


Article

# Coping with Criticism and Embracing Change—Further Reflexions on the Debate on a Mental Health Care System without Coercion

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**Abstract:** In August 2019, a manuscript was published in this journal that aimed at imagining a mental health care system that renounces the judicial control to better focus on the will and preferences of those who require support. Alternative scenarios for dealing with risk, inpatient care, and police custody were presented that elicited strong and emotionally laden reactions. This article adds further reflections to this debate, aiming at contributing explanations for this unsettlement. A productive notion of criticism is discussed, and ways to achieve change toward a more human rights-oriented psychiatric practice are outlined.

**Keywords:** human rights; psychiatry; coercion; critique



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## 1. Introduction

In August 2019, a manuscript was published in this journal that aimed at imagining a mental health care system without coercion (Zinkler and Peter 2019a). Based on the UN Convention on the Rights of Persons with Disabilities (CRPD) and the reports and comments of several UN bodies, among them the High Commissioner for Human Rights, a system was conceptualized that renounces its power of social, judicial control to better focus on the will and preferences of those who require support. Alternative scenarios to those currently practiced in psychiatry were presented for dealing with risk, inpatient care, police custody, and mental illness in prison. It was concluded that with such a shift, mental health services could earn the trust of service users and thereby improve treatment outcomes.

The main arguments of this manuscript were also published in German language (Zinkler and Peter 2019b). Both manuscripts (in the following referred to as “previous papers”) elicited a lot of responses, among them rather strong and emotionally laden reactions: One of us (SvP) received E-Mails, in which mainly psychiatrist colleagues warned me not to drift too far into a “politically nonconformist corner” or to “become too much of an activist”, and that this publication had put me into the position of “risking my reputation”; I even heard the accusation of agitation and colleagues of mine were called and asked if they knew what I had recently written on. Similar instances happened to me (MZ), for instance at an online conference, when a well-known researcher in the field of coercive practices in psychiatric institutions referred to the authors of the paper on four occasions during a 15min presentation as “activists”.

These reactions astonished us even more as our arguments did not intend to radically deconstruct the psychiatric system (how could they via the simple means of a single publication?) but to open up the stage for further discussions of alternatives to the current coercive practices and to bring clinical practice and service provision in line with the human rights discourse at the UN and the WHO (United Nations 2013, 2014, 2017a, 2017b,

2018; WHO 2017). We wanted to create two critical pieces to “think with”, that may help us to imagine and maybe trigger new ways of dealing with the daily complexities we face in psychiatry. These pieces certainly had numerous shortcomings, potentially leaving the reader with more questions than providing answers to them: For instance, a detailed account is lacking on how social control would have to be organized differently, and what consequences this would have for the people concerned. Furthermore, our previous papers contained a strong message, arguing rather apodictic and somewhat normatively, thereby exceeding the borders of a mere gedankenexperiment. Yet, they deliberately did so, following the goal of stirring up and promoting the discussion on alternative practices to psychiatric coercion. In doing so, though, we did not intend to morally judge any concrete psychiatric practices but aimed at—ex negativo—shedding light on a fundamental infrastructure that constitutes them—the possibility to exert coercion and social control—and its wide-ranging impacts on the everyday actions and interactions in psychiatry.

Facing these rather benevolent intentions, the question arises as to why and how our arguments might have led to such an amount of disruption and unsettlement? In this article, we aim at giving answers to this question, following two hypotheses: In the first part, we argue that we lack a productive notion of critique in psychiatry and discuss the extent to which this might be one of the reasons to explain these reactions. In the second part, we postulate that psychiatric practices must change, also to be able to respond to the manifold ongoing transformations in society that happened during the last decades often referring to human rights as a legitimation, and followed by answers to the question, how these changes may best be achieved in the field of mental health. In both these parts, we refer to the German mental health service context, as this is the context that both our previous papers relate to, and in which both of us currently work. In the conclusion, both parts are woven together, culminating into the question of whether psychiatry may be too fragile to receive criticism, and ending with a call for survivor and user leadership in conceptualizing the necessary change in mental health care, as they are the objects of coercive practices, making it vital to integrate them in upcoming processes of change.

## 2. Coping with Fundamental Critique

In the context of a literature review that has been undertaken by a Berlin activist group focusing on milder means to avoid coercive interventions in mental health care, the wealth of scientific and theoretical papers on this topic became evident. Indeed, there is a wide range of techniques and strategies that may be used in the field of mental health to prevent, avoid, or combat coercive measures. A lot of efforts have been invested to develop and evaluate a variety of often complex interventions, such as approaches of assisted decision-making (Zentrale Ethikkommission 2016), advance directives (Bundesarbeitsgemeinschaft Psychiatrie-Recht 2019), or debriefing strategies (NASMHPD—National Association of State Mental Health Program Directors 2006). Various measures of organizational change have been proposed, most of them on the basis of a wealth of evidence, such as using data to inform praxis, open-door policies, Safewards as a multicomposite intervention (Gooding et al. 2018), a sufficiently high staff/user ratio (Steinert and Hirsch 2019), different peer led initiatives (Foxlewin 2012), and trauma-informed practices (Arthur et al. 2013).

Despite these efforts, at least in Germany, a nationwide, mandatory documentary system to systematically evaluate coercive measures in mental health care is still lacking, notwithstanding more than 30 years of activism and political struggles for it. In only one federal state, Baden-Württemberg, with a population of 11 Mio., has such a dataset been established, due to strong user participation in the legislative processes and a genuine commitment by the then regional government to listen to them. The rare studies on the prevalence of coercive measures in Germany demonstrate a rather wide variance between 0.3% bis 17.5%, with a mean of 6.7 resp. 8% (Steinert et al. 2015; Flammer and Steinert 2019). Likewise, a valid and a robust set of data on this topic is missing internationally: For instance, the rates of involuntary admissions vary remarkably in Europe from 4.6 to 18%, depending on the legal frameworks or procedures (Salize and Dressing 2004). The use of coercive

measures varies too, mostly depending on societal attitudes and clinical traditions (Raboch et al. 2010). Additionally, a recent study found a higher rate in involuntary admissions to be associated with higher GDP and health-care spending, and larger numbers of inpatient beds (Rains et al. 2019).

Facing these disparities and the overall high prevalence of coercive practices both nationally and internationally, critique may be perceived to be justified, even more as coercive practices severely violate the rights to liberty and personal integrity. To sharpen this argument, and vice versa, it seems that any form of reproaching such criticism seems to be in desperate need of explanation: How could you not criticize or try to find alternatives to practices that infringe human rights, and which also seem to be insufficiently regulated so that they occur with a high degree of variance without the necessary understanding of the reasons that might explain this? An answer to this question will be attempted in the following, using a structural reasoning that, instead of targeting our (ways of) arguing, points at its reception, i.e., at the ways in which our argument may have been received. To clarify our arguments, we—as two psychiatric researchers that are fairly deprived of detailed theoretical knowledge—rather eclectically take two theoretical stances on the nature of criticism as a starting point to further develop our arguments, without claiming to have understood these theories-in-depth.

### 2.1. Critique-as-Praxis

In what follows, we will refer to a concept of criticism—critique-as-praxis as opposed to critique-as-a-judgement—that, in our view, could facilitate its adoption. This concept is based on our reading of two remarkable essays, one by Michel Foucault “What is critique” (Foucault 1978), the other by Judith Butler, dwelling on the Foucault’s essay years later (Butler 2004). Both contributions conceptualize critique as a practice (praxis) that aims to analytically understand the constituents that make up the world we live in. According to their grasp, the primary task of critique-as-praxis is not to evaluate whether its targets are good or bad, but “to bring into relief the very framework of evaluation itself” (Butler 2004). Thus, critique is perceived as an investigative enterprise that intends to decode the very nature of our social order. Deconstructing reigning discourses and constellations of power, it may serve the goal to better understand the various contingencies that bring forward our ways of being, acting and thinking.

In contrast to us, Foucault, and, in his footsteps, Butler are not concerned with the uptake or reception of criticism—their project is of a much larger scale. At the same time, both essays presented a highly constructive reading of criticism (to us). By rigorously scrutinizing what structures the world, alternative possibilities of ordering become visible. Only a profound analysis leads to new ideas and creative approaches, thus carrying enormous potentials for change. Further, both essays can be read as a useful counter-argument to an understanding of criticism as a form of (morally laden) judgement. They made us understand that conceptualizing critique as a judgement may preclude us from recognizing the informative value of criticism and its ultimate message. Possibly leading to feelings of shame, guilt, and embarrassment, understanding critique as a judgement, thus, hinders the opening-up of our senses to the meaning and “truth” that often reside within it.

Certainly, the presented understanding of critique has a moral and judgmental side to it, too. It is an inherently political reading of critique that, in the tradition of the Enlightenment, supposes a resistance to authority (Foucault 1978). In this view, critique begins with questioning the demand for absolute obedience. This results into a state in which any statement of authority no longer is taken to be true, but critically analyzed in relation to its origin and nature. Yet, Foucault and Butler make clear that criticism usually emerges in situations—also in our case—in which there is a “tear in the fabric of our epistemological web” anyway (Butler 2004), situations that are preceded by conflicts and incongruities. Perceiving critique-as-praxis in these situations must be taken as a major

chance, a project of liberation that enables new solutions, and more freed positions and possibilities of being in this world.

## 2.2. Critique as a Judgement

The reactions to our two previous papers reminded us in a threefold way of the typical reactions to the critique by survivors and users of psychiatry: (1) In both cases, critique is allowed only if the foundational basis of psychiatry as an institution is kept uncriticized; if not, critique is being renounced quite harshly or kicked into the field of antipsychiatry. (2) In both cases, the reactions often target the *how* of a critique, in the sense of how a critique has been applied, instead of the what, its message. (3) The responses to our previous papers involved a sort of identity politics that that we usually know only from situations, in which survivors and users of psychiatry express fundamental critique. This comparison is not to state that we are on the same page with the survivors here. Instead, it aims at clearing the way also for the criticism of the survivors and users that is so urgently needed for the making of alternative mental health care practices, especially in relation to coercive practices, in which they usually find themselves on the downside of power.

Coming back to the first comparison, we see a recurrent divide between phenomena that may be criticized without eliciting strong reactions and phenomena whose criticism leads to disturbance and trouble. For instance, a frequent critique of survivors of psychiatry concerns the detrimental long-term side effects of antipsychotics, that often are overlooked or attributed to other problems, such as lifestyle, lack of exercise, smoking, etc. A survivor of psychiatry may argue “you are killing us” or may use the term “torture” in relation to coercive practices (thereby following the report of the UN Special Rapporteur on torture, [United Nations 2013](#)). Both utterances touch on sacrileges (“doctors do more good than harm, they don’t engage in torture”), usually leading to strong reactions. Seemingly, our questioning of the psychiatry’s sovereignty to exert social control touched on such a sacrilege, disrupting its self-understanding and power. Yet, we may ask: Is that a problem of our criticism or rather of the nature of the phenomenon we criticized? We will attempt for an answer to this question in the conclusion of our manuscript.

Concerning the second comparison, survivors and users are often judged for the ways in which they apply critique ([Daya et al. 2020](#)). Vehement debates followed the publication of our previous papers, the opponents often becoming rather personal in their arguments, at times even losing their temper and turning out to be highly emotional. Apparently, there are topics that make it difficult to stay calm, as they relate to one’s own, often painful experiences or represent a serious threat to one’s self-understanding. Yet, in the case of the survivors’ critique, these reactions are often condemned or even pathologized as “bad manners”, “irrational”, “over-sensitive”, or “over-reactive”, usually leading to a demand for “tone policing” or a refusal to further communicate. We have observed this on numerous occasions: Users or survivors of psychiatry make their point loudly, as it concerns them directly. Psychiatry’s response is indignation at this way of arguing—and often the whole point is lost in the process. Such a tactic prioritizes the how over the what, thus, often silencing valuable insights that have the potential for change and transformation.

What is more, such a reaction denounces the one who criticizes as a valuable informant. Applied to our case, positioning our critique as “activism”, accusing us of nonconformism, and charging us with agitation resulted in denying the authority of our arguments. It negated their argumentative character, leading to their disqualification, without even the need to regard their content. Thus, framing critique to be activist can be used as a tactic to get rid of it, a phenomenon—and here is the third comparison—that often occurs in the case of the survivors’ criticism, too: Marking their claims and experiences to be activist or radical, the survivors are negated as knowledgeable subjects who have the right and ability to contribute valuable insights, leading to various forms of epistemic injustice ([Fricker 2007](#)). In a definitely less oppressive, but somewhat comparable way, the rejection of our reasoning had the intention—as we perceived it—to silence our argument, using a

formalist claim to muzzle criticism. This tactic certainly did not correspond to an act of epistemic injustice, but still led to a substantial devaluation of our contribution.

### 2.3. *How to Cope with Criticism*

Two years back, one of our psychiatrist colleagues published an experiential report in a politically left newspaper on how it feels to apply forced treatment and restraints. He wrote about his feelings of shame and guilt and about the ethical dilemma between acting out a law (he personally did not create) and having to deal with its harmful impact on the daily interactions in psychiatry. Again, the reactions to this article were highly controversial: Our colleague was accused of betraying or exposing the psychiatric guild in the public, his role was naturalized (“this is expected from a psychiatrist, if you are not able to cope, you may well choose another job”), and he was asked severalfold to refrain from future contributions alike.

Similarly, Chris Chapman writes in a very personal way about his experiences as a social worker in a treatment center for Aboriginal children in Australia, where he used physical restraints and confinement as part of his job (Chapman 2010). He describes in detail, how the hurting and oppressing of others gradually became something normal or acceptable to him. In the beginning, still struggling with it, Chapman was taught by the institution that coercion was an inevitable part of his job, an unfortunate one, but one “that comes with helping children who are damaged” (Chapman 2010). Week by week, he learned how to normalize and rationalize relations of power, how to legitimize and perpetuate oppression, and how to overcome his moral concerns with it. Gradually, alternatives became unthinkable, only until Chapman left this job, years later.

Given these ethically complex and (also to us!) painful questions, one deeply understands why there is such a shortage of personal accounts on how it is feels to apply restraints and coercion in psychiatry and as a psychiatrist—a shortage that is striking given that this question of how it feels is often asked by survivors or lay people if one talks about this topic. To our knowledge, only a scant dozen articles deal with this topic (Aasland et al. 2018; Bigwood and Crowe 2008; Bregar et al. 2018; Dahan et al. 2018; Morandi et al. 2021; Van Doeselaar et al. 2008; Husum et al. 2011; Kinner et al. 2017; Lepping et al. 2004; Marangos-Frost and Wells 2000; Molewijk et al. 2017; Raveesh et al. 2016; Nielsen et al. 2018), which from our point of view does not satisfy the underlying ethical problem. Facing this shortage, one may ask how both the authors mentioned above managed to confront themselves with their experiences, and write about them in public? How did they achieve to openly articulate how they contributed to perpetuating a system that also exerts coercion and control and their related feelings of shame and guilt, one of the authors even using the word “perpetrator” to designate his role?

In our view, taking critique as a (moral) judgement most probably was not part of this achievement. Instead, both authors took themselves as a case to elaborate on a larger, structural problem. In their essays, they make clear in how far their own actions were contingent to the logic of a larger institutional structure. Maybe this is meant with critique-as-praxis that we understand ourselves to be part of a social order that makes us act and think in certain ways. This social order has been made so natural that any criticism leads to highly emotional rejections and disturbed responses. This may occur even more, if the problematic effects of such social order are morally blamed on singular persons, individualizing guilt and responsibility to an extent that it becomes intolerable to them.

To be clear, our argument does not intend to victimize psychiatrists or other staff in psychiatric system: We all have agency, we all have a range of options to fill our roles in many ways and for different purposes. Yet, the vocabulary of deliberate intention or personal blame does not do justice to our everyday situation. Even more, it seems to close our view so that we no longer manage to confront our feelings and see the possibilities for taking responsibility. Thus, if we want to overcome or improve this system, we must focus on the structural problems of it. This is what we have tried with our two previous papers: We attempted to focus on the contingencies of an institution that is legally allowed to exert

social control and coercion, and on the consequences of this option on its daily practices and interactions.

To summarize, so far, we have argued that criticism of psychiatric coercive practices is justified, given the shortage of both national and international studies that explain their highly varying prevalence, and the fact that international bodies have characterized these practices as violations of human rights (Council of Europe Committee on Social Affairs, Health, and Sustainable Development 2019, several documents from the UN summarized in: (United Nations 2020)). Second, we attempted for some explanations for the disturbances that followed the publication of our two previous papers by drawing comparison to the situation of users and survivors, without claiming that we share the same situation, but to illustrate fundamental ways of reacting to structural criticism of psychiatry. Third, we presented an understanding of criticism that may facilitate its acceptance—critique-as-praxis—having the potential to pave the way for the implementation of more human rights-oriented changes within the psychiatric system. To do justice to such an understanding, in what follows, we will introduce a few practical options that may offer guidance on this way of transformation. Chosen for their heuristic value, these examples well demonstrate that change is possible, and can be embraced (instead of being resisted) once it is considered a gain and benefit.

### 3. Embracing Change

We know that it is not easy to be exposed to fundamental criticism that demands structural changes. Neither is it easy to convert a time-honored institutions' longstanding behaviors and routines. Psychiatry has developed in its way over years. It has dutifully taken up the responsibilities to exert control and coercion that had been transferred to it by society. It has fulfilled this duty assiduously and has certainly exerted itself during this process many times. Yet, in the meantime, this very society has changed, partly dramatically and often referring to human rights as a legitimation: Marginalized and discriminated voices are becoming more and more audible (De Sousa Santos 2014), violence is broadening as a concept (Haslam 2016), and hitherto ignored or unconceptualized forms of injustice and inequities are being increasingly exposed and indicted (Crichton et al. 2017). The world is changing. Values and attitudes are changing. Why should the mental health care system be spared?

The UN has tried to adapt to these societal changes and commissioned an extensive report on alternatives to coercion (Gooding et al. 2018). Equally, the Council of Europe has criticized the psychiatry's coercive practices vehemently, proposing alternatives to it, and strongly recommending their application (Council of Europe Committee on Social Affairs, Health, and Sustainable Development 2019). In this manuscript, we will focus on the recent efforts of the World Health Organization in this direction, on the QualityRights initiative from 2017 (WHO 2017) and the related work on a good practice document that collects non-coercive practice from around the world and examining the related resource implications and transferability. Thus, on the level of policy and supernational politics, change is not only strongly advised, but also underpinned with concrete proposals and programs. The conceptual direction seems clear, the question is how this change will arrive in practice?

In the following, three strategies are distinguished that may be undertaken to achieve and embrace change of coercive practices in mental health systems and services. This distinction follows the above-mentioned WHO QualityRights initiative, as summarized by Funk and Drew Bold (Funk and Bold 2020). The first strategy regards capacity building as a means to change the attitudes and practices of the stakeholders to better promote human rights of the user of psychiatry. The second strategy targets the transformation of the mental health care system and related services. The third strategy recommends aligning policy and law with the principles of the Convention on the Rights of Person with Disabilities (CRPD). In the following, each of these strategies will be touched upon

briefly, followed by national and international examples to make a little clearer how we may achieve the necessary changes of the mental health care practices.

### 3.1. *Strengthening Knowledge and Capacity*

In 2019, the WHO launched the QualityRights training program that aims at promoting human rights based mental health care systems and services (WHO 2019). This program was developed with broad participation from high- as well as middle- and low-income countries, from people with lived experience, practitioners and scholars in the fields of psychiatry, psychology, disability and human rights. The training material moves on from a traditional approach towards coercion (“permitted in certain exceptions”) towards practical non-coercive solutions. The guiding principles of person-centeredness, recovery-orientation, and human-rights adherence point towards community-based support systems, individual definitions of treatment goals, and a choice of treatment options, as well as the full enjoyment of rights, as it has been codified in the CRPD, especially the right to equal recognition before the law (Art. 12) and the right to liberty and security of the person (Art. 14).

The QualityRights manual aims at capacity building and at strengthening the knowledge of the mental health systems stakeholders. It aims at fundamental change of this system, intending to alter its structural foundation. This change is to be incremental, making its agenda a reformist instead of revolutionary one. Yet, the request of one of us (MZ) to the general assembly of the German Association for Psychiatry, Psychotherapy, and Neurology (DGPPN) to translate and recommend the training program, was publicly rejected by its executive committee, stating that the training content was not consistent with the rulings of Germany’s Federal Constitutional Court. Shortly before, as an answer to the same inquiry, the German ministry advised to obtain broad professional consensus first, as it were “aware of a critical discussion” within the field of mental health—an answer that took the ministry almost a year. Despite these obstacles, finally, the motion passed, as a vote was held on it among the members of the DGPPN, although the executive committee recommended not to support the motion. It remains to be seen how the DGPPN will implement this decision.

QualityRights has now been recommended by the World Psychiatric Association (WPA 2020) in a recent position statement on alternatives to coercion. WPA calls on psychiatrists to take an active role “in generating political will, developing evidence-informed policy, sharing experiences with colleagues in other settings, and advocating for the involvement of service users and their families and carers in policy-making”. Psychiatrists need to work with “health institutions . . . to shift professional, sectoral, and public norms surrounding the use of coercion in mental health services” (WPA 2020). This indicates that the task of finding alternatives to coercion has arrived within the psychiatric profession.

The second example aims at illustrating how human rights-oriented practices may be implemented on a trans-institutional level, gradually changing the mental health service culture of a region. The “open-door and no-restraint system of care for recovery and citizenship” of Trieste, Italy (Mezzina 2014) is a WHO collaborating center. The institution has transformed from an old-school asylum to a network of community-based and rights-based support services with a strong focus on recovery. Coercion has not disappeared completely but is at a remarkably low level (Sashidharan et al. 2019). Italy has the lowest rate of involuntary treatment in Europe (17/100.000 pop. in 2015), and within Italy, the Trieste-Friulia Region has the lowest rates in the country (Mezzina 2018). Mechanical restraint has been abolished in Trieste, and the service runs an open-door policy (Mezzina 2018). The Trieste network has consistently cooperated with the WHO and in a constructive dialogue transformed over the years. Despite political changes and financial constraints, the momentum to link in with the wider community and to “taking care of the social fabric” was maintained: “The organisation is based on 24 h CMHCs with a few community beds in each of them, a very small general hospital unit, a high number of social cooperatives and many innovative programmes in the area of recovery and social inclusion” (Mezzina 2018).

In 2021, WHO will publish a practice guidance document that will present information on community-based mental health services that promote human rights and the recovery approach (WHO 2021).

### 3.2. Transforming Mental Health and Related Services

The WHO QualityRights training manual contains an assessment toolkit that enables countries to assess their services against the standards derived from the CRPD. It further provides for a framework and guidance on how to transform these services in line with CRPD standards towards the promotion of more participation and autonomy of users, the change of power dynamics to enable more empowerment and supported decision making, also in the event of conflicts and perceived threats, and to better comply with person- and recovery-oriented principles and values. In the following, two further examples are given to illustrate possible ways in which human rights-based services may be implemented in the field of mental health. Thereby, an example of institutional transformation will be followed by a model for systemic change to make clear that alterations on a micro level often depend on those of society.

The first example stems from a user-led research program, aiming at changing the services culture at the Psychiatric Unit of the Canberra Hospital/ Australia (Foxlewin 2012). During the years 2008–2010, the episodes of seclusion decreased from 14.7% to 0.7%, following the implementation of so-called seclusion and restraint review meetings (SRRM), in which (ex) users and staff came together to jointly and closely examine every incident of coercion to find out what happened, what could have been done differently, or what is working for prevention. The most significant factor was the inclusion of the user voice in the meeting, allowing for stories of exclusion and emotional restraint to be shared and heard. Yet, also the personal involvement of the staff, the possibility for them to speak subjectively of their own experiences and personal affection—similarly to our above-mentioned colleague who shared his experience on how it feels to exert coercion publicly—led to a change of the service culture towards more compassion, humanity, and honesty; followed by a significant reduction of coercion within a rather short period of time.

The second example refers to a transformative process on a system level that has occurred during the past decades, both on a national and international level. As a model for incremental change, the psychosocial support and treatment for people with substance abuse disorders has been transformed extensively over the last 50 years. Alcohol- or drug-dependent persons in Germany have access to a wide range of services, ranging from social support, counselling, self-help, inpatient detoxification, day-patient or inpatient rehabilitation, to methadone or heroin programs or consumption rooms for drug addicts. Yet, all these options are based on the will and preferences of the person of concern, without exception and despite the fact that alcohol and drug addictions have a huge impact on health and life. Most of these options are based in the community and usually work with the individuals' current and changing treatment goals (recovery orientation). This has not always been the case, but has developed over the last decades, maybe following continuously changing attitudes within society towards addiction and substance abuse (Uchtenhagen 1998; Hall et al. 2012).

### 3.3. Aligning Policy and Law

The third area of work that WHO has targeted as part of QualityRights is the development of new mental-health-related laws and policy and providing a direction in which to formulate and implement them into national legal frameworks. They justify this strategy by their observation that one of the main barriers for complying with human rights standards in the field of mental health is the lack of clear legislation to do so. Beyond merely reforming stipulations that are related to coercive practices in the mental health care system, concrete political and legal directions are needed to provide for practical solutions and strategies for safeguarding and upholding the rights of people with psychosocial



disabilities and “for ending coercion and abuse in mental health” (Funk and Bold 2020, p. 73).

Noteworthy in this context is that Germany’s jurisdiction and legislation has moved forward in this direction on several occasions: In 2011 and 2012, the German Federal Constitutional Court and Federal Supreme Court ruled on coercive treatment in psychiatric institutions, stating that the existing laws were not in line with the German constitution. Henceforth, all federal state laws and guardianship law had to be changed to reflect these rulings. The criteria for coercive treatment were narrowed and procedural safeguards were introduced (Lincoln et al. 2014; Zinkler 2016)

As a further step to strengthen will and preferences as guiding principles in mental health law, in 2017, Germany introduced an additional condition for coercive treatment, demanding that the “compulsory medical measure complies with the will of the person in care, which must be observed in accordance with section 1901a” (Bundesgesetzblatt 2017). Effectively, this regulation stipulates that in order to treat a person against her will, a court of law must be convinced that the treatment is in line with a previously stated preference. This may be an advance directive specific to the current situation or a so-called “presumed will”: “The presumed will is to be determined on the basis of concrete indications. In particular, previous oral or written statements, ethical or religious convictions and other personal values of the person under care shall be taken into account” (Bundesgesetzblatt 2009, 2017, translation by MZ). Thus, the new law incorporates the concept of will and preferences from Article 12 of the convention into domestic legislation. Paradoxically, perhaps, the new regulation stipulates that treatment against the will of a person is only possible if it follows the will and preferences of the person. With few decisions challenged in court, it remains to be seen how this translates into day to day application of the law.

#### 4. Concluding Remarks

As clinicians in mental health services, who work in acute care settings, we are not the sort of critics that argue from the side-line. We have both administered coercive measurements or continue to do so. We are part of the very system that we criticize, having ourselves inflicted pain on our patients as we could not find solutions to situations of conflict other than exerting coercion. Yet, we are not content with this status-quo; we are affected by the unrest, shame, and guilt that resides within these situations, and the violation of human rights that is connected to them. For these reasons, we criticized a system in which coercive practices are permitted and sometimes demanded from us. We tried to be as analytical as possible with this criticism, by imagining alternative scenarios in which psychiatry’s legal obligations are separated from its therapeutic functions. Instead of personal blame, we pointed to the mode of ordering in our society that justify and lay the foundation for acting out coercive practices, and to their impact on the daily psychiatric interactions.

The German survivor researcher, Elena Demke, has shown in the newsletter of the German Association of Users and Survivors (BPE) in September 2019 how strongly the perspective on psychiatric coercion depends on the position one takes on it. If one takes a human rights position, a fundamentally different argumentation may follow than if one relies on a medical-psychiatric reasoning logic. These are two worlds with only a few contact areas to another, the former focusing on questions such as self-determination, will, and preferences, whereas the latter rather concentrates on capacities to consent, protection, and coverage. This points to the importance of taking on a human rights perspective towards psychiatric care, especially when it comes to the subject of coercion. Given the above-mentioned deficit of clear and reliable data that may explain the enormous differences in the use of psychiatric coercion both nationally and internationally, this imperative becomes even stronger.

Another thought came to our mind when further reflecting on the reactions to our two previous papers: Usually, the term fragility is applied to the people that ask for help in the (mental) health system in general (Diaconu et al. 2020; Rogers and Walker 2016).

What if we turn the wheel around and apply this term to the (mental) health care system that tries to condition this help-seeking to its inner logics and foundational structures? Psychiatry is contested as a system (Priebe 2016; Rose et al. 2018; Bracken and Thomas 2010), as it is the medical system in general (Gupta and Upshur 2012; Luhmann 1990). There are many reasons for this contestation ranging from critique of its lack of reflexivity (Cuthbert 2014), its lack of empirical legitimacy (Bracken and Thomas 2001), its normative foundations (Glas 2019), as well as its universal applicability (Bracken et al. 2016). What if the strong and emotionally laden discussions following our contributions were indices of a fragile system that has outlived its usefulness and is struggling for its *raison d'être*? Was the (perceived) threat to the system so great that this system had to respond aversively for fear of total collapse? If not, then why was it often so difficult to have a balanced, rational discussion on the arguments in our two previous papers? In the first part of our article, we drew comparisons with the usual responses to the criticism of users and survivors. Thereby, we did not intend to idealize their criticism or positions, nor did we imply, as mentioned, that we are in the same boat. The criticism of the survivors is usually devalued much more than ours, and their voices have been silenced for decades. Yet, it seemed to us that the defense mechanisms to our and their criticism are comparable, in both cases blocking the structural change of mental health care practices that is so urgently needed. This change cannot be dealt with as another topping to the same cake, as a quick fix, using just a further ready-to-hand intervention. Instead, a fundamental reorganization of the supportive infrastructures will be required, including major epistemological adaptations (Russo and Wooley 2020)—and expertise to do so. This is another reason for us to have referred to the psychiatric users and survivors: As they may contribute a long-standing expertise in these matters, having developed an extensive body of alternative, human rights-oriented approaches to support persons in psychosocial crises. Let us live up to our responsibility and listen to their and others' critique to pave the way for the necessary human-rights transformation of the mental health care system.

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