dependency relationships through their acts of care (even though these are often motivated altruistically). This is closely tied to a disregard for the high variability of the phenomena of old age and disability across different individuals. Elderly or disabled individuals who need care are unique personalities, just like all other human beings. They have their own unique biography including personal preferences, beliefs, and values, the practical importance of which is not at all diminished by the fact that their circumstances usually also involve the loss of some somatic, mental, and social functions due to illness, disability, or old age. Honouring the unique life history of each care recipient demands not only acknowledging their individuality, but also encountering them with respect. This includes taking the patient's articulations of will seriously as part of his wellbeing even if the process of will formation is impaired or leaning in a direction which runs counter to the caregivers' notion of a well-lived life.

Here the desired resource-oriented approach to old age and disability can involve its own unique risks. As desirable as it may be to preserve and foster the potential for action and self-determination in people dependent on care, one has to guard against overlooking their changing needs or withdrawing from them (including emotionally) in case the successes hoped for or expected by caregivers do not materialise. The respect due to old and disabled people must not be conditional upon the caregivers' expectations of how these individuals should be performing, but must be reliably granted to every human being until their death.

Re (2): Another challenge concerns the low-level forms of coercion used in the context of *measures intended to activate care recipients*. In the case of care recipients suffering from illness, social isolation, or neglect, motivating them to participate in measures that help them to be more active may initially be difficult even though these activities may seem necessary to staff in order to restore, preserve, or develop the individual's resources. In this situation the whole range of motivational techniques using positive incentives and reinforcement should first be employed. More forceful efforts to get a nursing patient to be active despite their repeated refusal already fall under the umbrella of coercion as understood in this Opinion. Such efforts should only be made on the condition that they have been explained to the patient in a comprehensible way before being undertaken and are subject to critical monitoring. It is important for the care recipient to develop a discernible, sustainable motivation to continue with the activities of her own accord not too long after she has begun to take part in them based on the beneficial effect she perceives the activities to have on her subjective wellbeing. Conversely, this implies that enforced activities which the recipient continues to reject *over a significant period of time* are not justified, even if professionally considered they would most likely benefit her state of health.

Re (3): So-called *mechanical measures that restrict freedom* must be subject to in-depth scrutiny. It must be investigated

whether in principle alternative forms of action are available and whether the actual means employed are commensurate with the situation. Further, the degree of invasiveness, frequency, and duration of the interventions must be taken into account, as well as their concrete impact on the patient's self-experience and on their level of trust in the caring environment. Generally, the required degree of justification rises considerably as the degree of invasiveness, frequency, and duration of the coercive acts increases. Physical restraints in particular – for instance being strapped to a bed or chair – not only pose a significant risk of physical harm through injury or strangulation, but can also violate the recipient's dignity due to their traumatising effects. Therefore, using such measures on a regular basis is out of the question. However, even in the case of less drastic restrictions of bodily movement – which range from bedrails, tray tables, removing walking frames or other physical aids, to installing trick locks or keeping doors locked – it must be carefully determined whether these measures do in fact serve the recipient's welfare rather than merely making the caregivers' life easier or protecting third parties, and whether there really is no alternative. While it is necessary to take reasonable, professionally appropriate precautions against falls, given the inherent safety risks of physical restraints it must be assumed that in the majority of cases mechanical restraints – the use of which is declining, though still far too frequent – have no plausible ethical justification.

Re (4): When it comes to using psychotropic medication in order to *restrain* residents in care homes for the elderly or disabled *via pharmacological or chemical means*, the possibility cannot be excluded that the use of such medications may be medically indicated in certain acute situations of intense or extreme agitation, suicidal tendencies, or depression, and that they might mitigate the patient's suffering considerably despite his occurrent incapacity to consent to the treatment in a fully responsible manner. However, due to the significant degree of invasiveness of this type of intervention and the risk

of changes to the recipient's personality, especially strict criteria of diligence must be applied to the concrete diagnosis, determination of medical indication, and dosage of the medication, as well as to regular reassessments of the necessity of continuing the treatment. In care facilities, psychotropic medications are commonly prescribed abusively, i.e. without a personal assessment of the patient and without close monitoring of their individual state of health. These medications can have countless negative side-effects impairing the waking state and the health of people dependent on care who usually have already been suffering from multiple kinds of damage prior to receiving such treatments. Since such drugs are often administered in a concealed form, which constitutes a targeted and intentional deception of the care recipient, the relationship of trust between caregivers and care recipients can come under severe strain or may even be destroyed. Moreover, if psychotropic medication is administered frequently, this might indicate a lack of suitable instruments of control. It also raises the question whether some of the acute situations could be avoided if more prevention-focused approaches were employed. This might allow discernible psychological escalations to be interrupted at an early stage by means of alternative strategies (for example mobility exercises). Such approaches should be included in ongoing training and continuing education as a matter of course.

Re (5): Care recipients' ability to communicate verbally can often be limited. This can create dilemmas even for experienced carers: On the one hand, they feel obligated to respect care recipients' declarations of will and to care for the wellbeing of the patients for whom they are responsible. On the other hand, the will of the person in question may be impossible to determine, it may vary significantly depending on their state on a given day, or it may run counter to the standards which from a professional perspective constitute good care. The situation becomes even more complicated when relatives develop their own ideas, which often have little internal consistency,

about the concrete acts of care that should be taken or refrained from for the sake of their family member's welfare, and forcefully demand their implementation. Unsurprisingly, in these circumstances professional caregivers often experience significant *uncertainty about their actions* as well as *moral conflicts* since it is a very challenging task to reconcile these different values, and a consensus about the right solution cannot always be reached in a pluralistic society. It is universally agreed that appropriately conceived care must be oriented towards promoting the recipient's self-determination, participation, and quality of life, which usually prohibits the use of coercion. In practice, however, situations often occur in which these values are in conflict with each other because the care recipient is about to cause serious and irreparable harm to herself. In virtue of their duty of care caregivers are then faced with the challenge of examining how determinate and well-considered the care recipient's expression of will actually is and what degree of concrete and foreseeable self-harm would be involved in implementing her will. In the case of serious long-term harm to her physical integrity and/or her future capacity for self-determination, means and ways must be considered that might prevent her from carrying out her self-harming behaviour without employing coercion.

Still, in practice difficult borderline situations are bound to occur in which professionals ultimately arrive at the conclusion that certain coercive acts are unavoidable to secure the welfare of care recipients whose capacity for full responsibility is impaired. Caregivers often have to make far-reaching decisions under time pressure and while lacking important knowledge (for example about the patient's will, the actual consequences of particular actions, or the probability of harm occurring). Further, even tried and tested moral principles have to be applied freshly each time based on an individual's judgment and the unique circumstances of a given situation. Consequently, strengthening caregivers' faculty of judgment,

for example by implementing ethical support services, is particularly important.

Re (6): Even so, the non-negotiable goal of minimising the use of coercion as much as possible must not be understood to be the responsibility solely of individual caregivers. Rather, a sustainable reduction of overt and covert forms of coercion presupposes increased efforts on the professional, cultural, and legislative levels. As important as it may be to establish an appropriate framework of (social) legislation in order to provide the necessary financial resources and staff in the field of nursing and care, one must guard carefully against assuming that unjustified uses of coercion can be eliminated simply by using financial or legal instruments. Even sanctions imposed by criminal law run the risk of merely causing a shift to a different technique of coercion rather than substantially reducing the amount of coercion that actually takes place, unless they are accompanied by genuine change in the attitudes of professional caregivers and corresponding innovations in the policies, procedures, and communication processes employed at care facilities. Truly sustainable change not only presupposes that situations of conflict are discussed openly and handled together as a team, but also requires an improved transfer of knowledge via suitable training courses and continuing education programmes, as well as implementing instruments facilitating a culture of ethical reflection in the most sensitive fields of practice that fall within the responsibility of institutional care home operators.

6 EXECUTIVE SUMMARY

Subject and objectives of this Opinion

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

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

3) A person is incapable of acting with full responsibility if she is temporarily incapable, no longer capable, or generally incapable of adequately understanding her life situation and the consequences of her decisions and actions or of acting accordingly. Such an incapacity can be due for example

to age, illness, or physical or psychological limitations. Being unable to act fully responsibly does not mean, however, that a person has no will. She can still express her wishes and strivings: she may want to move around, accept or refuse a medical procedure, etc. To distinguish these cases from actions that are genuinely fully responsible in the emphatic sense, legal scholars use the term “*natural will*”. When determining whether the overriding of another person’s will amounts to coercion, it is immaterial whether or not their will is fully responsible. Overriding someone’s natural will also constitutes coercion.

4) The present Opinion examines coercion in the context of the health and social care professions. Thus, the following reflections are solely concerned with *professional caring relationships*. In this context, coercion can take the form of one person using direct and unmediated force on another person’s body in order to restrict or eliminate the range of decisions and actions available to them. In the caring professions coercion in this narrow, primary sense of the term occurs, for instance, when a patient with dementia who is thrashing about and presenting a danger to herself is physically held down or strapped to the bed by a caregiver. Secondly, there can be mediate coercion, for example locking the door to the ward or withholding a walking frame from a patient who is dependent on it in order to restrict her movement.

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

Despite its undeniable importance in the context of professional caring relationships, *structural coercion* – for example

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

5) This Opinion of the German Ethics Council has three *objectives*. First, we wish to raise public awareness of the problems and complexities around benevolent coercion and of the tensions between welfare and self-determination in the context of professional caring relationships. Second, we want to alert politicians, legislators, and anyone involved in the practice of these professions to the shortcomings in the regulations governing this field and in their implementation, and we formulate recommendations to contribute to the solution of these problems. Third, we aim to support the health and social care professions in the ongoing reorientation of their self-conception and their practices as professional caregivers. In this endeavour we are guided by the principle that the framework, structures, and processes of these fields should be designed in a way that allows coercion to be avoided whenever possible. It must be admitted, however, that emergencies can arise in which using coercion against a recipient of care must be considered as a last resort. This Opinion aims to provide orientation regarding situations of this kind as well.

Ethical foundations and core assumptions

6) Professional *care* should of course always promote or at least maintain the welfare of the recipients of care. On the other hand, it should respect their self-determination, especially in circumstances in which the decisions a person makes regarding herself are difficult or even impossible for others to understand. Conflicts between these two equally fundamental principles occur whenever respecting someone's self-determination entails allowing them to put themselves at risk of serious harm. In these circumstances the question arises whether

violating someone's self-determination by means of coercion can be considered benevolent.

7) The question under what circumstances coercive measures intended to serve the recipient's *welfare* are benevolent cannot be answered by reference to a notion of welfare defined in abstract or general terms. Rather, the challenge lies in determining where the line should be drawn between an individual's decisions that must be respected on the one hand, and permissible interference for the sake of her welfare on the other. Here the following considerations must be taken into account: First, no definition of welfare could be convincing unless it accords a prominent place to a person's subjective experience of herself. Therefore, an individual's welfare should never be determined in the abstract, much less by reference to the interests of third parties, but rather by reference to the individual's own point of view. Second, it must be assumed that the concept of welfare represents a multi-layered and complex category which comprises not only a person's occurrent subjective wishes and preferences, but also their individual biography (including past preferences, values, and goals) as well as societal and cultural ideals of the good life and basic norms (for example human dignity). Third, there is sufficient empirical evidence for the claim that an individual's subjective assessment of her own welfare is not static but rather undergoes a process of change or development, depending on circumstances.

8) In this Opinion the concept of *self-determination* is used as an umbrella term to cover the whole range of possible gradations from small children's elementary expressions of will to the fully responsible self-determination of adults. Self-determination presupposes certain fundamental conditions and abilities which make it possible in the first place. It is these physical and psychological preconditions of living a self-determined life whose core can be jeopardised by a person's situational decisions, actions, or expressions of will. In a paradoxical situation of this kind, the use of benevolent coercion is intended to resolve the acute dilemma by serving as a last

resort for protecting and (re-)establishing the essential physical and psychological preconditions of living a self-determined life.

9) When determining under what circumstances coercive measures aimed at preserving or restoring someone's capacity for self-determination can be considered legitimate, defining the distinction between fully responsible decisions on the one hand, and voluntary decisions which do not meet the criteria for full responsibility on the other is of paramount ethical and legal importance. This distinction constitutes the boundary between soft paternalistic and hard paternalistic interference with someone else's freedom of choice. *Paternalism* denotes actions which, firstly, consciously override someone else's expressions of will and secondly, are performed with the sole or at least primary intent of protecting the recipient from putting himself or his fundamental interests at serious risk. An action is called *soft paternalistic* if the person performing it can be certain that the recipient would consent to the action were he currently able to make fully responsible decisions or determine his will accordingly. The recipient of a soft paternalistic measure is incapable of deciding against it in a manner that is fully responsible. His opposing natural will does deserve to be acknowledged as a form of self-determination and an expression of dignity; however, it does not possess the same degree of dignity as a fully responsible decision. In contrast, an action is called *hard paternalistic* if it overrides the fully responsible and thus truly self-determined decision of another person. This distinction yields different requirements for the possible justification of paternalistic coercive measures: the more closely a self-determined decision approaches the criteria for full responsibility, the more significant are the argumentative hurdles any justification of coercion needs to clear.

10) There is a broad consensus that under certain conditions soft paternalistic acts can be morally legitimate, provided the care recipient is *undoubtedly not yet capable, no longer capable, or temporarily or permanently incapable* of making a fully

responsible decision in the given situation. In addition, in order to be considered truly legitimate in situations of this kind soft paternalistic measures must meet the following criteria:

- » The coercive measure must aim at developing, fostering, or restoring the recipient's capacity to live a self-determined life in the context of the available possibilities and the physical and psychological preconditions essential to this aim. This holds true even if the capacity to act with full responsibility can no longer be achieved.
- » The coercive measure must be suitable, necessary, and appropriate (i.e. the extent and duration of interference must be commensurate) with respect to these aims.
- » The prevention of a primary harm must not cause another undue or potentially irreversible harm ("secondary vulnerability").
- » The coercive measure must be the only possible way to prevent the harm in question or achieve the stated aim.
- » The measure should be such that the recipient would consent to it were he currently capable of making fully responsible decisions.

11) In a situation in which the *fully responsible nature of a decision can reasonably be doubted*, the above criteria must be supplemented by the rule that the person's resources for living a self-determined life, which do exist in principle, should be activated as much as possible in the given situation by giving appropriate assistance, or at least that these resources must not be damaged substantially by the coercive measure. If the uncertainty about the fully responsible nature of the decision cannot be resolved, the evidence for and against must be weighed, and a clear preponderance in favour of the probable absence of full responsibility must be established. In this kind of doubtful case, only soft paternalistic forms of coercion which aim at the limitation of (further) harm are legitimate. Further, the harm to be prevented must be significant and of a

kind that could have a substantial negative impact on the person concerned. This certainly includes emergencies in which a person's self-harming actions would very likely lead to his death and there is no time to investigate whether his actions are fully responsible. The same verdict applies in cases in which it is not the person's physical existence that is at risk but rather the cognitive, social, and affective capabilities on which his future capacity to produce self-determined decisions and actions depends. In these cases especially, preventing someone from causing harm to himself can turn out to be a blessing for him later on despite the use of coercion. However, if the self-harming actions do not threaten the person's life or his future capacity for self-determination, things look quite different. Suppressing such harmful actions by means of coercion could cause significant harm in and of itself, for example to the recipient's self-respect.

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

13) The people or groups of people who are subject to benevolent coercion in the context of professional caring relationships usually possess a very high degree of *vulnerability*. Many recipients of care (for example individuals with mental

illness, disabilities, dementia) face serious limitations while simply going about their daily lives, and thus are less able than others to look after their own interests. The limitations inherent in someone's primary vulnerability (illnesses etc.) often give rise to further limitations within their life situation with regard to subjective factors. A form of *secondary vulnerability* reveals itself here which concerns the cognitive, motivational, and especially the volitional factor. Repeated experiences of coercion can accumulate and engender a more or less pervasive sense of being disrespected in the recipient, no matter how "benevolent" others might consider them. This can turn into open rebellion or social shame as well as a loss of self-confidence and self-respect. However, self-confidence and self-respect are crucial components of the experience of one's own dignity as a human being. This is connected with the experience of a strong feeling of belonging to a community and a society which accepts all its members as equal in rights, duties, and life opportunities. Since any experience of coercion is an experience of powerlessness and defencelessness, it can severely damage this feeling of belonging in connection with a sense of self-respect and self-confidence, and can in fact lead to social exclusion.

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

15) Making decisions about coercion is not part of the daily routine of professional caring relationships and poses

special challenges for the caregivers' *judgment*. Particularly in situations of time pressure or limited knowledge about the care recipient, a professional caregiver's ability to arrive at a judgment that is adequate to the complexity of the situation can be severely tested. However, even after the most careful assessment of a situation a caregiver involved in acts of benevolent coercion can be caught in a feeling of *moral perplexity*, insofar as all available courses of action are morally problematic. Caregivers can experience the use of coercion as a violation of the important value of the recipient's self-determination, while refraining from using coercion can seem like a lack of care in the face of the imminent danger of self-harm on the part of the recipient, which can cause the caregiver to feel equally guilty. Thus, when a caregiver in an extreme situation feels impelled to make the tragic decision of disregarding their fundamental obligation to respect others' fully responsible decisions and does override another person's self-determination with the aid of coercion, the moral perplexity that gave rise to this choice should not be dismissed. However, coercive measures of this kind cannot be morally justified. In addition, caregivers acting in this way are subject to legal sanctions.

16) This Opinion evaluates acts of care involving benevolent coercion that are embedded in professional settings where they are carried out by individuals with specific professional roles and responsibilities. Therefore, the fundamental considerations regarding the legitimacy of using benevolent coercion in acts of care must be elaborated more specifically in an ethics of professional caregiving.

17) In general, when addressing questions of professional ethics one must keep in mind the interaction between three different tiers of responsibility in which any professional act of care (including acts of benevolent coercion) is always embedded in virtue of being performed under the aegis of an institution (a hospital, a home for the elderly or disabled, child protective services, etc.). On the micro-level there is the personal responsibility of each professional caregiver in their immediate

relationship with a recipient of care. On the meso-level there is the caregiver's personal responsibility as a member of a team which shapes the caregiving and assumes shared responsibility for it as a *systemic actor*. On the macro-level there is the responsibility of senior management, which is perceived as corporate in nature. This tier is responsible for the implementation of appropriate regulations and especially for the institutional framework within which the members of the organisation fulfil their responsibilities on the micro- and meso-levels. In addition, with respect to systemic factors the relevant political players such as the legislative authorities should also be included since they determine the regulatory framework of the healthcare system and make decisions regarding the specific allocation of resources. If the interrelationships between these different tiers are disregarded, the common feeling – frequently complained about by caring professionals – of lacking realistic options for implementation and impotently facing abstract moral imperatives of what ought to be done is intensified.

18) A widely acknowledged demand of professional ethics in the fields of nursing, care of children and youth, and medical care states that processes should be designed in such a way that both the recipient of care and those who are legally responsible for her (for example parents, representatives, legal guardians) are involved. In principle, this right to participate extends to all phases of a professional intervention, from the initial assessment of the care recipient's life situation to the consideration of possible courses of action, the decision to choose a particular intervention, its implementation, debriefing, and evaluation. Ensuring that care recipients take part in the process as extensively as possible constitutes a fundamental building block of establishing trust between caregivers and care recipients and can significantly reduce the probability of having to use coercion of any kind.

19) Coercive measures must only ever be used as a last resort. Therefore, they always have to be preceded by the attempt to use appropriate explanations and transparency in order to

convince the care recipient of the necessity of the proposed intervention and to obtain his informed consent. In this endeavour, considerations of practicability (such as the amount of effort expended, time pressure etc.) must not play any role. One must take special care to ensure that the attempt to convince does not morph into persuasion, and that the recipient's realistic decision space is not intentionally restricted by dramatising the situation, withholding information about possible alternatives, or similar manoeuvres. Indeed, such actions could be said to meet the definition of benevolent coercion themselves. Here professional caregivers have to act highly sensitively, especially in situations in which consent is ultimately given without full conviction but rather after long deliberation, hesitantly, or even reluctantly.

20) These considerations of professional ethics entail several additional criteria for the justification of benevolent coercion which mostly relate to the procedures by which it is carried out.

- » Professional acts of care must meet the quality standards of the relevant discipline, i.e. the act in question must be professionally appropriate. In the case of coercive measures, the execution of the coercive act must also be professionally appropriate. In other words, there must be a twofold justification by reference to professional standards, both of the measure itself and of its coercive implementation.
- » It has to be determined to a sufficient degree of certainty whether or not the recipient of care is capable of making a fully responsible decision regarding the proposed measure.
- » The presence of the above-mentioned criteria – the person's welfare, including their own subjective assessment; the measure being necessary to restore the capacity for leading a self-determined life; coercion as a last resort; secondary vulnerability; potential consent in hindsight; etc. – must be ascertained to a sufficient degree of certainty, and any available scope of discretion must be clarified.

- » The care recipient must be taken seriously as a person and must participate in the preparation, implementation, and aftercare of the measure in question.
- » In the case of children and youth, parents or other guardians must participate in the decisions about the use of coercive measures. In the case of adults, the same holds true for representatives or legal guardians if applicable.
- » The relevant criteria must be implemented and secured through appropriate procedures. This includes for instance a professionally qualified and responsible individual ordering and supervising the coercive intervention, as well as documenting the pivotal reasons for the measure, its implementation, and the type and duration of monitoring of the effects.

Legal foundations and regulations

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

However, a person might be temporarily incapable of mustering a fully responsible act of will regarding possible

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

22) From the state's duty to protect the Federal Constitutional Court has also derived that legislative authorities have to permit coercive medical treatment if severe, imminent damage to someone's health, including the risk of death, can be averted by performing a treatment that is not excessively invasive and that has a high chance of success, provided the recipient refuses the procedure by his natural will solely because his illness has compromised his ability to understand the situation and form appropriate judgments. However, the Court has also stipulated that legislators must take the patient's liberties which are in abeyance into consideration as much as possible. For instance, the patient's fully responsible will must be respected even if it can only be known by inference from the available evidence, especially from statements the patient made in the past or from the quality of the occurrent natural will. Only if this is impossible, i.e. if there is no conclusive indication showing that the patient's refusal of the treatment represents her fully responsible will, her opposing natural will may be overridden as a last resort.

23) It is the view of the Federal Constitutional Court that respect for an individual's self-determination entails the obligation to ensure ahead of any medical procedure that the patient is sufficiently capable of insight and judgment regarding the proposed measure so that she can determine her will freely and hence bindingly. If this is not the case, her free will may

be ascertained by reference to an advance medical directive or wishes regarding treatment stated in the past. If a patient is incapable of insight and judgment and opposes a proposed measure by her natural will, an attempt to convince her of the necessity and reasonableness of the intervention must first be made before treatment may be administered coercively as a last resort.

24) As far as procedural regulations are concerned, the Federal Constitutional Court prescribes that coercive measures to be used against a patient must be ordered by a physician. Further, there must be effective judicial and legal protection, and all coercive measures taken against the recipient's will must be documented, including the fact that they were indeed coercive, the manner of implementation, the pivotal reasons, and the monitoring of their effects.

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

Benevolent coercion in psychiatry

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

27) Whenever a patient is incapable of making fully responsible decisions, situations can arise – not just in psychiatry but in all medical specialties – in which the patient refuses a measure which appears indispensable to his health and well-being. The question whether or not it can be legitimate in these situations to administer the required intervention coercively has long been the subject of controversy, especially in psychiatry. If a coercive measure is intended to prevent a mentally ill patient from causing harm to herself or from suffering harm by refusing medical treatment, it constitutes “benevolent” coercion in the sense used in this Opinion. Historically, however, psychiatric practitioners have often used coercion against the mentally ill not only for the purpose of providing professional help to individuals by averting harm, but also for a different purpose: to protect society from the socially challenging or threatening behaviour of the mentally ill.

28) Psychiatric illnesses like schizophrenia and severe depression often compromise a patient’s ability to make fully responsible decisions. These conditions can impair perception, thinking, feeling, motivation, and behaviour to such an extent that patients affected by them are incapable of understanding the significance or implications of a given situation, arriving at their own judgment about the situation, or of acting accordingly. From a psychiatric point of view, coercive measures appear

necessary when a patient's perception of reality is distorted due to a disease-induced crisis and he is subject to impulses which put him at high risk of inflicting permanent and serious harm on himself, including suicide. Depression, anxiety disorders, and schizophrenia are correlated with a significantly higher rate of suicidal behaviour. Under these circumstances, the patient may be unable to control the impulses arising from within by his will, or they may be ephemeral states of consciousness that do not correspond to the declarations of will made by him before and after the illness-induced crisis. From a professional perspective it follows that in these cases treatment should be administered, if necessary even against the patient's currently expressed natural will, especially if his life is in danger. Thus, psychiatrists maintain that the use of coercive treatment and other coercive measures can be minimised but not completely eliminated.

29) Like other fields of practice, psychiatry makes use of *coercive measures that restrict or deprive of liberty*, for instance restricting or entirely suppressing someone's freedom of movement by means of fixating them or having them committed. Moreover, *coercive treatment* is sometimes administered, which includes measures of psychiatric treatment and care such as diagnostic examinations, medication, electroconvulsive therapy, or diets that are administered against the patient's will.

30) In recent years, the legal foundation of the use of coercion in psychiatry has been challenged from a human rights and fundamental rights perspective a number of times. Groups of (former) users of mental health services have called for a categorical ban of coercive treatment. They justify this demand primarily by reference to the prohibition of torture and cruel, inhuman or degrading treatment or punishment set down in various human rights conventions. Even so, such a ban cannot categorically prohibit all coercive measures used in the care of psychiatric patients. For instance, people with mental illness sometimes refuse to take medication even though a careful assessment has shown that the treatment is

clearly medically indicated even if administered coercively. If, due to her illness, the patient is incapable of understanding or assessing the consequences of refusing the treatment due to her illness, and if her illness and her refusal represent a serious risk of exclusion and of compromising her long-term ability to lead a self-determined life, then – provided everything has been tried and failed to convince the patient of the necessity of the treatment – coercive treatment does not constitute a cruel, inhuman or degrading treatment in the sense specified in the prohibition of torture, and thus does not violate the patient's human rights.

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

32) If a patient has a legal representative (parents or legal guardians of a child, a legal proxy acting under power of attorney or a court-appointed legal representative of an adult), *coercive measures that restrict or eliminate freedom* may only be performed with the representative's consent. Any such measures

may be carried out only if the patient is incapable of insight or judgment, if she is in serious danger of causing significant harm to herself, and that the risk cannot be remedied by any other less drastic means. If the patient is to be *deprived of freedom by being placed in an institution*, or if his freedom is to be *restricted in another way* on a regular basis or for a significant period of time, then approval from a court based on an expert psychiatric evaluation is required, except in emergencies.

33) The German state legislation relating to involuntary commitment and mental illness (*Psychisch-Kranken-Gesetze*) permits the *involuntary commitment* of mentally ill persons not only for the protection of others, but also for the protection of the person herself, provided she is putting herself at serious risk and the imminent harm cannot be averted in any other way (crisis intervention). So-called civil commitment is initiated by the relevant administrative authority and must be approved by a court on the basis of an expert psychiatric evaluation. In addition, there are state laws governing the use of *other measures depriving the patient of liberty* while committed. The Federal Constitutional Court has recently demonstrated the need for extensive reform in this area.

34) Generally speaking, medical treatment may be performed only with the patient's consent, or in the absence of his consent with the consent of the patient's representative or legal guardian, or in emergencies based on the patient's presumed will. Physicians are obliged by civil law and the laws governing their profession to document all important interventions and results pertaining to the patient's treatment.

35) Regarding the special case of administering coercive treatment that overrides a patient's natural will, none of the laws in effect at the beginning of the century's second decade fulfilled the appropriate human rights and constitutional rights standards, as determined by the Federal Constitutional Court, the *Bundesgerichtshof* (Federal Court of Justice), and other German courts. In some German states, the relevant state legislation lacks regulations regarding coercive treatment

altogether to this day. However, most states have reformed their legislation in this area. The question whether these new regulations do meet the required fundamental rights and human rights standards is still contentious.

36) In psychiatric practice, the *guidelines* published by the relevant expert bodies are of great significance. They are formulated based on the most up-to-date scientific knowledge and aim to provide security and orientation to the professionals administering care. While physicians themselves remain crucial to identifying the most suitable treatment in each individual case and taking responsibility for their choices, the guidelines are widely accepted by medical professionals and thus form an important contribution to the realisation of good clinical practice.

37) When making ethical judgments regarding benevolent coercion in psychiatry, it is not enough to consider individual actions or courses of action in isolation. Rather, the personal attitudes and opinions underpinning the actions as well as the concrete decision-making procedures and communication processes must also be taken into account. Moreover, each patient's specific situation should be considered when evaluating particular measures. Finally, the preconditions for benevolent coercion to be morally legitimate cannot be defined in abstract or general terms, but rather are the result of concrete lines drawn by individuals who need to justify their decisions. Therefore, the use of benevolent coercion must be subject to a *procedure of scrutiny involving multiple steps and criteria*.

38) From a normative point of view, it is necessary to distinguish between a care recipient's right to the restoration of his mental health and assuaging of his mental suffering and his rights to self-determination, humane treatment, and equal participation in society. Based on these distinctions coercion may be indicated as part of appropriate psychiatric care if there is good reason to assume that it can avert the danger of a patient causing serious harm to himself while lacking a fully responsible will and that it can restore his mental health. Here

the benevolence of the measures taken must be assessed, first-ly, in terms of mitigating the patient's current subjective and objective suffering and, secondly, with a view to preserving his interest in a life free from mental illness, his options for leading a self-determined life and participating equitably in society.

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

40) Situations can occur, especially in psychiatry, in which coercion used against someone whose will is evidently opposed can be experienced as traumatic, even if the action is judged to be benevolent by the standards of third parties. These individual responses to coercion must be factored into the overall evaluation of the benevolent aims that can realistically be accomplished because they can counteract the intended purpose of the measure and undermine the patient's trust in the medical field and/or his social environment. This is especially important in the case of patients with chronic mental illness where the goal of restoring their health becomes less and less relevant because it is probably unachievable. Instead, individuals in this category should be given the opportunity to lead a life that is

acceptable to them, including full participation in society, despite having a more or less debilitating mental disability.

41) An important means of ascertaining a patient's wishes is an *advance declaration of will* (for example an advance medical directive). From a medical and ethical point of view, the patient should receive appropriate counselling from a physician and then make a joint decision about the future course of action to be taken in case of illness or loss of the ability to give consent. These wishes should be set down in a medical directive. Drawing up such a directive also serves as an expression of a cooperative relationship between physician and patient and of mutual respect. It can form a suitable basis for conversations between physician and patient in future crisis situations and can thereby help to prevent or reduce the use of coercive measures.

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

the long-term perspective to the patient from the beginning, and to examine jointly in hindsight whether the use of coercion did indeed contribute to the patient's self-determination and participation and was therefore justified.

Benevolent coercion in the care of children and youth

43) Child and youth support services encompass a broad spectrum of types of social work, spanning general support for children, youth, and their families (for example day-care centres, services and activities for youth, and family education), specific help with child rearing in special circumstances (for example if the parents' child-rearing capabilities are limited), and so-called intensive educational measures, which in especially dramatic crisis situations include committing adolescents displaying extremely challenging behaviour to a closed ward. The paramount principles informing the structure of child and youth services are (a) *preventing* the development of precarious biographies in children and youth, (b) *integrating* the individuals concerned into society while preserving their unique character, and especially (c) allowing children, youth, and their parents or families to *participate* in the planning and execution of professional help. The welfare of children and youth lies at the centre of child and youth services. It must be secured and promoted through targeted educational interventions, for instance by facilitating the unfolding of an individual's developmental potential. If decisions have to be made about the medical treatment of minors, these are the parents' responsibility in principle. However, children do have the right to participate in any decisions affecting them in the form of having their opinion heard and taken into account.

44) The child and youth services run by the state have undergone fundamental change over the last few decades. Until the 1980's, the dominant approach in the field was focused on deficits, so that "difficult" children and youth were usually viewed as neglected, evading work, or delinquent. In the course of the *educational turn*, the coercive nature of the

“total institution” of the care home was scrutinised critically, and alternatives based on progressive educational ideas started springing up, for example alternative child care centres, shared houses for adolescents, and other forms of individual care situated in the recipients’ ordinary life circumstances. Approaches of conforming education to the attributes and needs of children gained increasing acceptance. The pedagogical tools based on these ideas build on the existing skills and developmental potential of the child or youth and take special care to honour their right to self-determination and participation in decision-making processes in an age-appropriate way. The chief purpose of these reforms was the restoration of the essential core of all educational interventions: to establish relationships between educators and children or youth that are characterised by mindfulness and trust and are therefore sustainable. Interventions are always embedded in an interactive relationship between an educational professional and the individuals in his care.

45) Like punishments, the coercive elements of an educational intervention often form the sobering climax of an escalation, inevitable as they may appear in an acute crisis. In addition to their antecedents, such interventions have an aftermath that threatens to negate their intended effect. Coercion can damage or destroy the educational relationship, which depends on mindfulness and trust, because it often leaves children and youth experiencing themselves as the mere object of devaluing or humiliating treatment. If care recipients respond with severe opposition, professional caregivers are often overwhelmed, especially if there are not enough staff in a given situation to provide individual responses to the problems at hand. This increases the danger of further escalation. Hence, coercive measures often have the opposite effect of how they were intended; they don’t succeed at diminishing challenging behaviour and calming the situation down.

46) The same holds for professional educational relationships, which are often confronted with a *pedagogical paradox*,

since aiming to promote a sense of responsibility and self-determination in children and youth over the course of their development sometimes necessitates educational interventions that override the child's current level of self-determination and thus seem to counteract the original goal. These measures include all forms of coercion. However, entirely forgoing such measures equally detracts from the aim of educational interventions, i.e. promoting children's and adolescents' development into autonomous and responsible personalities. This aim presupposes being sensitive to their specific experiential world and surroundings. At the same time, it often requires changing their daily routines. Developmental processes have to be instigated, sometimes against the child's or youth's opposition.

47) Occasionally, *different professional perspectives can collide*, for instance regarding the involuntary commitment of care recipients to youth institutions, because in this context child and adolescent psychiatrists play an important role alongside the educational experts. The former evaluate the individuals to be committed and are responsible for any supportive treatment that may be necessary during their stay. However, educational and psychiatric expert bodies differ in their assessment of the necessity of this kind of commitment. From the point of view of child and adolescent psychiatrists, even medium and long-term measures that deprive the recipients of liberty often turn out to be necessary and useful, at least for children and youth who have certain risk factors, such as an unstable or conflicted social environment, a history of failure in different youth institutions, or on-going substance abuse. In contrast, educational expert bodies tend to highlight novel methods for dealing with "difficult" children and youth based on cooperation and respect, which in their view are successful.

48) In part, the different logical frameworks for arriving at knowledge and action found in educational versus psychiatric approaches result from the different situations in which they are used. Child and adolescent psychiatrists mainly operate in acute crisis situations in which urgent help is needed. Hence,

they obviously concentrate on psychopathological disturbances and mainly employ scientifically validated therapeutic interventions. On the other hand, child and youth services based on social pedagogy focus on the long-term care and support of children and youth in difficult life situations, as well as the sustainable development and promotion of the care recipients' own resources in order to help them shape and master their lives successfully. Consequently, both perspectives are professionally valid. The tensions that tend to arise between them must not be resolved in favour of one of the two poles. Problems in this area usually occur because a collaboration based on mutual understanding could not be established and the accomplishment of the fundamental goals is being made more difficult or even impossible by interventions from the other "camp".

49) In virtue of the *specific triangular relationship* between the child or youth, her legal representative (usually the parents), and the state authorities exercising their duty to protect the child, the different forms of coercion in the context of child and youth services have one feature in common. Due to the primacy of parental custody, any intervention affecting the child or youth requires the (parental) guardians' consent. This can result in problematic constellations: In order to divest a benevolent professional intervention of its coercive nature, (age-appropriate) consent from the child or youth as well as the parents' consent are required. If both are lacking, then the measure is as it were doubly coercive: it is coercive towards the child or youth whose wellbeing is at stake, and towards the parents, who are equally bound to care for and serve the child's welfare. Even if the guardians consent to the measure out of their own free will, their consent does not negate the coercive nature of the measure since it still overrides the will of the child or youth in question.

50) *Intensive educational approaches involving coercive elements* represent a special form of coercion used in child and youth services. These approaches are often part of a firmly

established and, more importantly, easy-to-understand system of privileges enacted in residential youth institutions to modify behaviour. There are two kinds of systems of privileges: point and level systems. In a point system, the child or youth “earns” points for specific kinds of behaviour, which are added up over time and can then be exchanged for desired things or activities. In a level system, rule-conforming behaviour is rewarded by advancing to another level that includes more privileges, while rule violations are punished by getting relegated to a lower level with fewer privileges. Another intensive educational measure that is coercive in nature is the use of time-out rooms. These so-called “crisis rooms”, “calm-down spaces”, “isolation rooms”, or even “reflection chambers” are used to isolate a child or youth for a certain amount of time in order to calm them down and terminate their challenging behaviour. Such intensive educational approaches are unjustifiable because they lead to experiences of powerlessness on the part of the child or youth and to external compliance based on resignation, thereby defeating the original benevolent intent.

51) The *welfare of children* is the central concern of the (legal) regulations governing acts of care involving benevolent coercion in child and youth services. Apart from averting all forms of danger to life and limb, this concern manifests itself especially as fostering the child’s development and educating him to become a responsible and community-oriented personality. The framework for securing and promoting the child’s welfare mainly rests on the following basic presuppositions: the substantial requirements to respect the child’s subjectivity and individuality as well as his right to be raised non-violently, and the structural requirements set down in the relevant human rights legislation, articles of the Basic Law, and sub-constitutional legal regulations which establish the primacy of parental custody and the state’s mandate of watching over the children.

52) Children and youth must be included as participants in any intervention undertaken by public child and youth

services in accordance with their current level of maturity. They have their own right to receive counsel, to be taken into care, and – provided they are entitled to services – the right to express wishes and make choices. If support with child-rearing and integration into society is needed, children and youth should receive counselling and participate in the development of a roadmap for the interventions.

53) One of the essential elements of the welfare of children is their legally protected *right to be raised non-violently*. When bringing up children one must encourage them to respect others; therefore, one obviously must not engage in degrading treatment towards the child oneself. This principle entails certain restrictions regarding the use of coercion when enforcing parental commands or prohibitions. For instance, coercive measures must not involve emotional wounding or degrading treatment. When it comes to state authorities, the dictate of non-violence and the principle of respect for the child are even more obligatory, especially in adolescent services (either statutory ones or private ones commissioned by state authorities). However, state authorities can only take action if and to the extent to which the child herself, her guardians, or a court order has instructed them.

54) According to the Basic Law *parents have the right as well as the duty to care for their child*. They are responsible for the child's welfare. Therefore, in principle acts of care involving benevolent coercion may be used in child and youth services only at the parents' request and within the scope of their authority. If an act of care involving benevolent coercion is opposed to the parents' will, it is only permissible if and to the extent to which interference with the parents' primacy of care is authorised by the *state's duty to watch over the children*. Consequently, parental custody fundamentally serves as a protective shield for the child, even if the proposed measures are, or are meant to be, benevolent. The state becomes involved in its function of watching over the family if the child's welfare is in jeopardy or if either the parents or the child request

an intervention. The primary duty of the state consists in enhancing the parents' competence as caregivers, for instance by offering child-rearing support. The state only has the right to intervene in parental custody if support measures are unlikely to succeed and the child's welfare would otherwise be endangered.

55) Coercive measures are often experienced as humiliating by the children or adolescents subject to them. Furthermore, far too little is known about the long-term effects of using coercion in child and youth services. However, presenting convincing empirical evidence would be a necessary, albeit not a sufficient condition for the moral justification of restrictions or deprivations of liberty and of restrictive and confrontational educational approaches based on coercion in the field of child and youth services.

56) The specific problem with justifying coercion in child and youth services consists in acknowledging the legitimate and indeed imperative goal of helping the child or adolescent develop into a fully responsible person, while on the other hand not treating him as an instrument in the service of that goal in concrete situations, which would violate his dignity. This holds for all the forms of benevolent coercion in professional educational constellations, i.e. physical coercion, restrictions or deprivations of liberty, intensive educational approaches involving coercive elements, as well as coercive therapeutic measures.

57) Only if the child or youth is not (yet) capable of full responsibility can benevolent coercion ever be justified. It has to be ascertained in each individual case and context whether a given child or adolescent is capable of making fully responsible decisions, bearing in mind that this capacity may already exist in minors. A general rule based on age ranges, while set down in law in relation to third parties for good reason, is not appropriate for ethical evaluations because it does not do justice to the child's or adolescent's individuality. Determining whether the capacity for full responsibility is present or not can often

be difficult, especially in the case of adolescents. Nonetheless, it must be assessed all the more carefully and conscientiously, and the reasons for one's assessment must be made transparent.

Benevolent coercion in elderly and disability care

58) Coercive measures are also used in professional nursing towards people requiring a high degree of assistance, support, and care. This category includes individuals with complex special needs and elderly people who are dependent on care. These two groups of people are often subject not only to measures involving deprivation of liberty, but also to educational or rehabilitative measures intended to activate them that are performed against their will. Another shared attribute of these groups is that they tend to live in care homes where they are subject to structural coercion. However, this type of coercion is not covered in this Opinion.

59) As people approach old age, the prospect of becoming dependent on care renders the issue of benevolent coercion increasingly significant. Coercion used to suppress deviant or obnoxious behaviour, for example in individuals with dementia who are dependent on care, is often justified by appeal to their welfare and the care required to maintain it. When caregivers have to make a decision for or against a nursing patient's self-determination, they are often worried about incurring guilt for failing to care sufficiently for the patient, or about being held responsible if a nursing patient is injured in a fall, for instance, which could have been prevented by bedrails. This can drive caregivers to employ measures that deprive patients of liberty or to enforce acts of care coercively.

60) The fields of elderly and disability care have also seen a shift in their professional self-conception from an *orientation focused on deficits to one focused on competencies*. This can cause conflicts if staff or relatives are leaning towards the competency-based approach to old age while the patient herself holds the deficit view. Caregivers might try to enforce particular exercises or activities for training and rehabilitation against

an elderly person's will because from a professional point of view they serve to preserve or promote skills, self-determination, participation, and quality of life. However, many elderly people reject such measures based on the belief that positive change is not possible in old age.

61) With respect to helping elderly people with disabilities be more active, it must be noted that these individuals' biographies often include comprehensive care but little or no encouragement to develop independent initiative and self-determination. Often these persons were even considered "uneducable". The reason for this is that until well into the 1990's, many institutions providing disability care were following an approach of "provision and care" rather than one of fostering resources. As a consequence, certain forms of dependency such patients exhibit were (and still are) the result of institutional practices. In particular, elderly people with special needs do not always receive the degree of activation that would be functionally appropriate given their potential for plasticity.

62) Regarding the living situation of the elderly, moving into a residential institution can become an important concern, especially if the person's family does not have sufficient resources to care for them at home (anymore). Elderly people often experience this move as being forced on them against their will. This problematic constellation cannot be solved merely by expanding the range of ambulant and part-residential types of care. In addition, families must consider the question how the care of elderly family members should be handled in good time and determine what kind of arrangement they prefer.

63) In principle, the legal regulations governing professional acts of care involving benevolent coercion in the context of elderly and disability care and in the treatment of the mentally ill are the same. The basic rights and human rights of people who are dependent on care entail their right to appropriate nursing and medical care aimed at mitigating their suffering and restoring their health. Coercive measures might be

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

64) The task of carrying out the work of nursing and care in a way that serves the recipients' wellbeing encounters limitations not only in dependent patients' resistance to particular allegedly benevolent acts, but also in the caring professionals themselves. Their working conditions, especially in elderly care, are characterised by a high workload, understaffing, dissatisfaction with how the work is valued, low pay, and a lack of career opportunities. Professionals in this field describe themselves as overstretched and emotionally exhausted.

65) Professional carers should determine carefully in each individual situation whether the quality of self-determination articulated by a care recipient positively falls below the threshold of a fully responsible volitional process, whether there is well-founded reason to doubt their full responsibility due to specific impairments of their health or cognitive functions, or whether a patient's will is fully responsible beyond reasonable doubt, at least in the given context of action.

66) Institutions providing elderly or disability care often have *complex structures of responsibilities*. Thus, in order to prevent responsibility for existing shortcomings from being rashly attributed to a single individual, or alternatively to the operator of the institution or to the care system as a whole by overgeneralisation, it is necessary to conduct a detailed analysis of the coercive acts in question in order to identify their actual causes, which are often multi-layered.

67) Especially in the field of professional care of the elderly and the disabled, the characteristic *volatility* of these individuals' processes of determining and articulating their own will must be taken into account. Their will can exhibit different degrees of autonomy and determinacy at different times. Hence,

manifold ambivalences, ambiguities, and gradations are to be expected.

68) Coercion always begins in the mind of the person who feels entitled, or even obligated, to perform particular coercive acts. Especially if professional caregivers have a one-sided, deficit-focused view of old age and disability, they tend to overlook or underestimate the resources that are in fact available to the care recipient to determine and articulate her will independently. For the same reason, they can inadvertently strengthen existing dependency relationships through their acts of care (even though these are often motivated altruistically). This is closely tied to a disregard for the high variability of the phenomena of old age and disability. Honouring the unique life history of each care recipient demands not only acknowledging their individuality, but also encountering them with respect. This includes taking the patient's articulations of his will seriously as part of his wellbeing even if the process of will formation is impaired or leaning in a direction which runs counter to the caregivers' notion of a well-lived life.

69) As desirable as it may be to preserve and foster the potential for action and self-determination in people dependent on care, one has to guard against overlooking their changing needs or withdrawing from them in case the successes hoped for by caregivers do not materialise. The respect due to old and disabled people must not be conditional upon the caregivers' expectations of how these individuals should be performing, but must be reliably granted to every human being until their death. In cases of care recipients suffering from illness, social isolation, or neglect, motivating them to participate in measures that help them to be more active may initially be difficult even though these activities may seem necessary to staff in order to restore, preserve, or develop the individual's resources. In this situation the whole range of motivational techniques using positive incentives and reinforcement should first be employed. More forceful efforts to get a nursing patient to be active despite their repeated refusal already fall under the

umbrella of coercion as understood in this Opinion. Such efforts should only be made on the condition that they have been explained to the patient in a comprehensible way before being undertaken and are subject to critical monitoring. It is important for the care recipient to develop a discernible, sustainable motivation to continue with the activities of her own accord not too long after she has begun to take part in them based on the beneficial effect she perceives the activities to have on her subjective wellbeing. Conversely, this implies that enforced activities which the recipient continues to reject over a significant period of time are not justified, even if professionally considered they would most likely benefit her state of health.

70) So-called *mechanical measures that restrict freedom* must be subject to in-depth scrutiny. It must be investigated whether in principle alternative forms of action are available and whether the actual means employed are commensurate with the situation. Further, the degree of invasiveness, frequency, and duration of the interventions must be taken into account, as well as their concrete impact on the patient's self-experience and on their level of trust in the caring environment. Generally, the required degree of justification rises considerably as the degree of invasiveness, frequency, and duration of the coercive acts increases. Physical restraints in particular – for instance being strapped to a bed or chair – not only pose a significant risk of physical harm through injury or strangulation, but can also violate the recipient's dignity due to their traumatising effects. Therefore, using such measures on a regular basis is out of the question. However, even in the case of less drastic restrictions of bodily movement – which range from bedrails, tray tables, removing walking frames or other physical aids, to installing trick locks or keeping doors locked – it must be carefully determined whether these measures do in fact serve the recipient's welfare rather than merely making the caregivers' life easier or protecting third parties, and whether there really is no alternative. Given the inherent safety risks of physical restraints, it must be assumed that in

the majority of cases mechanical restraints – the use of which is declining, though still far too frequent – have no plausible ethical justification.

71) When it comes to using psychotropic medication in order to *restrain* residents in care homes for the elderly or disabled *via pharmacological or chemical means*, the possibility cannot be excluded that the use of such medications may be medically indicated in certain acute situations of intense or extreme agitation, suicidal tendencies, or depression, and that they might mitigate the patient's suffering considerably despite his occurrent incapacity to consent to the treatment. However, due to the significant degree of invasiveness of this type of intervention and the risk of changes to the recipient's personality, especially strict criteria of diligence must be applied to the concrete diagnosis, determination of medical indication, and dosage of the medication, as well as to regular reassessments of the necessity of continuing the treatment. In care facilities, psychotropic medications are commonly prescribed abusively, i.e. without a personal assessment of the patient and without close monitoring of their individual state of health. These medications can have countless negative side-effects impairing the waking state and the health of people dependent on care who usually have already been suffering from multiple kinds of damage prior to receiving such treatments.

72) When participating in coercive measures, professional caregivers often experience significant *uncertainty about their actions* as well as *moral conflicts*. On the one hand, they feel obligated to respect care recipients' declarations of will and to care for the wellbeing of the patients for whom they are responsible. On the other hand, the will of the person in question may be impossible to determine, it may vary significantly depending on their state on a given day, or it may run counter to the standards which from a professional perspective constitute good care. Professional caregivers often have to make far-reaching decisions under time pressure and while lacking important knowledge (for example about the patient's will, the

actual consequences of particular actions, or the probability of harm occurring). Further, even tried and tested moral principles have to be applied freshly each time based on an individual's judgment and the unique circumstances of a given situation. Consequently, strengthening caregivers' faculty of judgment, for example by implementing ethical support services, is particularly important.

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

7 PRINCIPLES AND RECOMMENDATIONS

A. Universally applicable principles and recommendations

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

A2. Coercive measures may only be considered if the recipient's capacity for self-determination is impaired so severely that they are incapable of making fully responsible decisions. Neither having been diagnosed with a mental illness or cognitive impairment, nor being a minor, nor refusing a measure that may be medically indicated in and of themselves preclude the existence of full responsibility. Rather, it has to be determined in each individual case whether a sufficient capacity for insight, judgment, and action regarding the proposed measure is present. If this cannot be established beyond reasonable doubt and the uncertainty cannot be resolved, the evidence for

and against the presence of full responsibility must be weighed, and a clear preponderance in favour of its probable absence must be found. The criteria for establishing the presence of the required capacities for insight, judgment, and action which constitute full responsibility must be specified and developed in a transdisciplinary fashion.

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

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

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

- » Before enacting any measure coercively, an attempt must have been made to obtain voluntary consent or cooperation from the recipient of the measure. This includes providing sufficient information and trying to motivate the recipient in an appropriate and considerate way to voluntarily cooperate with the measure or at least permit it to be performed. The recipient must be given the opportunity to shape the circumstances and the execution of the intervention in a way that makes it acceptable from his point of view.
- » If a coercive measure is to be considered, all other less invasive means at one's disposal that could accomplish the same goal must have been exhausted. The chosen form of the intervention must put the least strain on the recipient and pose the least danger of secondary harm (for example

humiliation, traumatisation, or loss of trust). All direct and indirect negative consequences must be factored into this assessment. Moreover, it must be ensured that the duration of the coercive measure is as short as possible and the risk of harm, including possible (re-)traumatisation, is minimised.

- » The expected benefit of the coercive measure for the recipient must significantly outweigh the drawbacks experienced by her. When gauging this ratio, both the current and the future welfare of the recipient must be taken into account. This frequently involves difficult judgments and trade-offs. These must incorporate the recipient's perspective, including his fears, needs, wishes, and personal circumstances, in a material way.

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

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

A8. Any measure may only be performed coercively if the recipient would share the goal of the measure were she currently able to make fully responsible decisions or if she would judge it to be right and necessary in hindsight. In order to

determine her presumed will, her past declarations of will and any other available information containing clues to her will and preferences must be considered.

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

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

A11. Coercive measures that are especially intense or long-term, such as depriving someone of liberty by committing them to a closed institution or ward, or applying coercive treatment over a longer period of time, may only be performed if the above-mentioned prerequisites have been demonstrated to be fulfilled in advance by an external and impartial entity, for example a court of law, possibly based on an expert evaluation (this does not include emergencies which do not permit delays; emergencies, however, still have to be appraised retroactively). Furthermore, procedural safety mechanisms have to be in place (for example procedural attendants, guardians ad litem, or patients' ombudspersons).

A12. It must be ensured that the duration of any coercive intervention is as short as possible. In addition, the recipient of

the measure must be monitored at appropriate, regular intervals in order to determine whether the prerequisites for using coercion still obtain.

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

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

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

A16. Institutions as well as courts of law and other authorities that deal with coercive measures should be required to collect anonymised information about the actual incidence of these measures. This data should be made publicly available for scientific and statistical purposes as part of quality management, and to keep the general public informed.

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

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

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

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

A21. In hospitals with psychiatric wards, care homes, and child and adolescent protection authorities, institutionalised staff committees should be established to evaluate the use of coercion prospectively and retrospectively. Conferring among colleagues in this way should serve the purpose of making intellectually well-founded and responsible decisions about using coercive measures to prevent patients from harming themselves (for example ethics consultations in a hospital), as well as reflecting on and evaluating the use of coercive measures

retrospectively (for example case conferences at a public authority).

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

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

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

B. Principles and recommendations – psychiatry

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

B1. Decisions about using a coercive intervention to treat a patient should first be discussed in a cross-disciplinary team which includes the caregivers and then be made jointly if possible, while observing the rule that the final responsibility rests with the treating physician and that obtaining a guardian's consent (parents or other guardians, patient representatives, or legal guardians) will usually be necessary. If the team cannot agree on how best to serve the patient's welfare, whether she possesses the capacity to make fully responsible decisions, or what the least harmful means of treatment is, then guidance

should be sought from a clinical ethics advisory service. In hospitals with psychiatric wards, the members of the hospital's ethics committee should be specially trained for this purpose.

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

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

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

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

law but any and all coercive measures, irrespective of their legal foundation.

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

C. Principles and recommendations – child and youth services

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

C1. In order to render coercive measures in the care of children and youth legitimate, the parents' or other guardians' consent must usually be obtained. Without their consent such measures may only be performed in emergencies in which the parents cannot be reached in time, or if the parents themselves pose a substantial danger to the child's welfare.

C2. Coercion used against children and youth must not involve corporeal punishment, emotional wounding, or other degrading forms of treatment, even if the parents consent to it. The choice of treatment must be based not only on the idea of

the person the child will one day become, but must always take her current wishes and needs into account as well.

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

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

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

C6. Communities and public child and adolescent services must be obligated to enable their staff to care for children and youth in an individual, intensive, and participative way, keeping the number of cases per staff member to a professionally viable level. The administrative tasks of maintaining documentation and appropriate monitoring must not be completed at the expense of personal care for children and youth. Staff hours should be planned and adjusted accordingly. Public child and adolescent services and the operators of institutions for children and youth should establish case conferences in order to confer with peers and formulate decision-making guidelines for difficult cases prospectively, and to reflect critically on the actual use of coercion retrospectively.

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

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

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

C10. Institutions providing child and youth services should establish procedures for complaints management, allowing children and youth who wish to make a complaint to turn to a trusted adult within the organisation without fear of negative consequences. Complaints management needs to be documented, and the resulting decisions should be discussed with the child or youth in question. In addition, easily accessible independent complaints bodies (ombudspersons) should be established across the country. Children and youth should be informed of the possibility of contacting an ombudsperson in any meetings they attend in which support measures are planned. In residential institutions, staff members of the complaints organisation should also proactively seek contact with children or youth who have been subject to coercive measures or are at risk of being subject to them.

C11. Every future reform of the laws relating to child and youth services should secure and strengthen the effective

rights of children and parents to participate materially in any procedures in which support measures are planned.

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

D. Principles and recommendations – senior and disability care

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

D1. The elderly and the disabled usually require long-term care and support for their needs, which often increase over time. Therefore, caregivers and therapists must take special care to respect the dignity of this group of care recipients, even when the individual preferences of its members conflict with caregivers' professional self-conception.

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

D3. In order to minimise the use of coercion in elderly care, staff should be familiar with the symptoms and progressive

course of geropsychiatric illnesses, especially dementia. They should be able to understand the specific symptoms, assess them, and treat patients professionally and respectfully. Continuing education and training should be obligatory.

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

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

D6. The facilities and staff requirements at institutions providing elderly or disability care should allow for individualised care and support of nursing patients and people with disabilities. In particular, to effectively avoid structural coercion the number of staff and their working hours should be determined based on the needs of the recipients of the care and support to be provided. In order to deescalate conflicts, sanctuaries and open spaces for residents as well as manageable care units should be created.

D7. It is not only the number, but also the attitude of professional caregivers and institutions that determines how nursing patients and the disabled are treated and hence whether they are likely to be subject to coercion. The attitudes and moral concepts of caregiving staff have a material impact on their ability to perceive the needs of residents in care homes for the elderly or disabled. Therefore, the development of a respectful

attitude in professional caregivers should be fostered, especially their capacity for mindfulness, sensitivity, and empathy, as well as the ability to reflect on their own values.

DISSENTING VOTE

Despite unequivocally endorsing the overall goal formulated in this Opinion of identifying and, if possible, eliminating unjustified uses of coercion in the context of professional caring relationships, the undersigned finds it necessary to point out a number of conceptual and argumentative weaknesses of the present treatise which in his view have not been resolved. These primarily concern the question of the legitimacy (or otherwise) of using coercion against so-called fully responsible care recipients (cf. recommendation A2).

1. According to this Opinion, coercive measures can only be justified if “the recipient’s capacity for self-determination is impaired so severely that they are incapable of making fully responsible decisions” (p. 213). The Opinion argues that coercion is justifiable in principle – on certain conditions which are elaborated in the text – in situations in which the care recipient undoubtedly lacks full responsibility (constellation a), or in which there are at least well-founded doubts regarding his or her present capacity for full responsibility (constellation b). However, if a care recipient does have the capacity for full responsibility in a given situation (constellation c), this is said to constitute an absolute demarcation which categorically forbids any consideration of coercive measures. A care recipient is deemed “fully responsible” if she is “able to consent, refuse, or choose between different available options, if she understands what she intends to carry out or refrain from (including both the immediate and secondary consequences foreseeable for her), and if she can place her decision in the context of the vision she has for her life” (p. 26).

Despite constituting the lynchpin of the criteria for the justification of coercion, the concept of so-called “full responsibility” seems to be in need of clarification in several respects. First, the relationship of this concept to the established notions of mental competency and the capacities for decision-making

and consent, respectively, should be defined with precision in order to create a unified terminology across different fields and professions. In particular, this involves examining if and how the stated conditions can be justified, given that some of them are very demanding (for example knowledge of the “immediate and secondary consequences foreseeable” and the ability to “place her decision in the context of the vision she has for her life”), especially since these criteria clearly exceed those for the established categories of, for instance, mental competency and the capacity to give consent.

Second, it should be clarified whether or not the criteria formulated in the Opinion are to be understood cumulatively as they are not used consistently in the text (cf. p. 38).

Third, the Opinion rightly points out that “determining the boundary between fully responsible decisions on the one hand, and expressions of will which do not meet the criteria for being fully responsible on the other, is a somewhat precarious task” since “the central concepts of the faculties of knowledge, judgment, and action, currently do not have concrete definitions agreed upon across disciplines; such definitions are yet to be developed” (p. 62). Hence, despite the different procedural remarks in the text, it is not sufficiently clear how this criterion – supposedly crucial from a normative perspective – can be reliably operationalised by the different agents in professional caring relationships who approach this task with different backgrounds of training and education.

Fourth, the concept of full responsibility, which is an unusual one in the field of ethics, vacillates between the morally neutral category of “free will” or “free decision” on the one hand, and the positively connotated concept of “justifiability” in the morally approving sense (i.e. “acting responsibly”) on the other. However, whether or not the latter concept does in fact apply to individuals whose self-harming actions appear highly irrational is precisely the issue at stake.

2. Based on the foundational concept of full responsibility, the Opinion employs the distinction between so-called “soft”

and “hard paternalism” (cf. section 4.3) to demarcate legitimate from illegitimate forms of coercion. First of all, such a binary distinction often does not do justice to the actual dynamics, volatility, and ambiguity of care recipients’ volitional processes encountered in practice since these have too many gradations and grey areas. Further, there is the risk of obfuscating the need for normative justification by stipulating a particular terminology with its preexisting connotations (i.e. a legitimate “soft” paternalism and an illegitimate “hard” paternalism). However, whether a particular coercive measure is morally justifiable or not must be demonstrated by suitable arguments in each individual case. Thus, such judgements are *synthetic*³³⁹ and cannot be derived analytically, i.e. in a circular fashion, from terms stipulated in advance.

3. It is not contentious that *as a rule*, coercive measures that override the explicit free will of a care recipient are morally inadmissible. However, the question arises whether this rule, like most rules, might have extremely rare *exceptions* in which even so-called hard paternalistic measures (in the sense of constellation c) can be morally justified provided certain conditions are met. The Opinion explicitly denies this possibility by declaring that such measures “cannot be justified in the context of professional caring relationships” (p. 69) since “none” of the four arguments adduced in favour “yield sufficient reason for qualifying the principle that benevolent coercion used against fully responsible individuals is impermissible” (p. 73). There are two aspects here that require clarification and elaboration.

First, it is not a matter of qualifying a plausible “principle” as such, but rather to point out the potential limits of its applicability. Experience shows that even rules and principles of

339 Translator’s note: In the Kantian sense of affirming a predicate which is not contained in the subject. Broadly speaking, this means that the property ascribed to the subject is not part of its definition. In contrast, in analytic judgements the predicate is part of the definition of the subject, e.g. “all bachelors are unmarried”.

action that are generally well-founded (i.e. *ut in pluribus*)³⁴⁰ can in exceptional situations conflict with other rules that are equally plausible. In these cases a trade-off between the goods and values in question which minimises infringements must be arranged. The present Opinion actually contains a certain ambivalence regarding this question since on the one hand, it rightly emphasises that the moral justifiability of using benevolent coercion against individuals whose actions must undoubtedly be considered fully responsible is “generally” doubtful (p. 15). On the other hand, it seems to endeavour to exclude any possibility of borderline cases *tout court*. This is probably motivated by the concern that allowing exceptions to exist might spiral into admitting much more serious constellations (for example complex coercive treatments), even though this danger is neutralised from the start by the stated criteria for coercive measures (for example short duration, only mildly invasive).

Second, in my view the four possible arguments adduced in favour of justifying so-called hard paternalistic measures should be evaluated more carefully than the Opinion has accomplished. While appealing to the doctrine of “duties towards oneself” and the category of “conscience” does seem to be unsuccessful at justifying the use of coercion against care recipients who are capable of judgement and consent, in my view the plausibility of citing the “necessary protection of the individual’s future prospects” and “human dignity” should not be dismissed lightly. Quite apart from the fact that it does not seem very convincing to subsume all instances of suicidal behaviour under the category of “emergencies” (and hence under constellation b) (cf. p. 73), the way the Opinion deals with complex borderline cases makes it clear that the argumentative strategy it endorses comes with a high price.

³⁴⁰ Translator’s note: Short for the Latin “*lex valet ut in pluribus*” (the law is valid in most but not all cases).

First, the resulting position runs the risk of either having to completely deny the existence of difficult and extreme cases in which a care recipient engages in irrational self-harming behaviour in an isolated area of his or her life, or of ultimately having only one solution to resolve these constellations, namely *casting doubt on the reality of the individual's full responsibility* (cf. the symptomatic treatment of the neglect scenarios and the argument from dignity, p. 73). Hence, the very line of argument that was intended to protect care recipients' self-determination is revealed to have a surprising flaw. When it comes to so-called "moral dilemmas" (p. 85), this implies that according to this Opinion, the ultimate cause of experiencing such dilemmas must lie in purely subjective misjudgements, which in turn are the result of professional caregivers misunderstanding "their fundamental obligation to respect others' fully responsible decisions" (p. 85). However, this interpretation only appears plausible if complex categories such as the recipient's "welfare" are covertly reduced to his or her individual self-determination. Amongst other things, this would effectively destroy the foundation of the theological theorem of the "necessary acceptance of guilt" (cf. p. 85), which was developed to cope with extreme situations of conflict.

Second, the line of argument the Opinion pursues also fails to do justice to the temporal dimension of conflicts in which a person's *occurrent* free determination of will runs counter to the *medium and long-term* preservation of his or her capacity for self-determination. Anyone convinced that in this situation the recipient's *occurrent* free will constitutes the predominant or even the sole factor to be taken into account in a moral assessment is guilty of an *actualist narrowing of self-determination* which seems strongly counterintuitive. It makes no sense to constantly pay homage to the highly significant shift in perspective towards a person-centred and resource-centred orientation on the one hand, and on the other hand to reduce the capacity for self-determination and responsibility, of all things, to a momentary articulation of will and ignore a person's future

potential – especially in the case of young people. Therefore, the criterion mentioned elsewhere in the Opinion (cf. recommendation A8), namely that the care recipient must be able to share the aim of the coercive measure “in hindsight” and hence judge it to be “right and necessary” after the fact, should also be applied to the problem of justifying rare instances of hard paternalistic coercion.

Third, the implicit equation in section 4.3 of a care recipient’s occurrent free determination of will, her welfare, and her dignity ultimately results in *conceptual fusion*. Here, the text falls short of the more nuanced discussion of the concept of welfare in section 2.3, propagates a one-sided, subjectivist interpretation of the notion of welfare, and hence violates its own well-founded demand for a “procedure of scrutiny involving multiple steps and criteria” (cf. p. 111). Moreover, from a metaethical perspective this also commits the argument to an *internalist* interpretation of so-called *normative reasons*, the plausibility of which is highly contentious in contemporary moral philosophy.

4. One final defect of the line of argument proposed in this Opinion that should be mentioned is that it *fails to distinguish sufficiently between the legal and the ethical perspective*. For instance, based on a direct reference to existing legislation the Opinion asserts that it is “morally legitimate for a patient to make a fully responsible decision to refuse a medical procedure even if it is medically indicated and failing to carry it out would put the patient at risk of grave harm or even death” (p. 70). There are of course good reasons why the law provides comprehensive protection for patients’ decisions even if these decisions are irrational; however, this is quite distinct from determining the specific moral standing of such actions. The same holds true for the question of what a morally appropriate response from third parties to these scenarios of patients refusing therapy should look like. There is a broad, if contentious, spectrum of possible reactions here – depending on the patient’s presumed motives, concrete circumstances, and

social constellations – ranging from caring interventions to tolerant inaction combined with substantial disapproval of the behaviour, to appreciative respect. There is no trace of a reliable consensus in contemporary medical ethics and bioethics regarding numerous concrete problems of the precise scope of individual self-determination. Therefore, the conflation of the legal and ethical perspectives in this Opinion seems highly idealised and does not do justice to the plurality of different options and theoretical traditions in moral philosophy.

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- OLG Köln, Order of 7 September 2012 – 2 Ws 644/12 (BtPrax 2012, 256)

ABBREVIATIONS

AA	Akademieausgabe (Academy edition)
BGB	Bürgerliches Gesetzbuch (Civil Code)
BGBI.	Bundesgesetzblatt (Federal Law Gazette)
BGH	Bundesgerichtshof (Federal Court of Justice)
BGHZ	Entscheidungen des Bundesgerichtshofes in Zivilsachen (Decisions of the Federal Court of Justice in Civil Cases)
BT-Drs.	Bundestagsdrucksache (Bundestag printed paper)
BtPrax	Betreuungsrechtliche Praxis
BVerfG	Bundesverfassungsgericht (Federal Constitutional Court)
BVerfGE	Entscheidungen des Bundesverfassungsgerichts (Decisions of the Federal Constitutional Court)
CHRB	Convention on Human Rights and Biomedicine
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EU	European Union
FamFG	Familienverfahrensgesetz (Family Proceedings Act)
FamRZ	Zeitschrift für das gesamte Familienrecht
GDR	German Democratic Republic
GG	Grundgesetz (Basic Law)
GmbH	Gesellschaft mit beschränkter Haftung (private limited company)
ICCPR	International Covenant on Civil and Political Rights
ICD	International Classification of Diseases
ICESCR	International Covenant on Economic, Social and Cultural Rights
JGG	Jugendgerichtsgesetz (Youth Courts Act)
LT-Drs.	Landtagsdrucksache (Landtag printed paper)
MBO-Ä	(Muster-)Berufsordnung für die in Deutschland tätigen Ärztinnen und Ärzte ((Model) Professional Code for Physicians in Germany)
NJW	Neue Juristische Wochenschrift
OLG	Oberlandesgericht (Higher Regional Court)
para.	paragraph*
SGB	Sozialgesetzbuch (Social Code)
Suppl.	Supplement
UN	United Nations
UN-Doc.	UN document

* In the original German citations, “Rn.” (Randnummer, or literally “number on the margin”) refers to the practice of numbering paragraphs in the margin of many German legal opinions. Here, “Rn.” is translated as “para.”.

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