



"They Don't Know About Suffering": Reasons from Physicians and Users for the Use of Coercion After a Suicide Attempt in Latin America

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Abstract

The use of coercive practices worsens recovery processes in mental health. These practices have various forms of presentation that must be identified to incorporate a rights-based approach into care processes. The aim was to describe and analyze the reasons perceived by physicians who employed coercive practices and by the individuals on whom these practices were employed, following a suicide attempt in Caldas, Colombia, in 2023 and 2024. A qualitative, transversal, and descriptive research design was used. Data collection was conducted in two phases: in-depth interviews with individuals who had attempted suicide were carried out between January and December 2024, and interviews with healthcare professionals were conducted between November 2024 and January 2025. A total of 30 participants were included, all of whom had attempted suicide and for whom coercive measures had been taken at a clinical level. In addition, 22 medical professionals who treated one of the 30 participants during their suicide attempt were included. Through content analysis, the interviews were divided into two themes. The first, based on interviews with individuals who had attempted suicide, was titled *Reasons perceived by people using health services after a suicide attempt* and comprised three categories: *Lack of knowledge*, *Lack of willingness to help*, and *Obligation*. The second theme, *Reasons perceived by medical professionals*, comprised categories such as *Coercion as a primary resource*, *Coercion in medical training*, and *Coercion as medical protocol*. Coercive measures, even though they are protocolled by health professionals, cause great suffering and hinder the recovery of people who have experienced coercive practices in mental health.

Keywords Suicide attempt · Coercion · Human rights · Mental health services

Introduction

The mental health crisis is growing worldwide, so transforming practices, especially regarding the adoption of a human rights-centered approach, is essential (Patel et al., 2023). The functions of mental health services consist of providing

care and treatment in a safe environment that promotes recovery and enables therapeutic growth, always based on respect for human dignity and the promotion of the fundamental right to autonomy and respect (Hallett et al., 2024).

This implies that coercive actions must be restricted (Castro Garcia, 2024). This focuses attention on coercion as it transgresses fundamental human rights and ethical principles of healthcare, such as autonomy, freedom, decision-making capacity, and physical integrity (Chieze et al., 2019). Furthermore, it has been associated with physical harm (Newton-Howes, 2013), adverse events such as heart problems, intense sedative effects (Muir-Cochrane et al., 2020), psychological impacts such as shame and guilt (Au et al., 2022), lower satisfaction with treatment (Sampogna et al., 2019), and post-traumatic stress (Herrera-Imbroda et al., 2025).

The United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006) established that the

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rights of people experiencing mental health problems must be respected. However, there are difficulties in implementing participatory and rights-centered approaches (Muusse et al., 2022). For example, mental health professionals may attempt to influence the decisions of people with mental health problems in what they consider to be in their best interest, to improve treatment adherence and prevent their disengagement from service provision (Valenti & Giacco, 2022).

Coercion is defined as an act through which power is exercised, and the behavior of others is influenced (Lee, 2014), using deception, intimidation, threats, violence or extortion (Raveesh et al., 2025), pressure or restrictions, and force or violence. There are other less obvious forms of coercion such as the lack of understanding or knowledge of the professional who performs the approach, about certain diseases, preconceived ideas about specific clinical manifestations, unconscious biases towards certain populations or even the arrogance of assuming a position of superiority (Baggio et al., 2024; Wang et al., 2025). International health policies include the transition towards the eradication of the use of coercion in mental health services, and initiatives such as Quality Rights (WHO, 2019) establish the framework of obligation to evaluate services and transform them towards permanent respect for human rights and monitoring.

Addressing coercive practices requires the collaboration of several disciplines. In mental health services, physicians occupy a decisive position in the prescription and supervision of coercive practices. In organizational contexts strongly oriented towards risk management, their professional judgment often lies at the intersection of the duty of beneficence—to protect life and prevent harm—and respect for patient autonomy, which can favor the adoption of restrictive measures when they are perceived as clinically necessary or as the only available alternative.

In this sense, social work plays a central role in preventing coercive practices and in the effective validation of human rights within mental health services (Ross & de Saxe Zerden, 2020). From its professional identity, characterized by the articulation between clinical intervention, case management, and the defense of rights in hierarchical institutional contexts, social work is strategically positioned to challenge responses focused exclusively on risk and to promote alternatives based on dignity, autonomy, and social justice (Ross & de Saxe Zerden, 2020).

The disciplines that contribute to the implementation of the human rights framework, social work has a fundamental role (Donoso et al., 2021). Evidence shows that institutional cultures marked by stigma and exclusion can normalize restrictions and violations of rights (Gill et al., 2024), which demands a reflective practice capable of identifying how organizational dynamics reproduce inequalities. Within

this framework, explicit human rights training has been associated with changes in professional attitudes and practices, contributing to a reduced acceptance of coercive interventions (Agudelo-Hernández & Urrego-García, 2024). Thus, social work not only acts as a mediator between users and institutions, but also as a transformative agent that promotes more participatory, respectful, and consistent care environments with international human rights standards (Wang et al., 2025).

The Present Study

In Colombia, coercion in mental health services remains common (Agudelo-Hernández et al., 2025). The Colombian legal framework is broad and includes, among others, the Political Constitution, which forms part of the constitutional bloc, Law 1616 of 2013, and the jurisprudence generated by the Constitutional Court. However, this jurisprudence is not always precise or exhaustive regarding the clarity that should exist concerning the confinement of people who use mental health services (Isaza-Piedrahita, 2025). Inequalities, difficulties in accessing mental health services, and stigma, among other factors, have been described. Hospitalizations and emergency services are the most frequently implemented mental health services, with a low proportion of community-based services (Agudelo-Hernández et al., 2024), which could increase the risk of greater use of coercive practices (Gill et al., 2024).

It is necessary to address the need to understand the perceived reasons for the use of coercive practices from the perspective of individuals who have received hospital care after suicide attempts and from the perspective of the professionals who employ these practices. This is done to provide a theoretical and practical framework that strengthens capacities and public policies for promoting mental health and preventing adverse mental health outcomes. The objective of this study was to describe and analyze the reasons perceived by physicians who employed coercive practices and by the individuals on whom these practices were employed, following a suicide attempt in Caldas, Colombia, in 2023 and 2024.

Methods

Study Design

A qualitative, transversal, and descriptive research design was used, consisting of in-depth interviews. To determine the variables associated with psychosocial recovery in people who attempted suicide, a stratified random sampling was carried out on all people who experienced suicide attempts

between January 2023 and June 2024 in the Department of Caldas (Colombia is divided into 32 departments, of which Caldas represents one of the three with the highest suicide rates).

Of 1876 registered people, 650 were included in the study, which exceeded what was indicated by the type of sampling. From this sample, all people who experienced coercive practices were selected. A total of 30 participants were included. In this sense, the inclusion criteria were having been reported as a suicide attempt in the records of the Epidemiological Surveillance System of the Department of Caldas and having the ability to communicate in Spanish, willingness to participate, and signed informed consent. No exclusion criteria were considered.

The participants' contacts were obtained from the Caldas department's suicidal behavior report, which comes from the completion authorized by the Colombian Ministry of Health within the framework of the epidemiological surveillance established for suicide attempts, by healthcare providers. The interviews were conducted face-to-face by trained personnel with experience in psychological first aid. In the case of participants under 18 years of age, the information was obtained from their primary caregivers. The study was conducted in collaboration with the Caldas Health Directorate, which provided access to the data from the notification form.

The study involved two groups of participants and corresponding data collection periods. Interviews with individuals with a history of suicide attempts were conducted between January and December 2024, whereas interviews with healthcare professionals were conducted between November 2024 and January 2025. The interviews were audio-recorded, the participant had previously read the information sheet, agreed to participate, and signed the informed consent form. The interview included questions to explore this objective, such as: "Have you ever felt mistreated by medical staff in healthcare settings?" If the answer was yes, the question was posed: "In what ways were you mistreated? Why do you think this happens in healthcare settings?"

From this question, participants were invited to describe their views on their perception and experience of these practices. The interviews were conducted near people's homes, in community centers, or at people's homes. Some interviews were also allowed to take place in locations where people felt more comfortable. On average, the interviews lasted approximately 50 min.

In a second stage (January 2025 to April 2025), in-depth interviews were conducted with 22 medical professionals who treated individuals who had attempted suicide in the department of Caldas. These professionals were identified through the completion of notification forms, which are typically filled out by healthcare professionals following a suicide attempt. The objectives of the study were explained to them, data confidentiality was emphasized, and information

on strategies for promoting human rights in healthcare services was shared after the interviews. These interviews explored the meanings, perceptions, and reasons the professionals held regarding the use of coercive practices.

The interviews were conducted by a community psychologist and a psychologist specializing in occupational health and public health policy, without prior contact with the professionals or the institutions where they worked at the time of the suicide attempt. For data triangulation, two individuals with lived experience and a psychiatrist were consulted. They supported the transcription of the interviews and assisted with the thematic analysis.

A hybrid deductive-inductive strategy was employed, using an a priori codebook complemented by iterative analysis of the transcripts. This method involved coding the data and developing themes that reflected the participants' concepts. This thematic analysis was performed using N-VIVO software. A subsequent analysis of the saturation index showed that only 2% of the ideas were new, validating the saturation point in each group. Citations are named according to the number of appearances in the analysis and with M for male and F for female. The methods and results of the study were reported according to COREQ checklist. The data were analyzed using thematic analysis (Braun & Clarke, 2024).

Ethics Approval Statement and Patient Consent Statement

This study followed the guidelines for biomedical research described in the Declaration of Helsinki of the World Medical Association. The names of the participants were kept strictly confidential and all participants gave their informed consent. The research was approved by the Bioethics Committee of the Caldas Territorial Directorate and the University of Manizales (act CB_04-2025). Although a procedure was designed to manage situations in which emotional support was required, none of the participants required it, even though some expressed discomfort in one or more specific situations. All interviewees were offered recommendations based on Quality Rights (WHO, 2019).

Theory Calculation

Coercive practices include the use of physical restraint, forced medication, being forcibly and unwillingly transferred to another location, verbal abuse, threats for refusal to follow instructions, deliberate ignoring, and barriers and obstacles to participation (Hallet et al., 2024). Coercive practices in mental health services are often associated with a combination of clinical, organizational, and regulatory factors. Among the most frequently cited reasons are the perception

of imminent risk, pressure to guarantee institutional security, a shortage of human and training resources for de-escalation interventions, and organizational cultures that normalize restraint as a rapid response to crisis (Lessard-Deschênes et al., 2025; Sugiura et al., 2020).

These practices can cause significant and lasting emotional trauma and impact, as well as hinder recovery and undermine trust in institutions, increasing stigma and suffering (Gill et al., 2024). The comprehensive approach to hospitalizations due to psychiatric events is generally carried out in an interdisciplinary manner, whose technical teams are transversalized by health and social work professionals, ensuring that their rights are respected and that they receive adequate treatment, seeking the dignity of people, supporting their defense and promotion of human rights as well as dignity (Donoso et al., 2021).

Results

Regarding sociodemographic characteristics, the average age was 22.9 years ($SD = 13.56$) for those who attended health services and 33.4 years ($SD = 11.12$) for physicians. Among the group of individuals who had attempted suicide, 50% identified as female, 46.6% as male, and 3.34% as transgender. In the group of professionals, 66.67% identified as male and the remaining percentage as female.

Content analysis identified 298 quotes, 191 of which were from individuals who had attempted suicide and the remainder from healthcare professionals. These were grouped into two themes: one for individuals who had attempted suicide

and another for physicians. Each theme was further divided into three categories (Table 1).

Reasons Perceived by People Using Health Services After a Suicide Attempt

Lack of Knowledge

This category addresses the perception of coercion as a lack of knowledge of other tools for addressing psychosocial distress in emergency situations. Regarding this, one man added: “Doctors only know how to prescribe pills. Their knowledge falls short when it comes to other issues; they only ask about sleep, diet, whether you’re having regular bowel movements” [M25]. Another young woman said: “They [the doctors] don’t know about suffering, even though they’re supposed to be specialists, psychiatrists. Sometimes, to understand suffering, you just must be human, and even then, they don’t know... They seem dehumanized. They don’t know about suffering, and yet they’re in charge.” [F9]

Another participant added:

When you ask for advice about simple things in life, like what to do if loneliness worsens or you can’t see the future, or if you want to repair a broken relationship, they don’t answer anything. They say that’s for the psychologist or the therapist, but I seek therapy and all they tell you is that they’ll call me, and they never do. [F117]

Table 1 Themes and categories

Theme	Category	Definition
Reasons perceived by people using health services after a suicide attempt	Lack of knowledge	Perception by people using health services that professionals do not know emotional support techniques
	Lack of willingness to help	Perception by people using health services that professionals deliberately choose coercive practices over other options for emotional support in a crisis
	Obligation	Perception by individuals using healthcare services that professionals are required to implement coercive practices as part of their duties within the healthcare system
Reasons perceived by medical professionals	Coercion as the main resource	Physicians’ perception of coercion as the primary clinical tool in the face of psychomotor agitation
	Coercion in medical training	Physicians’ perception of coercion as a key element of their medical training in mental health courses
	Coercion as medical protocol	Recognition by physicians of coercive measures as part of the commitments that must be carried out in the health institutions in which they work

Lack of Willingness to Help

This category addresses the perception that professionals choose coercive practices over other options for emotional support in health services. An example of this was stated by a young woman: “When I go to the doctor, even the psychiatrist, they make me repeat the same story, and they don’t pay attention. They seem annoyed sometimes; they don’t like suicidal people or drug users. You can tell.” [F30]. This was corroborated by another adult participant: “They restrained me. And I felt that the professionals enjoyed it; I even felt like they were making jokes with me. I was very distressed, but I remember their laughter and their false compassion. It wasn’t laughter at something funny; it seemed like they were enjoying it.” [M2]. Another adult also noted: “I don’t know why the doctor told me things about his life... He said he had learned to be grateful since his mother died, and that I was ungrateful. He said that angrily. It’s unlikely that they teach that; it was more of a personal thing.” [F120]. Other comments such as: “You can tell they enjoy it” [M131] or “They should know that they don’t help much, they traumatize, and yes, you stay still, but you continue to suffer” [F125], also formed part of this category.

Obligation

This category specifically addresses perceptions of people attending health services regarding coercive practices as a mandatory procedure by health professionals in response to agitation. In this regard, the same adult quoted earlier (M2) noted: “But there are also others [doctors] who don’t seem to enjoy it, who don’t like to restrain anyone, who suffer with you, but who can’t do anything because it’s what they have to do.” [M3]. Similarly, a woman mentioned: “You hear all the time, ‘I’m sorry, but it’s the protocol, it’s the protocol when you’re not cooperating, we can’t let you hurt yourself, it’s the protocol.’” [F103]. Someone else also mentioned: “I imagine it’s what they have to do, it’s their job, you really are uncontrollable sometimes, and well, it’s their job.” [F93]. Another participant added, referring to physicians who practice coercive measures: “They’re just doing their job.” [M112]

Reasons Perceived by Medical Professionals

Coercion as the Main Resource

In this category, coercion is presented as an essential clinical resource in addressing crises of psychosocial suffering, along with a lack of consideration for recovery elements related to health services and other care strategies. One professional noted: “Sometimes there are no medications, appointments aren’t scheduled on time, patients remain unstable, they come to the emergency room, and we must

restrain them. Then they’re discharged, only to return in the same state, and so on, it’s the same thing.” [M74]. Regarding this, another professional mentioned: “Although I know it’s not ideal, sadly, the emergency room is the only contact mental health patients have with health services.” [F44]. It was also mentioned: “You restrain them, refer them to the psychiatric clinic, they come out a few weeks later calmer, but the patients relapse and are referred again. There are people in this municipality who are already used to that.” [M71]. Other comments such as “there is nothing else to do [than mechanical restraint]” [M7], “what else does one do in those cases?” [F43], or “One cannot let someone hurt themselves, so it is necessary” [M3], reinforced the relationship of physical restraint with the lack of other strategies to respond to crises.

Coercion in Medical Training

This category emphasized the teaching of coercive practices as part of medical training, especially in the region’s medical schools. One physician mentioned: “It’s what our professors teach us in medical school. And we don’t know psychological first aid. We refer that to psychology when possible.” [F62]. Another participant also noted: “I think the problem is that we see comfort as more of a psychological approach, and that’s why they don’t teach us how to provide that support. They teach us to resolve situations with more definitive methods.” [M28]. A female physician added: “The easiest thing is to restrain them. You do it yourself because the patient is sedated, or the police do it. The most difficult thing is the verbal aspect. You’re left not knowing what to say to someone who is agitated.” [F98].

In addition to the above, a doctor mentioned when asked about the words of support given at those times: “We don’t say words of support as such. The words we say are the rules of the service, what happens if they don’t cooperate and calm down.” [F92]. When asked about this practice in medical training, a psychiatrist added: “They talk to us about protocols, that is, they talk to us about something that is done in a generalized way. And they never teach us to ask the patient how they would like to be treated if one of these events were to occur.” [M187]

Coercion as Medical Protocol

This category includes coercive practices as part of the institutional protocols that must be followed “when patients do not comply with the institution’s rules or when they arrive aggressive” [M212]. Similarly, a female doctor stated: “We must know the procedures. When we enter the institution, three protocols are important: the resuscitation protocol, the delivery protocol, and the agitation protocol” [F221]. When asked about this protocol, the professional mentioned: “It

mainly includes medication dosages, the team's procedures for immobilization, and how to tie knots" [F214]. Another professional, when asked about verbal support techniques, stated: "The agitation protocol says what to do with medications, and we coordinate with the police. It says nothing about psychological first aid. That's the psychologist's job, but not when the patient is uncontrollable" [M264]. Another professional added: "And it's not a matter of the institution; I've worked in five institutions, three primary care and two large hospitals, and it's the same in all of them." [F220].

When asked about the professionals' perceptions of the protocols, positive aspects were mentioned, such as "It's a procedure to help" [F223] or "It's what we should do as doctors" [M246]. Negative aspects were also pointed out, such as: "These protocols end up being carried out with the police" [F248], "We put ourselves at risk when we're alone on duty" [F258], or "It's a problem when the agitated person is a neighbor or someone from the town; towns are small, we all know each other. Looking someone from your community in the eye after you've restrained them still seems strange to me, but oh well, it's what must be done" [F219].

The word clouds revealed that the three most frequently mentioned terms by professionals were "Control," "Protocol," and "Collaborate." The three most frequently used terms by individuals who experienced coercive practices were "Recovery," "Suffering," and "Difficulty."

Discussion

This study explored the reasons perceived by physicians who used coercive practices and by the individuals to whom these practices were applied, following a suicide attempt. This aimed to provide a deeper understanding of the healthcare system, the approach to mental health within healthcare services, and the implementation of a human rights-based approach in care. The themes found show factors in health personnel to improve the treatment of people who come to the services, to reduce the need to use coercive measures, promote collaborative decision-making and strengthen the sense of community.

The results show that, in the population approached in the department of Caldas, Colombia, during some hospitalizations for events related to suicidal behavior, coercive measures are applied. These practices included those described by the literature, such as physical restraint, administration of medications without consent and isolation, to which are added the failures in the health system and in the continuity of care. The perception of those who suffer from it and of the professional who exercised it is related to security, describing it as unwanted, although necessary to maintain

it, which contrasts with the literature (Doedens et al., 2020; Hem et al., 2018).

As with the present research, it has been noted that ambiguous legal frameworks or those focused on protecting public order, along with the fear of legal repercussions, can reinforce coercive decisions (Sugiura et al., 2020). Taken together, the literature suggests that these practices do not respond solely to characteristics of the people who use health services, but to structural and legal dynamics that shape professional decision-making (Lessard-Deschênes et al., 2025; Sugiura et al., 2020).

It is important, then, to explore strategies such as those proposed by dialogue between people with lived experience, their family or friends support networks, and health personnel, to improve the experience of health services (Eiroa-Orosa & Incera-Rosas, 2025). Like other studies carried out in similar contexts (Agudelo-Hernández et al., 2024), principles such as the validation of autonomy, rights, and a person-led recovery process were also central elements in this dialogue, which coincides with global indications (Gill et al., 2024; Patel et al., 2023). Importantly, it is necessary to consider the interaction between systemic, environmental and individual factors as fundamental to prioritizing the necessary structural transformations in inpatient services that are essential to minimize harm, including increasing the choice, control, and freedom of the person with lived experience (Griffiths & Foye., 2025).

Appropriate treatment by staff, information provided, and respect are listed in the literature as influential in perception, so satisfaction with treatment should include efforts to improve procedures such that decreasing perceived coercion could increase treatment satisfaction (Agudelo-Hernández et al., 2024; Ling et al., 2015) and decrease the risk of new hospitalizations in suicide attempt (Grossmann et al., 2025). Another critical aspect is the need to understand what constitutes Lived Experience, which can guide role design and optimize strategies, which in turn improves effectiveness and support for the peer workforce (Byrne & Roennfeldt, 2025). It is necessary to strengthen data collection, documentation, and reporting of cases of abuse, considering that this is fundamental, given the centrality of human rights.

Among professionals, the findings show that many coercive practices are justified as the only available option in the absence of community-based services, intermediate support, or rights-based alternatives, thus creating an apparent dilemma between autonomy and beneficence. However, this conflict becomes more complex when situated within institutional and political contexts that restrict real options. Expressions such as "Although I know it's not ideal, sadly, the emergency room is the only contact mental health patients have with health services" do not describe a professional's personal stance on a practice taught as "clinical," but rather a structural deficiency that prevents the recognition of genuine

evidence-based practices. In this sense, coercion appears as a systemic response to fragmented services and organizational logics focused on risk management, which can mask forms of structural violence and render meaningless the guarantees recognized by the Convention on the Rights of Persons with Disabilities.

In this context, social work is often situated at the intersection of policy implementation, case management, and rights advocacy, thus confronting institutional imperatives focused on risk control and ethical commitments centered on dignity and social justice. More than a disciplinary problem, the challenge lies in managing power asymmetries and making visible how structural barriers are reinterpreted as individual failings. From this perspective, social work can play a key role in identifying, articulating, and managing community-based alternatives, strengthening rights-based reflexivity, and contributing to transforming institutional cultures that normalize coercion under the premise that “there is no other option.” Related to this, social workers also have the capacity to address systemic barriers that hinder continuity of care, where these professionals act as mediators, case managers, or advocates for the rights of people who access health services (Ross & de Saxe Zerden, 2020). Therefore, it is crucial that global social work education incorporates human rights dimensions into training programs, including in regions with recent histories of human rights violations, such as Latin America (Agudelo-Hernández & Urrego-García, 2024).

The results highlight that the word most mentioned by the health professionals was “Control,” followed by “Protocol,” which contrasts with the word “Recovery” as the most frequent term of the people interviewed. This invites us to consider people as agents of recovery, and not as clinical patients, which is decisive in strengthening processes (Zimmerman & Rappaport, 1988). The above makes it necessary that people’s previous experiences be integrated into clinical decisions as experts due to their experience, as well as in research and teaching (Krieger et al., 2018).

Related public policies must be aligned and contemplate political commitment, sufficient support from the actors involved, amplification of the voices of people with lived experience and family members (Bryson et al., 2017). The implementation of the rights-based approach in its public policies must be prioritized, which begins by more clearly combating coercion, stigma and social exclusion. Colombia must move towards reducing coercive practices in mental health, not only because of the evidence showing that restrictive practices can have harmful physical and psychological effects such as the marked suffering of people with lived experience of this, but also because of compliance with new regulations (Mental Health Commission, 2023).

The policy for training human talent in health requires addressing professions such as social work to incorporate

initiatives such as Quality Rights of the World Health Organization (Gill et al., 2024), developing visible strategies to rethink the respective interventions and research (Wang et al., 2025). Likewise, it is necessary to strengthen processes of reflexivity on human rights, improve sensitivity towards people, strengthen spaces for exchange between teachers, mental health professionals, and students, emphasizing the role of social work regarding the identification and management of inequities highlighted by the intersectional vision of mental health, better mobilizing human rights in mental health services (Agudelo-Hernández & Urrego-García, 2024).

Limitations

Although the study followed a rigorous methodology, given the differential regional attention to mental health in Colombia, the regional differences in its approach and conception, and the participants in the population study, the comparison and generalization of our findings is limited. Furthermore, other psychosocial aspects associated with recovery, other academic aspects related to psychiatric training, and the role of mental health professionals other than physicians could have been better explored. Future research could address, from the perspective of health service administrators and decision-makers, those factors that link health professionals to coercive practices, especially the lack of continuous management and alternative care.

An additional limitation of this study is the potential for recall bias, as participants were asked to retrospectively describe suicide crisis events and the interventions that followed. In some cases, these experiences may have occurred several months before the interviews, which could have affected the precision, completeness, or interpretation of the accounts. This is particularly relevant given the emotionally intense nature of suicidal crises, as participants’ recollections may have been shaped by the passage of time and by their subsequent experiences with care.

Conclusion

In this qualitative study conducted in Caldas, Colombia, coercive practices used after suicide attempts were described by service users as distressing and as interfering with their recovery processes. Healthcare professionals and service users also identified a range of perceived reasons for the use of these practices, including limited training in non-coercive responses, the normalization of coercion within

clinical practice, institutional protocols, and the absence of alternative and continuous forms of care.

These findings do not establish causal relationships, but they suggest that coercive practices are embedded in broader organizational and training contexts. The results highlight the need to further examine how rights-based and recovery-oriented approaches can be incorporated into suicide crisis care, particularly through non-coercive support strategies, continuity of care, and greater availability of community-based services.

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Data availability The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics Approval The present study adhered to the guidelines for biomedical research established in the Declaration of Helsinki of the World Medical Association. Absolute confidentiality of the names of the study participants, who gave their consent to participate, was guaranteed. This research was approved by the Ethics Committee of the Bioethics Committee of the Caldas Territorial Directorate and the University of Manizales (act CB_04-2025). Although a procedure was designed to manage situations in which emotional support was required, none of the participants required it, even though some expressed discomfort in one or more specific situations. All interviewees were offered recommendations based on Quality Rights.

Consent for Publication Not applicable.

Competing interests The authors declare no competing interests.

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