CoMHWA Position Paper – Coercion in Mental Health Services

Purpose

To end the practice of coercing consumers who engage with mental health services and supports.

The Issue

In the mental health system, consumers often face **pressures to follow particular treatments and medication, or to agree with diagnoses and other opinions put forward by clinical staff**. People experiencing mental health distress should be granted their universal human rights, including the right to have their autonomy respected, and freedom of choice in relation to medical treatment upheld.

Coercive practices can be present in all health services, facilitated by the power imbalance where medical professionals apply informal pressure through their recommendations. **Coercion impacts the free exercise of choice and control** made about what kinds of treatment and support a person might want, and **can manipulate people into complying with actions and opinions** that **they might rather decline** if they were offered a safe or genuine alternative.

The issue of **consumer coercion** in mental health settings is a **problem** that is **not simply limited to obvious displays of clinical power** such as **restrictive practices and involuntary admission** into hospitals, which are sometimes called *formal coercion*.[1] **Coercive practices** can be **undertaken by mental health professionals** less directly, whether they are aware of this or not, **in routine treatment** when consumers are seeking help and support. **These are called 'informal' coercion**, and can include:

Examples of Informal Coercion
• Making the ongoing care for a consumer depend on them agreeing to follow a particular course of treatment.
• Gatekeeping particular service options from consumers through suggesting that they 'may not belong [at a specific service]' and tacitly communicating disapproval.
• The use of implicit or veiled threats about more severe or 'escalating' responses (e.g. involuntary admission) if a consumer refuses a recommended treatment and is then deemed to be 'non-compliant' with the proposed course of action.
• Only assisting consumers with additional support, such as helping fill out forms for housing or NDIS applications, if a person agrees to follow the course of treatment that the clinical staff are recommending.

The practice of **informal and formal coercion stand at odds with the underlying principles of personal autonomy and choice** that informs the right to health in the International Covenant on Economic, Social and Cultural Rights[2]:

"The right to health contains…the right to control one's health and body…and the right to be free from interference… [such as] non-consensual medical treatment"[3]

Simply stated, consumers should be assumed to have capacity to make decisions when working with clinical staff to decide on a course of action in this therapeutic relationship.

Background

Practices of 'Formal' and 'Informal' Coercion

Consumers are often all too familiar with practices of *formal coercion*, such as involuntary admission to hospital, or the use of seclusion and restraint. However, there are other, less obvious practices that are sometimes used to coerce people into acting against their preferences in the context of mental health support.

These involves **actions that are intended to ensure a person complies** with a professional's advice, such as **staying in an inpatient setting, following a particular treatment path, or using a specific medication**. Researchers have identified four sequentially more serious forms of 'treatment pressure', escalating from attempts to explain and persuade people under care, to practices that are clearly coercive:[4]

Treatment Pressures
• **Persuasion**: The clinician sets out strengths of a treatment, offers information, answers questions, and listens to concerns. The person receiving care can choose whether to accept or reject this advice.
• **Interpersonal Leverage:** The clinician uses the personal relationship with the person receiving care as *leverage* to influence the decision-making process, indicating that compliance or non-compliance may impact existing goodwill and affect the therapeutic relationship the person has with their clinician going forward.
• **Inducement**: The clinician implies or suggests that the person receiving care will receive additional support or services if they agree to participate in the suggested course of treatment. Conversely, it may be implied that additional supports or services may be *withheld* if the person refuses to comply with a clinician's recommendations.
• **Threats**: The clinician suggests that important services or supports will be withdrawn if the person receiving care does not comply with the clinicians' proposed treatment; the clinician may also mention that the use of involuntary hospitalisation will be considered if the person is 'non-compliant'.[5]

Power Imbalance in the Context of Persuasion

Addressing informal coercion through policy or legislation is going to require data, currently often **unrecorded**, about coercive practices which would then allow for regulation of these practices and

transparent oversight. There can be **no transparency** when many incidents of coercion are, by their very nature, **informal and not subject to any level of monitoring and review**. Mapping the problem of informal coercion that consumers are subjected to is a difficult task—there are few straightforward paths to measure these practices, clinical staff have no duty to record many of these kinds of communication, and attitudes of both consumers and clinical staff can view coercion as merely a feature of regular treatment.[6]

In other words, a key problem with addressing coercion of consumers is that the practice of coercion can operate as a **tacit or hidden pressure** that is not immediately obvious, and does not need to necessarily be explicitly stated.

The ubiquitous nature of coercion in mental health services means that transparency about coercive practices is critically important. This transparency should include definitions of what constitutes coercion, accessible rules and regulations about when or if coercive practices can be undertaken by staff, and the rigorous and consistent recording of coercive actions in medical records.

Power and Persuasion

Some academics make the case that persuasion should not be understood as coercive in the context of clinical activities.[7] However, this overlooks the reality that persuasion—in the clinical context—Is undertaken in the context of a **power imbalance** between consumers and clinicians. Power imbalances can lead to the self-censorship of consumers who feel that their continued support requires keeping their supporting clinician 'onside' and satisfied.[8]

As a result of this power imbalance, consumers sometimes feel that persuasion around treatment contains implicit threats or consequences if they do not agree, irrespective of whether this is intended by medical staff. Considering that health services are tasked with promoting individual autonomy around healthcare choice and control, clinicians should be aware that persuasion may either be, or be perceived as, an informal coercive practice.

Inpatient Settings: Voluntary in Name Only (V.I.N.O.)

A ongoing concern raised by consumers is the **practice of coercing people who are voluntary inpatients at psychiatric hospitals to stay in this setting by 'warning' consumers that, if they leave, they will be made involuntary** through the provisions of Part 6 the Mental Health Act (2014).[9] However, there is no opt-out advocacy (delivered through MHAS) automatically connected to voluntary consumers, and accordingly there is a lack of oversight for consumers who may be informally coerced into accepting their treatment arrangements against their wishes. Paradoxically, in these instances, **coerced 'voluntary' consumers *may have fewer rights and oversight of their care* than a person who is admitted in an involuntary capacity**. This example of coercion highlights the way that coercion can operate hidden from view of reportable data and serves to limit the autonomy of consumers who have already taken steps towards seeking help.

It is important to note that, in a recent report on human rights conducted by the *National Mental Health Consumer Alliance*, **27% of survey respondents agreed to treatment out of fear of being subjected to involuntary treatment, and that 52% of respondents chose not to seek support to avoid coercive practice in inpatient units**.[10] This demonstrates the corrosive impact of coercive practices in mental health settings; offering evidence that consumers are often pressured into

treatment in the shadow of involuntary care, and dissuaded from seeking support because of the prevalence of coercion in inpatient settings.

What has been done

The issue of **consumer coercion** when seeking mental health support is an issue that, to date, has **not been adequately identified or addressed** directly by either the state government or other institutions involved in overseeing the delivery of mental health care in WA. This is demonstrated by the **lack of processes in place to capture data** about coercive practices, or to encourage consumers to share their specific experiences of both formal and informal coercion.

However, positive steps towards addressing the coercive practice of 'VINO' (outlined above) are set to arrive in the changes stemming from the review of the WA *Mental Health Act*. It is currently recommended that the revised *Act* (set to be brought before parliament in late 2026) includes a requirement for consumers in a voluntary inpatient setting to be informed of their *lawful right* to leave these locations both verbally and in writing upon admission, albeit alongside a discussion of the circumstances in which an involuntary order may be applied. This change represents movement towards transparency in inpatient settings, and ensuring that coercion does not fester in these settings without oversight. It is, however, important to note that CoMHWA opposes all forms of involuntary psychiatric treatment unless this provision is specifically requested by a consumer.

Shared Decision Making

It is also important to highlight that **coercive practices do not align with the principles of Shared Decision Making**, whereby clinical staff and consumers come together to discuss and decide upon a course of treatment *collaboratively*. Shared Decision Making is a crucial aspect of person-centred care, as outlined by the National Safety and Quality Health Service Standards.[11] The rigorous **adherence to the principles of Shared Decision Making** is one way for clinical staff to **avoid informal coercion** when trying to advise a consumer about a particular course of treatment. Practices of informal coercion are antithetical to genuine Shared Decision Making, preventing meaningful collaboration between services and consumers, while also perpetuating the dehumanised treatment of those who attend these services seeking support.

CoMHWA's Position

- CoMHWA is firmly **opposed to any practice of coercion exercised against consumers**, regardless of whether this is formal or informal coercion. The use of **interpersonal leverage, inducement, or threats** against consumers is **unacceptable** and prevents genuine Shared Decision Making.
- CoMHWA strongly **believe in the right to autonomy, self-determination, and the dignity of risk for consumers**, and oppose all practices that subvert, ignore or breach these rights. We call on all services to commit themselves to ensuring that consumers are supported by being made aware of their rights in a transparent and accountable fashion.
- CoMHWA believes that there must be **mandatory education about informal coercion provided to all clinical staff in mental healthcare** settings, and moreover that legislative

instruments should compel the recording and monitoring of informal practices of coercion in these environments.

- CoMHWA believes that **all incidents of coercion, both formal and informal, must be subject to mandatory reporting requirements in order to gather data around the frequency of this practice**. Furthermore, consumers leaving inpatient services should be provided with exit surveys that ask about potential experiences of informal coercion, supplemented with clear examples of these practices to facilitate understanding of how coercion can appear.
- CoMHWA holds the view that more **attention should be applied to complaints that relate to practices of informal coercion**, and that HaDSCO and other appropriate bodies should ensure that **investigations of these complaints are thorough**, in order to account for the subtle manner in which much informal coercion is practiced and general absence of records relating to these practices.

Getting Involved

If you would like to inquire about ongoing actions and advocacy around this issue, please feel free to get in touch with our Systemic Advocacy team at sysadvocacy@comhwa.org.au.

[1] Potthof et al. (2022) '"Voluntary in quotation marks": a conceptual model of psychological pressure in mental healthcare based on a grounded theory analysis of interviews with service users.' *BMC Psychiatry*, 22:186, p. 2 https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-022-03810-9

[2] International Covenant on Economic, Social and Cultural Rights (1966) https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

[3]International Covenant on Economic, Social and Cultural Rights. (2000). *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health*. https://humanrights.asn.au/ICESCR/GeneralComment14#

[4] George Szmukler (2008) Treatment pressures, coercion and compulsion in mental health care, *Journal of Mental Health*, 17:3, pp. 229-231. https://www.researchgate.net/publication/247508236_Treatment_pressures_coercion_and_compulsion_in_mental_health_care

[5] *Ibid.*

[6] Valenti, C. Banks, E. et al. (2015) 'Informal coercion in psychiatry: a focus group study of attitudes and experiences of mental health professionals in ten countries' https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7521205/pdf/nihms-1598948.pdf

[7] Szmukler, G. (2024). "Treatment Pressures" and "Informal Coercion": "Threats" in Mental Healthcare. *American Journal of Bioethics*. 24:12, pp. 89-91.

[8] Christin Hempeler et al. (2024) 'When Treatment Pressures Become Coercive: A Context-Sensitive Model of Informal Coercion in Mental Healthcare', *The American Journal of Bioethics*, 24:12, pp. 74-86. https://www.tandfonline.com/doi/full/10.1080/15265161.2024.2416148

[9]*Mental Health Act 2014* (WA) pp. 21-62 https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13534_homepage.html

[10] National Mental Health Consumer Alliance. (2025) 2024 *Human Rights Report*. https://nmhca.org.au/__static/jdj5jdewjes5chi2z1zwa1fvvwnyrlcw/2024-human-rights-report-final.pdf

[11] https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making