Symposium | Forensic Psychiatry：[Symposium 85] Coercion in mental health care: Working with partners to implement alternatives

Sun. Sep 28, 2025 10:40 AM - 12:10 PM JST | Sun. Sep 28, 2025 1:40 AM - 3:10 AM UTC Session Room 2 (Main Hall B)

[Symposium 85] Coercion in mental health care: Working with partners to implement alternatives

Moderator: Helen Herrman (University of Melbourne)

[SY-85]

Coercion in mental health care: Working with partners to implement alternatives

Kanna Sugiura[1], Helen Herrman[2], Samuel Law[3], Yoshikazu Ikehara[4] (1. National Center of Neurology and Psychiatry (Japan), 2. University of Melbourne (Australia), 3. Unity Health Toronto (Canada), 4. Tokyo Advocacy Law Office (Japan))

[SY-85-01]

From Control to Support: Shaping the Future of Involuntary Psychiatric Admission in Japan

*Kanna Sugiura[1] (1. National Center of Neurology and Psychiatry (Japan))

[SY-85-02]

Supporting alternatives to coercion in mental health care worldwide

*Helen Herrman[1] (1. The University of Melbourne (Australia))

[SY-85-03]

Do involuntarily treated psychiatric patients become accepting of treatment afterwards? - A scoping review

*Samuel F. Law[1], Deandra Osayande[1], Waverly Chan[2] (1. University of Toronto (Canada), 2. McMaster University (Canada))

[SY-85-04]

Roadmap to abolish involuntary hospitalizations and restore the dignity of persons with psychosocial disabilities by the Japan Federation of Bar Associations

*Yoshikazu Ikehara[1] (1. Tokyo Advocacy Law Office (Japan))

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Keywords：coercion、mental health care、alternatives、shared decision-making、collaboration、patient empowerment、policy reform

Coercive practices such as involuntary treatment, restraint, and seclusion remain common in mental health care and are often used to manage crises and ensure safety. However, these interventions can have long-lasting adverse effects, contributing to trauma, loss of autonomy, diminished sense of dignity and a distrust of services among service users. This symposium explores strategies that support alternatives to coercion in mental health care by fostering partnerships among mental health professionals, lawyers, service users, families, policymakers and communities.

Presenters will discuss emerging care models prioritising respect for rights and preferences. These models include shared or supported decision-making, peer support, staff training and safeguards built into the system. These approaches empower individuals to participate actively in their care and emphasise non-coercive, recovery-oriented practices. The symposium will feature case studies, research and organizational work demonstrating how collaboration across different sectors—mental health services, policymakers, and communities—can help create environments where alternatives to coercion are implemented and individuals are treated with greater compassion and respect.

Sessions will highlight the perspectives of mental health professionals, lawyers, and individuals with lived experience. They will show how training, support and new care models can promote healing without resorting to force or control. The sessions will also focus on policy reforms, community-driven solutions, and the need for cultural competence in responding to diverse needs.

This symposium aims to inspire fresh approaches to mental health care by showcasing successful alternatives to coercion and offering practical strategies that can be implemented in real-world settings. Attendees will leave with a deeper understanding of creating more person-centred care environments that emphasise empowerment, trust, and recovery.

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[SY-85-01] From Control to Support: Shaping the Future of Involuntary Psychiatric Admission in Japan

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Keywords：Coercion in psychiatry、Mental health law、Patient autonomy

Involuntary psychiatric admission remains an essential yet highly contested element of mental health care. While intended to ensure safety and provide necessary treatment during acute crises, it raises profound ethical and legal dilemmas regarding autonomy, dignity, and the risks of coercion.

Japan constitutes a particularly distinctive case. Despite being a high-income country, it maintains one of the highest levels of psychiatric bed provision globally, with average hospital stays far exceeding international norms. Involuntary admission occurs through iryō hogo nyūin (medical protection admission), which requires approval from a psychiatrist and a family member, or through sochi nyūin (compulsory admission by prefectural governor's order) in cases of risk to self or others. Both pathways operate with limited judicial oversight, often shifting responsibility onto families and entrenching long-term institutionalisation, while providing only weak safeguards for patient autonomy.

This presentation will examine Japan's legal and clinical frameworks for involuntary admission, with a focus on how reliance on long-term hospitalisation shapes service delivery and rights protection. While practices in other Pacific Rim countries—such as Korea's judicial review or Australia and New Zealand's tribunal and community treatment models—provide points of reference, the primary emphasis is on Japan's distinctive system.
The discussion will consider pathways for reform, including strengthening rights protections, expanding community-based alternatives, and promoting service innovations to reduce reliance on coercion while enhancing autonomy. Emerging models such as crisis resolution and home treatment teams, psychiatric advance directives, open dialogue approaches, and peer support offer promising directions. These approaches align with international standards, including the UN Convention on the Rights of Persons with Disabilities and the WHO QualityRights initiative, which advocate for supported decision-making and alternatives to coercion.

Ultimately, reducing coercion in Japan requires systemic transformation, robust community services, and regional collaboration to advance rights-based, person-centred mental health care.

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[SY-85-02] Supporting alternatives to coercion in mental health care worldwide

*Helen Herrman[1] (1. The University of Melbourne (Australia))

The World Psychiatric Association (WPA) advocates for a practical approach to implementing alternatives to coercion in mental health care. It adopted a Position Statement and Call to Action in 2020 that give special attention to provisions of the UN Convention on the Rights of Persons with Disabilities (CRPD). The WPA aims to continue promoting rights-based policies and practices through mutual support across its member societies in more than 120 countries. Collaborating with people with lived experience of mental health conditions and their families, and other government, research, and civil society groups is a pre-requisite for this process.
The call to action is relevant for people at all life stages and in all countries irrespective of resources available. Culturally sensitive changes to treatment and care including priority for early intervention and personalised care are needed in most places. Changes are needed to policy, laws, attitudes, human and financial resources, training and research, open access to data about coercive practices, and the readiness and capacity to work with people with lived experience and their families.

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[SY-85-03] Do involuntarily treated psychiatric patients become accepting of treatment afterwards? - A scoping review

*Samuel F. Law[1], Deandra Osayande[1], Waverly Chan[2] (1. University of Toronto (Canada), 2. McMaster University (Canada))

Keywords：Convention on rights of people with disability (CRPD)、involuntary hospitalization、involuntary treatment、capacity for treatment decisions、treatment acceptance

BackgroundThe UN Convention for the Rights of Persons with Disabilities (CRPD) - focusing on rights and not on capacity - advocates for the complete elimination of current mental health practices such as involuntary hospitalization, compulsory treatment, and substitute decision making. Controversies exist, as opponents believe this approach would render individuals, particularly those with severe mental illnesses who lack the capacity to make informed treatment decisions, much vulnerable as many of them would lack appreciation of their illness and necessity of treatment and elect to avoid treatment. Understanding how these patients view their involuntary treatment experience, outcomes, their long-term impacts, and if they later come to appreciate the treatment will help inform the reform mandated by the CRPD. This scoping review examines in particular the change in patients' views about their involuntary treatment.**Methods**The scoping review was conducted in accordance with the PRISMA ScR framework. Multiple platforms, including OVID, Embase, Journals@Ovid Full Text, PubMed, and Google Scholar, were utilized to search for pertinent articles. A total of 346 articles were retrieved across all databases using the keywords "("Involuntary admission" OR "Involuntary treatment") AND ("Retrospective views" OR "Retrospective Attitudes" OR "Patient Views" OR "Patient Attitudes")" and "("Involuntary admission" OR "Involuntary treatment") AND ("Retrospective views" OR "Retrospective Attitudes" OR "Patient Views" OR "Patient Attitudes")". After thorough full-text screening, 19 articles were selected.**Results**Research shows that, after initially found to be incapable and given involuntary treatment, 40 to 77% of these patients had positive attitudes toward their treatment afterwards. They came to appreciate their treatment and felt it was necessary once they regained their capacity. While many studies indicate that participants changed their views, there is limited research on the factors associated with these changes.**Conclusions**There is a diverse range of views about involuntary treatment, and such views do change after treatment, depending on factors such as capacity and overall experiences. Eliminating in voluntary hospitalization and treatment may lead to missing needed treatment for those who could benefit from it the most.

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[SY-85-04] Roadmap to abolish involuntary hospitalizations and restore the dignity of persons with psychosocial disabilities by the Japan Federation of Bar Associations

*Yoshikazu Ikehara[1] (1. Tokyo Advocacy Law Office (Japan))

Keywords：de-institutionalization、involuntary hospitalization、the Convention on the Rights of Persons with Disabilities、biomedical reductionism、roadmap

The features of the mental health system in Japan include huge numbers and long-term inpatients, and heavy use of medication and coercive measures compared with other OECD countries. It can be said that de-institutionalization has not begun yet, and mainstream mental health depends on biomedical reductionism. Italy and Japan seem to be upside-down. Japan ratified the Convention on the Rights of Persons with Disabilities in 2014. Japan Federation of Bar Associations adapted the resolution to abolish involuntary hospitalizations and restore the dignity of persons with psychosocial disabilities in line with the CRPD, and organized a task force to make it a reality. Our task force has developed a roadmap to achieve our goal, as required by the CRPD. Abolishing involuntary hospitalizations, promoting de-institutionalization, and protecting community living for persons with psychosocial disabilities cannot be accomplished overnight. We aim to reach a final stage by 2035, twenty years after the ratification of the CRPD. Some psychiatrists criticize JFBA's opinion, and the CRPD does not understand psychiatry. Now that WHO recommends rights-based, community-based, person-centered, and recovery-oriented mental health reform in line with the CRPD and proposes a holistic approach that embraces all social determinants, the requirements of human rights and mental health are consistent. Discussions on these controversial issues in Japan to date have been limited to theories. People who look in the same direction but have different opinions about how far they will reach have not started and walked partway together. They have spent all their time just discussing which goal is right. However, unfortunately, almost none of us have experienced a situation where there have not been vast numbers of psychiatric beds because we have kept those numbers of beds for over fifty years. Now is the time to start walking together based on the roadmap.