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Structural Racism and Its Influence on Coercive Practices in Mental Health Care

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Abstract

Within debates on mental health ethics, it is typically taken for granted that coercive interventions can be warranted when individuals with psychiatric conditions pose a risk to themselves or to others. Such actions are usually defended only when specific moral requirements—such as the proportionality of the intervention to the anticipated harm—are met. In this article, we argue that this widely accepted evaluative approach is insufficient in contexts where individuals with mental illness are exposed to structural racism. Using a clinical vignette from mental healthcare, we illustrate how judgments about proportionality can be distorted, including through inflated assessments of dangerousness shaped by racialized assumptions. We further contend that even when a proportionality judgment appears accurate and the intervention would be considered ethically legitimate within the conventional framework, the use of coercion can remain morally troubling. This is because the prevailing model does not interrogate the broader social and institutional conditions that give rise to coercive encounters. When structural racism plays a causal role in creating the circumstances in which coercion is enacted, such interventions risk reinforcing and intensifying pre-existing racial injustices. We therefore argue that ethical evaluations of coercion in psychiatric settings must attend to the potential for discriminatory bias and must explicitly integrate the ways structural inequities shape both clinical reasoning and the situations in which coercion occurs.

Keywords: Minority groups, Ethics- Medical, Coercion, Psychiatry

Introduction

Practices such as seclusion, mechanical restraint, and involuntary admission continue to be routinely implemented in psychiatric settings [1]. A central concern within mental health ethics is to determine whether coercive interventions can ever be justified and, if so, to delineate the circumstances under which they meet ethical requirements [1]. In this paper, we highlight an element that has received comparatively little systematic attention in these ethical debates: the extent to which structural racism shapes when and how coercion occurs in psychiatric care [2].

Recognition is growing that institutional forms of racism influence both who gains access to mental health services and the type of treatment they receive [2–4]. Empirical studies consistently show that Black patients face disproportionately high rates of compulsory psychiatric admission compared with their White counterparts [3, 5], and, once hospitalized, they encounter mechanical or physical restraint more frequently [6]. Because coercive interventions can inflict substantial psychological trauma and physical injury—sometimes resulting in death [7 8]—their use demands exceptionally robust ethical scrutiny.

In this article, we argue that the conventional ethical framework used to justify coercion in situations where a person with mental illness is thought to present a threat to others is inadequate when racist discrimination is part of the clinical context. To make this case, we analyse a

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fictional scenario from mental healthcare using the commonly applied ethical criteria for determining whether coercion is justified in circumstances involving risk of harm to others. We show, first, that racial bias can distort assessments of proportionality—for instance, by encouraging an exaggerated perception of dangerousness—which can undermine the correct application of the framework. Second, even if the criteria are applied accurately, the framework fails to interrogate the processes and social structures that produce the very situations in which coercion is used. We argue that ethical evaluation should explicitly consider structural racism, especially when coercive actions intensify or add to harms rooted in discriminatory treatment.

Our discussion draws primarily on German psychiatric practice, reflecting our familiarity with this context and acknowledging that coercive practices and their social meanings are embedded in particular sociopolitical histories. Nonetheless, the analysis may be relevant for other healthcare systems. Recent national data indicate that experiences of anti-Black racism in German healthcare are widespread [9], yet research on racism in Germany remains limited, partly because racial categories are not systematically collected in medical datasets. Consequently, where appropriate, we refer to empirical findings from the USA and UK [10, 11].

A case example and standard ethical analysis

Consider the following hypothetical scenario [4]:

David, a 23-year-old Black man living with psychosis, is voluntarily admitted to a psychiatric hospital in Germany. During his stay, he reports feeling that staff devote less time to him and treat him with less respect than other service users. Several staff members describe feeling uneasy when interacting with him alone and characterize him as intimidating; one nurse comments on having difficulty establishing rapport. One morning, after an increase in his antipsychotic medication, David refuses the new dose. He states he was not informed of the change and requests to speak with a physician. Staff tell him he must wait until the next ward round and offer a sedative to help him "calm down." David raises his voice, insisting that he will not take any medication until he has spoken to a doctor. The situation escalates: he moves quickly toward the staff in an apparent attempt to leave the room. Interpreting his actions as a sign that he might harm others if he exits in this state of anger, the staff place him in mechanical restraints.

In Germany, prolonged mechanical restraint, involuntary admission, and forced medication fall under state mental health legislation and require court authorization. Mechanical restraint is the most frequently used form of coercion, followed by seclusion [12], and continuous one-to-one observation must be provided throughout the period of restraint [13].

For the purposes of this analysis, we assume—as many mental health ethicists do—that coercion may sometimes be justified when an individual poses a credible risk of harming others [14]. These interventions are often defended with reference to Mill's harm principle, which permits restricting a person's liberty to prevent harm to third parties [14, 15]. Clinical staff may also have professional obligations to safeguard other patients, meaning that the duty to protect others' safety can, at times, supersede the obligation to respect a service user's autonomy [14].

Ethical justification for coercion is generally tied to compliance with a set of criteria [2, 16]. For instance, Gather *et al*. argue that a coercive intervention is permissible only when it is an effective means of eliminating the risk posed, when no less restrictive option exists, and when the intervention's harms are proportionate to the seriousness of the anticipated risk [13]. German mental health law embeds these requirements as well [17]. The Bavarian Mental Health Act, for example, permits involuntary hospitalization only if no "less drastic means" can mitigate the risk (least-restrictive-alternative requirement) and only if the intervention does not create a burden disproportionate to the intended protective benefit [18].

Applying these standards to David's case: staff interpret him as presenting an immediate threat of physical harm. Mechanical restraint is viewed as an effective strategy to neutralize that threat. Since offering sedative medication had already failed to de-escalate the situation, restraint appears to be the least restrictive option available. The measure also seems proportionate: given the perceived risk to staff and others, temporary restraint appears to match the severity of the danger.

Under this conventional ethical evaluation, the coercive action appears warranted. Yet, as the forthcoming sections illustrate, we argue that this assessment remains incomplete.

Proportionality criterion

The proportionality requirement evaluates whether the likelihood and seriousness of the harm that a coercive

intervention aims to avert justify the harm caused by the intervention itself. A coercive action is deemed permissible only when the burden it imposes is not excessive in comparison to the risk it seeks to prevent [13].

In this section, we show that when structural racism shapes clinical interactions, two systematic distortions can arise during proportionality assessments: (1) staff may inflate the perceived probability or severity of the danger, and (2) staff may diminish the perceived harm that the coercive measure inflicts on the individual subject to it.

Biases—whether consciously endorsed or unconsciously held—are associations linking certain social groups (eg, racial, gendered, or ability-based categories) with particular characteristics or emotional reactions [19]. Implicit biases operate automatically and often without awareness, learned through socialisation. Research shows that healthcare professionals display levels of implicit racial bias comparable to those of the general population, including more favourable perceptions of White service users and more negative assumptions about Black individuals. These biases influence communication, diagnosis, treatment decisions, and ultimately patient outcomes [20, 21].

The fictional case provides several clues that staff responses to David may have been shaped by such biases. Labelling him "intimidating" or noting "difficulties connecting with him" suggests that racialised and gendered stereotypes may have influenced how staff perceived him.

Multiple types of bias can distort danger assessments in psychiatric contexts [22]. First, findings from German research indicate that male patients are viewed as more aggressive than female patients and consequently experience longer durations of coercive intervention—even though women were approximately as likely to harm others and, in some instances, committed more serious assaults [23]. Second, racist stereotyping is well documented: Black men are frequently and incorrectly associated with heightened threat and dangerousness [24 25]. Third, stereotypes linking severe mental illness—particularly psychosis—to violence persist, despite substantial evidence showing that such predictions cannot be made reliably [26, 27]. Keating argues that when racism, sexism, and mental illness stigma intersect, a compounded figure of the "mad Black man" emerges—someone presumed dangerous simply by virtue of this intersectional identity [28].

The influence of bias is especially pronounced under conditions of stress or urgency [29]. When staff feel at risk and must make rapid decisions, the likelihood that implicit assumptions will guide judgments increases. Situations involving perceived imminent danger therefore create ideal conditions for biased overestimation of threat.

In David's case, these intersecting biases—racial, gendered, and related to psychosis—likely contributed to staff perceiving him as more dangerous than he actually was. This inflated perception of risk may have amplified estimates of both the probability and seriousness of the supposed harm. One can imagine that had the agitated patient been, for instance, a White female university professor demanding clarification about her medication change and attempting to leave the room, the same behaviour would likely have been interpreted less alarmingly.

A second distortion concerns the evaluation of how harmful the coercive measure is for the individual subjected to it. In the USA, Black patients continue to receive inadequate pain management, partly due to false beliefs among medical trainees and practitioners about biological differences in pain sensitivity between Black and White people [30]. Although similar dynamics have not yet been empirically documented in the context of coercive psychiatric measures, it is plausible that comparable underestimation occurs when assessing the harm of coercion for Black service users [31]. Staff judgments about the acceptability of coercion also depend on personal closeness or affinity with patients [32], meaning that racial bias can subtly depress concern about the harm experienced by those from marginalised groups.

In reality, coercive practices may produce greater harm for Black service users than for others. Black communities have historically borne disproportionate exposure to trauma and violence, heightening vulnerability to retraumatisation [33]. Moreover, psychiatry has played a role in pathologising and oppressing Black populations [34], contributing to distrust of mental health services and delays in seeking help [35, 36]. Coercion may therefore deepen existing mistrust and magnify prior harms.

Applying this to David, staff may have both overstated the danger he posed and understated the severity of the coercion's impact on him. This combination effectively lowers the threshold for deploying coercive interventions. If proportionality requires a substantial

risk of significant harm before coercion is ethically acceptable, then such biased judgments mean this requirement was not met in David's case. Under the standard framework, the intervention therefore would not be ethically defensible.

We maintain that the proportionality criterion is conceptually valuable for distinguishing ethically permissible from impermissible coercion. However, its vulnerability to discriminatory bias means that coercive measures are more readily—and incorrectly—judged permissible for Black service users. To strengthen ethical evaluations, we propose adding a safeguard question to accompany proportionality assessments:

Considering the service user's intersectional social identity, is there a reasonable possibility that staff overestimated dangerousness OR underestimated the harm of coercion?

A "yes" answer indicates that the proportionality judgment is likely compromised and must be reconsidered. This safeguard incorporates awareness of how multiple systems of oppression—racism, mental illness stigma, cis-heteronormativity, ageism—intersect [6]. In David's case, such an intersectional lens identifies how gendered racism and mental illness discrimination interacted to skew risk perception.

Developing structural competency [37] and completing implicit bias training may support clinicians and ethics evaluators in applying this safeguard effectively, though further research is needed to assess the impact of such interventions [38]. Such training would be beneficial for anyone tasked with evaluating the ethics of coercive psychiatric practices.

Insufficient consideration of context

Although the earlier analysis suggests that the mechanical restraint in the case likely failed to satisfy the proportionality requirement, one could still imagine a scenario in which staff correctly judged that David posed a genuine risk of physically harming others, and that mechanical restraint was an appropriately proportionate response. Under such an interpretation, the coercive action would be considered justified within the usual ethical framework.

However, even if we grant, for argumentative purposes, that David truly was dangerous and that all the standard justificatory criteria were fulfilled, we contend that the intervention could still constitute a moral wrong. This is because the dominant ethical model does not take into account how the circumstances that give rise to coercion are shaped by earlier experiences of injustice.

A substantial body of empirical research demonstrates that racialised service users frequently report harmful and alienating interactions within mental healthcare, which they commonly attribute to their marginalised social positions [9, 39–43]. Reported discriminatory practices include dismissive or disrespectful language, minimisation of concerns, inadequate attention to expressed needs, and exclusion from decisions about treatment. Additional studies show that many clinicians have limited knowledge of racism and therefore fail to detect discriminatory behaviour or minimise accounts of discrimination when service users raise them. From the standpoint of marginalised users, these experiences deteriorate trust, damage the therapeutic relationship, and degrade the quality of care. Service users report emotional responses such as anger, fear, and frustration. These forms of discrimination also undermine the collaborative treatment planning and shared decision-making processes that help prevent coercion [44].

In the case described, restraint was used because David became angry and aggressive. Yet his anger appears to have been provoked by staff refusing to provide information about a medication change—a perfectly reasonable request—and by a broader pattern of receiving less attention and respect than other patients during his hospital stay. Given extensive evidence of institutional racism in mental healthcare, it is plausible that this differential treatment reflects racialised discrimination, a possibility reinforced by the nurse's comment about difficulty "connecting" with him. David's anger, then, may have been an understandable reaction to inadequate and discriminatory care. In the setting of a psychotic disorder, such anger can escalate into violent behaviour [45]. Thus, even if David did present a danger, that danger may have arisen directly from the discriminatory treatment he experienced. In other words, had he been treated with equitable care from the outset, the situation requiring restraint might not have materialised. Racist discrimination therefore played a causal role in the chain of events leading to coercion.

To analyse this, the concept of compounding injustice is illuminating [46]. Hellman argues that an actor compounds injustice when two conditions are met: (1) the action engages with or relies upon circumstances that themselves resulted from an earlier injustice, and (2) the action intensifies that injustice by inflicting further harm on the person already disadvantaged.

Hellman illustrates this through the case of a woman who, after experiencing intimate partner violence, faces higher life insurance premiums because her risk of mortality has increased. The risk assessment may be factually accurate, and insurance companies routinely charge higher rates to individuals with elevated risk. Nonetheless, using the consequences of abuse as the basis for increasing her financial burden both builds upon and worsens the original injustice: she suffers not only the harms of the violence itself but also new, financially punitive harms.

Applying this framework to David, mental health professionals (1) relied on the fact that David was angry and aggressive—emotional states plausibly rooted in discriminatory treatment—as grounds for using coercion. They (2) compounded this earlier injustice by subjecting him to an additional harm: the coercive intervention. Even if restraint satisfies proportionality within the standard framework, the harm it causes becomes morally tainted when it is a downstream effect of racist discrimination. The coercive act thereby carries the original injustice forward and magnifies it.

Hellman maintains that actors have a moral duty to avoid compounding injustice, regardless of who is responsible for the initial wrongdoing. By engaging with and exacerbating the consequences of earlier discrimination, an actor becomes partially accountable for intensifying the harm. This constitutes a strong moral reason to refrain from such actions.

Consequently, the providers in this case face two conflicting ethical demands. They are obligated to protect others from serious harm and are, on the basis of the harm principle and usual criteria, seemingly permitted to restrain David. Simultaneously, they hold a moral obligation not to perpetuate or worsen injustice. If restraining David compounds injustice, then this obligation counsels against restraint. The situation thus resembles a genuine moral dilemma—where an agent is required to perform two actions, is capable of performing each, but cannot fulfill both simultaneously. In such circumstances, the agent appears destined for moral failure [47].

One might claim that this situation does not represent a genuine ethical conflict, arguing instead that the responsibility to prevent harm to others outweighs the responsibility to avoid reinforcing injustice. Hellman maintains that the duty not to deepen existing injustices can be overridden when stronger moral responsibilities arise [48], and in acute psychiatric contexts—where staff must act rapidly to stop imminent physical harm—it may initially seem reasonable to treat harm prevention as such an overriding obligation.

However, we argue that the duty to avoid compounding injustice is equally weighty, particularly given the profound and measurable consequences of structural racism, which includes widespread physical harm. In 2022, for example, the life expectancy of Black individuals in the USA was five years shorter than that of White individuals [49]. Structural racism shapes health outcomes through repeated exposure to discriminatory encounters and through inequitable access to opportunities, resources, and protections [50, 51]. Racism is also identified as a factor contributing to psychotic, substance use, and affective disorders [52]. Therefore, when comparing the obligation to protect third parties from immediate harm with the obligation not to reinforce injustice rooted in racism, the cumulative and life-shortening effects of racism must be acknowledged. Given this fatal impact, alongside the special professional commitment healthcare workers have to safeguarding the health of service users, we maintain that the duty not to exacerbate injustice cannot be cast aside easily.

This demonstrates that the conventional ethical criteria for evaluating coercion are inadequate for a full moral assessment. These criteria focus narrowly on assessing specific interpersonal interactions while ignoring the structural and institutional conditions that bring those interactions into being. Since racism and other forms of oppression operate at institutional and organisational levels within mental healthcare, an exclusive focus on individual actions falls short.

This indicates a broader limitation within mainstream approaches to mental health ethics. Ethical reflection should extend beyond individual encounters to question how healthcare and social structures must be organised to prevent discriminatory practices and to ensure that practitioners can fulfil their duty not to intensify injustice. This point has been made within Black bioethics, which analyses how structural systems of inequality—including racism—shape both bioethical theory and clinical ethics [53–60]. Yet these insights have not been fully integrated into dominant bioethical discussions [61]. In Germany, they remain largely absent from mental health ethics discourse and are not reflected in clinical guidelines addressing coercive measures [44]. Our analysis therefore aims both to draw attention to racism within the German setting and to broaden the

international discussion by linking Black bioethics with mental health ethics.

Conclusion

This paper has shown that the standard criteria used to ethically assess coercive measures are (1) vulnerable to racist biases and (2) insufficiently consider the influence of past injustices on situations where coercion is implemented. In contexts of racial discrimination, judgments about whether a coercive action is proportionate to potential harm are likely to be skewed. We therefore propose augmenting the proportionality criterion with an additional safeguard question. Nonetheless, even when the proportionality requirement is met and a coercive intervention would be deemed ethically permissible under conventional frameworks, its application may still exacerbate injustices stemming from prior discrimination. To properly address instances where racism directly shapes the circumstances of coercion in mental healthcare, ethical evaluations should incorporate considerations of broader social structures. Although our analysis is situated in the German context, it is adaptable to other settings experiencing comparable patterns of structural injustice.

Such coercive measures are also referred to as formal coercion, in contrast to informal coercion such as threats [62]. In the following, we will use the terms ‘coercive measures’ and ‘coercion’ interchangeably to refer to instances of formal coercion.

Taking a social constructivist stance, we understand racism as an oppressive system in which people are racialised if they occupy a social position of relative subordination or privilege, and if they are ‘marked’ in this system based on bodily features associated with presumed ancestral links to a certain geographical region [63].

Different terms are used to refer to people who use mental healthcare services, such as ‘patients’, ‘consumers’, ‘survivors’, ‘service users’ or ‘clients’. We use the term ‘service user’ that was developed within the service user movement [64]. We acknowledge that some people may prefer other terms for themselves. We capitalise the term ‘Black’ to highlight that it refers to a social position and to acknowledge its use as a political self-identification. We choose to also capitalise ‘White’ to highlight White as a social position and avoid framing Whiteness as a neutral standard [65, 66]. While our analysis may also apply to other racialised groups, we focus on Black people in this paper.

The case example is informed by our own experience within mental healthcare, empirical research on racism in psychiatry and healthcare more broadly, as well as media reports.

Translations by the authors.

Intersectionality is rooted in Black feminist scholarship and activism, see Crenshaw [67] and Hill Collins [68].

We acknowledge that some reject the possibility of moral dilemmas.47 For those, it would be necessary to give reasons why one of the obligations overrides the other, and our analysis would still be relevant to this question.

An in-depth discussion of the providers’ moral responsibility in this situation is beyond the scope of this article. Individual responsibility for structural injustice is a complex issue that has been discussed elsewhere, for example, by Young [69, 70], Russell [56] and Liebow and Riede [71].

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