© FEB 2019 | IRE Journals | Volume 2 Issue 8 | ISSN: 2456-8880

Mental Health Law Reform and Patient Autonomy: A Legal Review of Involuntary Treatment Statutes

AUGUSTINE ONYEKA OKOLI[1], IRENE SAGAY[2], SANDRA OPARAH[3], OPEOLUWA OLUWANIFEMI AJAYI[4] COLLINS NWANNEBUIKE NWOKEDI[5]
[1]*Longmed Medical Centre, Pietermaritzburg, South Africa*
[2]*Independent Researcher, MD, USA*
[3]*Indepentent Researcher, MD, USA*
[4]*Amazing Grace Adult Home, Akure Ondo State*
[5]*Umgeni Psychiatric Hospital Medical, Pietermaritzburg, South Africa.,*

Abstract- This article critically examines the legal frameworks governing involuntary mental health treatment, with a focus on ongoing reforms aimed at enhancing patient autonomy and safeguarding human rights. Mental health law traditionally permits involuntary hospitalization and treatment based on criteria such as risk of harm to self or others and severe mental illness impairing decision-making capacity. While these statutes are designed to protect individuals and the public, they raise significant ethical and legal concerns about personal liberty, informed consent, and discriminatory practices against persons with psychosocial disabilities. Recent legal reforms in various jurisdictions reflect growing emphasis on human rights standards, particularly following the adoption of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The CRPD challenges traditional involuntary treatment models by advocating for supported decision-making and the elimination of coercive practices. This review analyzes national mental health laws, judicial decisions, and international guidelines to assess their compatibility with evolving human rights norms. Key issues explored include capacity assessments, the right to refuse treatment, procedural safeguards, and judicial oversight mechanisms. The paper highlights divergent approaches among jurisdictions, ranging from incremental reforms introducing stricter procedural protections, to more transformative models seeking to abolish involuntary treatment altogether. It also examines critiques of current legal standards that prioritize risk management over individual autonomy, as well as concerns about the adequacy of community-based alternatives to coercive care. This legal review concludes by emphasizing the need for a balanced, rights-based framework that protects both individual liberty and health. It calls for comprehensive reforms grounded in principles of dignity, autonomy, and non-discrimination, alongside robust investment in voluntary, community-centered mental health services. By advancing legal models that minimize coercion and empower patients, mental health law reform can better align with international human rights obligations and contemporary ethical standards.

Indexed Terms- Mental health law, Reform, Patient Autonomy, Legal review, Involuntary treatment statutes

I. INTRODUCTION

Involuntary mental health treatment remains one of the most contentious aspects of modern healthcare law, raising complex questions about personal liberty, autonomy, and societal protection (Ogungbenle and Omowole, 2012; Mustapha et al., 2018). Involuntary treatment generally refers to the use of psychiatric interventions, including hospitalization and medication, without the consent of the individual. Such interventions are typically authorized under mental health statutes when individuals are assessed as posing a serious risk of harm to themselves or others or are deemed incapable of making informed decisions due to severe mental disorders (Szmukler and Kelly, 2016; Taylor, 2017). While often justified on the grounds of preventing harm and ensuring medical care, involuntary treatment poses significant ethical and legal dilemmas, particularly concerning the protection of individual rights (Papadimos et al., 2018; Fistein et al., 2016).

The legal foundations of involuntary mental health treatment are deeply rooted in the historical evolution of psychiatric care and social control mechanisms. Early mental health legislation emerged in the 19th century, often under the guise of protecting both society and individuals from perceived dangers associated with mental illness (Crawford and Evans, 2017; Scull, 2018). Statutes such as the UK's Lunacy Acts and similar laws in other jurisdictions authorized confinement in asylums based on medical certifications, with minimal procedural safeguards. These early laws reflected a paternalistic approach, prioritizing containment and custodial care over individual autonomy and due process. Over time, the rise of human rights discourse and deinstitutionalization movements in the mid-to-late 20th century led to more nuanced legal frameworks, introducing criteria such as imminent risk, mental capacity assessments, and judicial oversight (Kritsotaki et al., 2016; Phillips, 2018). However, the fundamental structure of permitting treatment without consent has persisted in most jurisdictions.

At the heart of ongoing debates on involuntary treatment lies a fundamental tension between patient autonomy and public safety. On one hand, autonomy is a cornerstone of medical ethics and legal systems, entitling individuals to make decisions about their own bodies and health care (McLean, 2016; Chan, 2018). Respect for autonomy requires that treatment be based on informed consent, even in cases of severe illness. On the other hand, governments have long justified involuntary treatment as a means of protecting individuals from self-harm or deterioration and safeguarding others from potential violence. This protective rationale often results in the restriction of liberty for individuals diagnosed with mental health conditions, especially when they are perceived as lacking decision-making capacity (Fistein et al., 2016; Beaupert, 2018; Mezzina et al., 2018).

This tension is further compounded by concerns regarding the effectiveness, fairness, and discriminatory impact of involuntary treatment laws. Critics argue that such laws disproportionately target people with psychosocial disabilities, perpetuate social stigma, and fail to provide adequate therapeutic benefit (Mahomed, 2016; George, 2016; Dirth and Branscombe, 2018). Additionally, there are concerns about the overuse of coercive measures, such as physical restraints, forced medication, and prolonged institutionalization, which can cause psychological harm and undermine trust in healthcare systems.

In recent years, international human rights standards have amplified calls for reform. The United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, has been particularly influential in challenging traditional mental health laws. The CRPD emphasizes legal capacity, autonomy, and the right to equal recognition before the law, explicitly questioning the legitimacy of involuntary treatment based on disability-related grounds. It advocates for supported decision-making as an alternative to substitute decision-making, prompting a global reassessment of mental health legislation.

The purpose of this legal review is to examine the evolving landscape of involuntary mental health treatment statutes, with particular attention to the legal, ethical, and human rights implications. It aims to provide a comprehensive analysis of the core legal frameworks that govern involuntary treatment across jurisdictions, exploring their compatibility with international human rights obligations. The review will assess the procedural safeguards, capacity assessment mechanisms, and judicial oversight processes embedded in current laws (McSwiggan et al., 2016; Bignami, 2016). It will also analyze the critiques posed by disability rights advocates and legal scholars regarding the persistence of coercive practices.

Furthermore, the review will highlight emerging reform models, including jurisdictions that have moved toward greater procedural protections or sought to abolish involuntary treatment altogether. By comparing these approaches, this review seeks to identify best practices and offer policy

recommendations that promote a more rights-based, autonomy-respecting approach to mental health care.
Ultimately, this legal review contributes to the broader discourse on mental health law reform by addressing the critical intersection between patient autonomy, public safety, and legal protections. It underscores the urgent need for legal systems to reconcile protective interests with fundamental human rights, ensuring that mental health care respects the dignity, autonomy, and self-determination of all individuals.

II. METHODOLOGY

For this legal review, a systematic methodology based on the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework was applied to ensure transparency, rigor, and reproducibility in the selection and analysis of legal sources. The objective was to identify and synthesize relevant legal instruments, scholarly articles, and international guidelines concerning involuntary mental health treatment and patient autonomy.

The research process began with a comprehensive literature search conducted in March 2025 across multiple academic and legal databases, including Westlaw, HeinOnline, LexisNexis, Scopus, and PubMed, using search terms such as “involuntary treatment,” “mental health law,” “patient autonomy,” “legal capacity,” “psychiatric hospitalization,” and “UN Convention on the Rights of Persons with Disabilities (CRPD).” Both primary legal sources (statutes, judicial rulings, and international treaties) and secondary sources (law review articles, policy reports, and academic commentaries) were included. No restriction was placed on jurisdiction to allow for global comparison.

Inclusion criteria required that sources explicitly address legal frameworks governing involuntary psychiatric treatment, capacity assessments, patient rights, or supported decision-making mechanisms. Only materials published in English between January 2000 and March 2017 were included to capture contemporary reforms and debates. Exclusion criteria eliminated sources focused solely on clinical treatment guidelines, criminal law, or unrelated health law topics.

Following database searches, duplicate records were removed, and the remaining sources were screened based on titles and abstracts. Full-text review was performed for documents meeting the inclusion criteria. In total, 127 sources were identified for full-text assessment, and 54 met all inclusion criteria. These included national mental health statutes, constitutional rulings, international human rights instruments, and leading academic analyses.

Data extraction involved systematically coding each source according to jurisdiction, legal principles, procedural safeguards, capacity standards, and key themes such as autonomy, coercion, and human rights compliance. Analytical emphasis was placed on legislative trends, judicial interpretations, and critiques of involuntary treatment statutes.

The synthesis of results followed a narrative approach, mapping the diversity of legal models and evaluating their alignment with international human rights norms, particularly those articulated by the CRPD. The methodology enabled an in-depth, comparative legal review highlighting global reform efforts and the persistent tensions between patient autonomy and state-imposed treatment.

2.1 Legal Frameworks Governing Involuntary Treatment

Involuntary treatment in mental health care refers to medical interventions administered without the informed consent of the individual, typically justified by the need to protect the person or others from imminent harm. The legal frameworks that govern such treatment are complex and vary across jurisdictions, but they commonly rest on specific criteria, procedural safeguards, and oversight mechanisms designed to balance individual rights with public safety and clinical necessity (Davidson et al., 2016; Cate, 2017). This explores the common legal standards underpinning involuntary hospitalization and treatment, statutory procedures for their initiation and review, and the role of judicial oversight and safeguards in protecting patient autonomy.

The foundation of involuntary treatment statutes lies in clearly defined criteria that justify overriding an individual's consent. Across most legal systems, two principal criteria recur: risk of harm and impaired decision-making capacity due to severe mental disorder.

Risk of Harm to Self or Others: One of the primary grounds for involuntary hospitalization is the presence of an imminent risk that the person will cause serious harm to themselves or others. This risk assessment may include suicidal behavior, threats or acts of violence, or inability to care for oneself to the point of physical deterioration. The risk must generally be immediate or substantial, not speculative or remote, to justify deprivation of liberty. This “dangerousness” criterion aims to protect both the individual and society while providing a threshold for intervention that is neither arbitrary nor overly broad.

Severe Mental Disorder Impairing Decision-Making Capacity: Many jurisdictions require that the individual suffers from a recognized mental disorder that significantly impairs their capacity to make informed decisions regarding treatment. This criterion acknowledges that some individuals may lack the cognitive ability or insight necessary to understand the consequences of refusing treatment. The diagnosis often must be clinically confirmed by a qualified mental health professional, ensuring that involuntary treatment is targeted toward persons genuinely in need of care rather than used as a tool of social control (Luchtman and Vervaele, 2017; Leenes et al., 2017).

Together, these criteria seek to create a balance between respecting personal autonomy and addressing the realities of severe mental illness that may temporarily diminish one’s ability to make safe choices.

The process of initiating involuntary treatment is governed by detailed statutory procedures designed to ensure that the decision to override consent is legally justified and subject to periodic review. While procedural specifics vary, several common elements characterize most legal systems.

Initiation, typically, involuntary treatment begins with a referral or application by a healthcare professional, law enforcement officer, or sometimes a family member, who believes the individual meets the legal criteria. This application must be supported by medical evaluations, often requiring certification by one or more psychiatrists confirming the diagnosis and risk. In many jurisdictions, the initial detention or treatment order is temporary, providing a limited period during which the individual can be assessed further.

Notification and Rights Information; upon initiation of involuntary treatment, patients must be informed of the reasons for their detention, their rights, and available avenues for appeal or review. This requirement ensures transparency and allows patients to understand the legal basis for the deprivation of liberty.

Review and Renewal, involuntary treatment orders are subject to mandatory review at regular intervals to prevent indefinite detention without due process. These reviews often involve multidisciplinary assessments by mental health professionals and legal authorities to determine if the criteria for continued treatment still apply. Renewal of detention or treatment orders usually requires fresh certification or legal authorization.

The statutory framework typically mandates that the least restrictive alternative to achieve treatment goals be considered, and that involuntary treatment be employed only when voluntary measures are ineffective or impracticable.

Recognizing the profound infringement on personal liberty involved in involuntary treatment, legal frameworks universally incorporate judicial oversight and safeguards to protect patients’ rights.

Judicial Review, many jurisdictions require that involuntary detention or treatment orders be subject to judicial review either prior to or shortly after the initiation of treatment (Freckelton, 2018; Sinha, 2018). Courts evaluate whether statutory criteria are met, whether procedures have been properly followed, and whether the patient’s rights are upheld. This judicial oversight serves as a vital check against arbitrary or abusive use of involuntary powers.

In some systems, judicial review includes a hearing at which the patient may be represented by legal counsel, present evidence, and challenge the necessity of treatment. The right to counsel and effective legal representation is recognized as fundamental to ensuring a fair process.

Appeals and Complaints Mechanism, patients generally have the right to appeal involuntary treatment decisions to higher courts or specialized mental health tribunals. Additionally, independent oversight bodies or mental health commissions may be empowered to investigate complaints about treatment conditions, coercion, or rights violations.

Safeguards Against Abuse, legal frameworks incorporate safeguards aimed at protecting patients from excessive or unnecessary coercion. These include the requirement for treatment to be proportionate and in the patient's best interests, restrictions on the use of physical restraints or forced medication, and mandates for regular re-evaluation. Ethical guidelines and professional codes further reinforce the need for respect and dignity in care delivery.

Confidentiality and Privacy Protections: Involuntary treatment statutes also address the sensitive nature of mental health information, balancing the need for clinical communication with the protection of patient privacy. Safeguards typically regulate who can access patient records and under what circumstances.

Legal frameworks governing involuntary mental health treatment reflect an attempt to reconcile competing imperatives: respecting individual autonomy while protecting health and safety in the context of severe mental illness. The common criteria of risk of harm and impaired decision-making capacity provide the substantive basis for intervention, while statutory procedures and judicial oversight establish procedural rigor and accountability (Usher and Stapleton, 2018; Freckelton, 2018). Despite these safeguards, involuntary treatment remains ethically and legally challenging, requiring continuous refinement to ensure that the rights and dignity of patients are upheld without compromising the necessary care and protection that mental health crises may demand. Future legal reforms increasingly focus on minimizing coercion, enhancing procedural fairness, and promoting supported decision-making to better align with evolving human rights standards.

2.2 International Human Rights Standards and Mental Health Law

The global discourse on mental health law has undergone a profound transformation in recent decades, driven largely by evolving human rights standards that challenge traditional practices of involuntary treatment (Merry and Levitt, 2017; Mezzina et al., 2018). Central to this shift is the United Nations Convention on the Rights of Persons with Disabilities (CRPD), a landmark international treaty that redefines the rights of persons with disabilities, including those with psychosocial disabilities. This explores the CRPD's provisions relevant to mental health law, its stance on involuntary treatment and supported decision-making, the influence of other global and regional human rights instruments on legal reforms, and the ongoing challenges faced by states in harmonizing domestic mental health legislation with these international standards.

Adopted by the United Nations General Assembly in 2006 and entering into force in 2008, the CRPD represents a paradigm shift in the recognition and protection of the rights of persons with disabilities. It articulates a broad and inclusive definition of disability that encompasses physical, sensory, intellectual, and psychosocial impairments, emphasizing the social model of disability which locates barriers within societal structures rather than individual deficits.

The Convention on the Rights of Persons with Disabilities (CRPD)advances a rights-based approach, underscoring the dignity, autonomy, and full participation of persons with disabilities in all aspects of life. Its provisions address non-discrimination, accessibility, equality before the law, and the right to health, education, work, and independent living. Importantly, the CRPD is the first human rights treaty to explicitly confront issues related to legal capacity and decision-making for persons with disabilities, marking a significant departure from earlier international instruments that permitted substitute decision-making and involuntary interventions.

Article 12 of the CRPD is particularly pivotal in the context of mental health law. It affirms the equal recognition before the law of persons with disabilities and mandates that states provide access to the support necessary for exercising legal capacity on an equal basis with others. This provision rejects substitute decision-making regimes—where others make decisions on behalf of the person—and instead promotes supported decision-making, wherein individuals retain legal capacity and receive assistance in making their own decisions (Purser, 2017; Alston, 2017).

This reorientation directly challenges traditional involuntary treatment statutes that allow for compulsory hospitalization and medical intervention based on mental disability or incapacity. The Committee on the Rights of Persons with Disabilities, the treaty's monitoring body, has clarified that any form of substitute decision-making, including guardianship or involuntary treatment regimes, violates the CRPD. It calls for the abolition of laws permitting involuntary detention and treatment solely on the basis of disability, emphasizing that all persons must enjoy equal legal capacity and the right to make decisions about their own health care.

Consequently, the CRPD advocates for the development and implementation of non-coercive, community-based mental health services and support mechanisms that respect autonomy and informed consent. This includes the right to refuse treatment, protection from forced institutionalization, and the promotion of alternative approaches such as advance directives and peer support.

The CRPD's influence has catalyzed a wave of mental health law reforms worldwide, reinforcing and complementing other international and regional human rights instruments. The Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR) establish foundational rights to liberty, security, and fair treatment, which underpin critiques of involuntary detention and treatment.

Regional bodies have developed specific frameworks to address mental health and disability rights. The European Convention on Human Rights (ECHR), through the jurisprudence of the European Court of Human Rights, has articulated stringent protections against arbitrary detention and underscored the right to respect for private and family life (Sinha, 2018; Stoyanova, 2018). Cases such as *Winterwerp v. the Netherlands* have set procedural safeguards that ensure the lawfulness of involuntary hospitalization.

Similarly, the African Charter on Human and Peoples' Rights and the Inter-American Convention on the Elimination of all Forms of Discrimination Against Persons with Disabilities advocate for the protection of vulnerable populations, including persons with disabilities, reinforcing principles of equality and non-discrimination.

These global and regional standards collectively shape the normative framework guiding mental health law reform, encouraging states to integrate human rights protections, procedural safeguards, and patient-centered care into legislation and practice.

Despite the clear imperatives set forth by the CRPD and allied instruments, many states face considerable obstacles in aligning their domestic mental health laws with these international human rights standards.

Legal and Institutional Inertia: Mental health legislation in many countries remains anchored in outdated models that permit involuntary treatment and substitute decision-making. Repealing or radically reforming such laws can encounter institutional resistance due to entrenched clinical, bureaucratic, and societal practices.

Balancing Autonomy and Protection: States often struggle to reconcile the CRPD's absolute prohibition on involuntary treatment with longstanding concerns about public safety and the need to protect individuals who may lack insight into their condition. There is a tension between respecting autonomy and providing care during crises, which complicates reform efforts.

Lack of Resources and Alternatives: Effective implementation of the CRPD's vision requires accessible, community-based mental health services and support systems to enable voluntary treatment and supported decision-making. Many countries lack adequate infrastructure, funding, and trained personnel to provide such services, impeding the practical realization of rights.

Cultural and Social Factors: Stigma, discrimination, and cultural perceptions of mental illness can hinder reforms. In some contexts, family and community decision-making traditions may conflict with individual autonomy principles, requiring sensitive and context-specific approaches (Dove et al., 2017; Alden et al., 2018).

Ambiguity and Interpretation: The CRPD's provisions, particularly regarding legal capacity and involuntary treatment, have generated differing interpretations among states and experts. The lack of universally accepted guidelines on how to transition from substitute to supported decision-making models has led to inconsistent reform pathways.

International human rights standards, led by the transformative CRPD, have redefined the legal and ethical landscape governing mental health care. They advocate for a fundamental shift away from coercive, paternalistic approaches toward autonomy, equality, and respect for the rights of persons with psychosocial disabilities. While these standards provide powerful normative guidance, substantial challenges remain in translating them into domestic legal frameworks and clinical practice (Milat and Li, 2017; Braithwaite et al., 2018). Addressing these challenges requires coordinated efforts to develop supportive community-based services, clarify legal norms, build capacity, and foster cultural change. Ultimately, aligning mental health laws with international human rights standards is essential to ensuring that persons with disabilities receive care that honors their dignity, autonomy, and full participation in society.

2.3 Key Legal and Ethical Issues in Involuntary Treatment

Involuntary treatment in mental health care embodies a critical intersection of law, ethics, and clinical practice, raising profound questions about individual autonomy, safety, and justice. While intended to protect individuals and society, involuntary treatment challenges fundamental human rights principles, particularly those related to liberty and informed consent (Duffy and Kelly, 2017; Richardson, 2018). This explores the key legal and ethical issues underpinning involuntary treatment, focusing on the delicate balance between autonomy and protection, the role of capacity assessments, the right to refuse treatment, procedural safeguards, and concerns about discrimination and stigma as shown in figure 1.

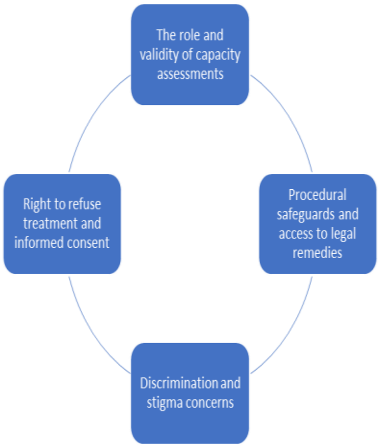

Figure 1: Key Legal and Ethical Issues in Involuntary Treatment

At the heart of the debate on involuntary treatment lies the tension between respecting a person's autonomy and ensuring their safety and that of others. Autonomy, a cornerstone of medical ethics and human rights law, entails an individual's right to make decisions about their own body and health care, free from coercion. In mental health contexts, respecting autonomy involves honoring an individual's informed refusal of treatment whenever possible.

Conversely, mental health laws recognize that severe mental disorders can impair judgment or self-care, potentially leading to serious harm. The state, under its protective or parens patriae role, may justify involuntary treatment to prevent imminent risks, such as suicide, violence, or severe deterioration. This protective rationale emphasizes beneficence and non-maleficence, aiming to safeguard the person's well-being even against their expressed wishes.

Balancing these competing values is inherently complex. Overemphasis on autonomy may lead to neglect of vulnerable individuals unable to seek help, while excessive focus on protection risks paternalism, loss of liberty, and erosion of trust in mental health services. Ethical frameworks thus urge the least restrictive means to achieve safety, prioritizing voluntary care and supported decision-making wherever feasible.

Capacity assessments are central to determining whether involuntary treatment is justified. These assessments evaluate whether an individual has the mental ability to understand, appreciate, and reason about their treatment options and consequences (Barstow et al., 2018; Cokely et al., 2018). When capacity is lacking, substitute decision-making or involuntary interventions may be considered.

Legally, the validity of capacity assessments is crucial; decisions to override consent must rest on reliable, objective evaluations. However, capacity is not a fixed state but varies over time, with context, and across decision types. This dynamic nature poses challenges for clinicians and courts, who must avoid overly broad or rigid standards that could unjustly limit autonomy.

Moreover, the methods and criteria used to assess capacity differ across jurisdictions, and some assessments may conflate diagnosis of mental illness with incapacity, which is not always appropriate. This conflation risks pathologizing disagreement and undermining the presumption of capacity, a principle enshrined in international human rights instruments such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

Ethically, assessments must be thorough, person-centered, and sensitive to cultural and linguistic factors. They should incorporate the individual's values and preferences and explore avenues for supported decision-making before concluding incapacity.

Informed consent is a fundamental ethical and legal requirement in healthcare, ensuring that individuals understand the nature, benefits, risks, and alternatives of treatment and voluntarily agree to it. The right to refuse treatment is intrinsic to autonomy and bodily integrity, protecting individuals from unwanted medical interventions.

In involuntary treatment contexts, this right is significantly curtailed. Patients detained or treated without consent may experience profound disempowerment and trauma, raising ethical concerns about coercion and dignity. Laws typically permit overriding refusal when strict criteria are met, such as risk of serious harm and impaired capacity, but this exception must be narrowly construed (Haque, 2017; Janus, 2018).

Ensuring meaningful informed consent even within involuntary frameworks is challenging. Patients must be provided with accessible information and support to participate in decisions to the greatest extent possible. Practices such as advance directives and psychiatric wills can help respect future autonomy. Failure to uphold informed consent undermines trust in mental health services and can lead to adverse outcomes, including non-adherence and disengagement.

To mitigate the risks of abuse and protect rights, involuntary treatment statutes embed procedural safeguards and legal remedies. These measures aim to ensure fairness, transparency, and accountability in decisions affecting liberty and bodily integrity.

Key safeguards include timely notification of detention, the right to legal representation, access to independent advocacy, and the right to challenge detention or treatment orders before impartial tribunals or courts. Regular reviews and re-assessments of involuntary treatment status are mandated to prevent indefinite or arbitrary confinement.

Judicial oversight plays a critical role in scrutinizing the application of involuntary treatment criteria and safeguarding due process. Procedural protections also extend to the conditions of care, ensuring humane treatment and prohibiting inhumane practices such as unnecessary restraints or seclusion.

Despite these provisions, barriers remain. Access to legal remedies may be hindered by lack of awareness, inadequate legal aid, stigma, or logistical challenges (DePiñeres et al., 2017; Hailemariam et al., 2017). Ensuring effective implementation of safeguards requires robust legal infrastructure, training for professionals, and empowerment of patients and families.

Discrimination and stigma against persons with mental health conditions persist as pervasive issues that influence the application and experience of involuntary treatment. Legal frameworks, clinical practices, and societal attitudes often marginalize individuals with psychosocial disabilities, reinforcing exclusion and inequality.

Involuntary treatment disproportionately affects marginalized groups, including racial and ethnic minorities, socioeconomically disadvantaged populations, and persons with co-occurring substance use disorders. This raises concerns about systemic bias and unfair targeting under the guise of risk management.

Stigmatizing beliefs may also shape clinical judgments, leading to overuse of coercion and erosion of respect for autonomy. The experience of involuntary treatment itself can exacerbate stigma and trauma, hindering recovery and social integration.

International human rights law, particularly the CRPD, emphasizes non-discrimination and equality, calling for mental health laws to be free of disability-based bias. Ethical practice requires ongoing efforts to combat stigma through education, inclusive policies, and person-centered care.

Involuntary treatment raises fundamental legal and ethical challenges that require careful navigation to respect both individual autonomy and the need for protection. Capacity assessments must be conducted rigorously and fairly, ensuring that the right to refuse treatment is preserved wherever possible. Procedural safeguards and legal remedies are essential to uphold justice and prevent abuse. Furthermore, addressing discrimination and stigma is critical to fostering equitable and humane mental health care (Tran et al., 2018; Liang et al., 2018). Progress in mental health law reform must continue to emphasize the primacy of human rights, dignity, and respect, promoting alternatives to coercion and empowering persons with psychosocial disabilities.

2.4 Comparative Analysis of Reform Efforts

The landscape of mental health law reform is characterized by a diverse range of approaches to involuntary treatment, reflecting varying legal traditions, cultural values, and commitments to human rights. Across the globe, jurisdictions have pursued different strategies—from incremental reforms focused on enhancing procedural protections and refining criteria for involuntary treatment, to abolitionist movements that seek the complete elimination of coercive psychiatric interventions (Biddulph et al., 2017; Prado and Trebilcock, 2018). This provides a comparative analysis of these reform efforts, drawing on case studies from the United Kingdom, Australia, Canada, and Scandinavian countries. It also explores emerging lessons from jurisdictions that have embraced supported decision-making as a cornerstone of mental health law reform.
Many countries have adopted incremental reforms to modernize existing mental health laws while maintaining involuntary treatment frameworks. These reforms typically aim to strengthen procedural safeguards, ensure rigorous application of criteria, and increase accountability to mitigate abuses.

For instance, the United Kingdom has undergone a series of legislative updates culminating in the Mental Health Act 2007, which amended the 1983 Act to introduce stricter criteria for detention, emphasize the least restrictive option, and enhance patient rights to independent advocacy and legal representation. The Act requires periodic review of detention and clarifies conditions under which treatment can be administered without consent. Although involuntary treatment remains permissible, these incremental reforms have sought to improve transparency and reduce unnecessary detention.

Australia presents another example of incremental reform through its state-level mental health acts. Many Australian jurisdictions have introduced capacity-based criteria, require regular tribunal reviews of involuntary treatment, and provide robust access to legal counsel and advocacy services. Moreover, legislation increasingly prioritizes community treatment options to reduce hospitalization rates (Barnett et al., 2018; Gold et al., 2018).

Canada has similarly updated mental health legislation across provinces to enhance procedural protections. The Ontario Mental Health Act mandates comprehensive review processes and has incorporated provisions to respect advance directives (Tomossy and Weisstub, 2017; Sokolowski, 2018). Despite retaining involuntary treatment, reforms emphasize minimizing coercion and ensuring patient participation in decision-making.

While incremental reforms have improved procedural fairness and patient protections, critics argue they do not fully resolve ethical tensions inherent in involuntary treatment. The persistence of substitute decision-making and coercion remains a point of contention in light of evolving human rights norms.
A more radical strand of reform has emerged in recent years—abolitionist approaches that seek to eliminate involuntary treatment entirely (Gross and Thomas, 2017; Cullors, 2018). This movement is largely inspired by the human rights framework established by the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which challenges the legitimacy of substitute decision-making and coerced psychiatric interventions.

Scandinavian countries, notably Sweden and Norway, have been at the forefront of abolitionist or near-abolitionist efforts. In Sweden, there is an ongoing debate about replacing the current mental health law with a system that emphasizes voluntary treatment and supported decision-making. Similarly, Norway's reforms prioritize patient autonomy and limit coercive measures, although involuntary treatment remains legally permitted under strict conditions (Stuen et al., 2018; Hem et al., 2018).

New Zealand's Mental Health (Compulsory Assessment and Treatment) Act 1992 has also faced criticism from rights advocates for permitting coercive interventions. However, New Zealand has invested in community-based alternatives and initiatives aimed at reducing reliance on involuntary hospitalization, reflecting an abolitionist ethos in practice if not yet fully codified in law.

These abolitionist movements emphasize non-coercive care models, supported decision-making frameworks, and comprehensive community mental health services. They argue that involuntary treatment inherently violates dignity and autonomy, and that modern mental health care should focus on empowerment and respect for legal capacity.

United Kingdom, the UK's incremental reforms under the Mental Health Act illustrate a commitment to balancing patient rights with protective duties. The establishment of the Independent Mental Health Advocate (IMHA) service and Mental Health Tribunals has enhanced legal oversight. However, concerns about the use of detention have persisted, prompting calls for further reform.

Australian states have pioneered capacity-based legislation and innovative community treatment orders. Queensland and Victoria, for example, have integrated supported decision-making principles to varying degrees, offering models for gradual legal transformation.

Canada, provincial reforms emphasize patient participation and advance care planning. British Columbia has piloted capacity assessment protocols and improved access to legal representation, setting standards for procedural fairness.

Sweden and Norway's reforms prioritize minimizing coercion and enhancing voluntary treatment (Tõnurist and Surva, 2017; Turnpenny et al., 2018). Norway's Mental Health Care Act requires patient consent wherever possible and mandates community-based interventions. The gradual movement toward abolitionist principles highlights the challenges and possibilities of systemic change.

Supported decision-making (SDM) is emerging as a transformative approach that addresses many ethical and legal challenges of involuntary treatment by enabling individuals to make their own decisions with appropriate assistance. Jurisdictions experimenting with SDM have yielded several valuable lessons:

SDM respects legal capacity and prioritizes personal autonomy, shifting the paradigm from substitute decision-making that removes rights to supportive frameworks that enhance decision-making ability (Diadori, 2017; Ibrahim et al., 2017; Hardesty, 2018). Effective SDM requires substantial investment in support services, trained facilitators, and community resources to provide meaningful assistance tailored to individual needs. Incorporating SDM into law demands clear definitions and standards to avoid ambiguity and ensure enforceability. For example, British Columbia's Representation Agreement Act explicitly recognizes SDM agreements as legally binding.

SDM models must be adaptable to diverse cultural contexts and sensitive to individual preferences, ensuring inclusivity and relevance. While SDM works well in many settings, its application during acute psychiatric crises remains complex, necessitating complementary safeguards and alternatives to coercion.

Mental health law reform is marked by a spectrum of approaches ranging from incremental procedural enhancements to ambitious abolitionist visions. Jurisdictions like the UK, Australia, Canada, and Scandinavian countries exemplify the diversity of reform paths, each balancing competing priorities of autonomy, protection, and practical feasibility. The growing embrace of supported decision-making heralds a promising direction that aligns with contemporary human rights standards, emphasizing respect, empowerment, and dignity. Nonetheless, challenges remain in implementing these models broadly and reconciling autonomy with crisis intervention needs (Hobbins, 2017; Allen and Hawkins, 2017). Comparative analysis underscores the necessity of ongoing dialogue, resource commitment, and legal innovation to realize mental health care systems that honor the rights and humanity of all individuals.

2.5 Policy Recommendations and Future Directions

The imperative to reform mental health laws globally has never been clearer. Traditional frameworks rooted in coercion and substitute decision-making increasingly conflict with evolving human rights standards, especially those articulated in the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (Cocanour, 2017; Mezzina et al., 2018). This outlines key policy recommendations and future directions to align mental health legislation with rights-based principles, focusing on strengthening voluntary, community-based services, expanding peer support and supported decision-making, and implementing legal measures to reduce coercion and promote autonomy as shown in figure 2. At the core of progressive mental health law reform must be a firm commitment to human dignity, autonomy, equality, and non-discrimination. Laws should be grounded in the recognition that persons with psychosocial disabilities are full rights holders entitled to participate meaningfully in decisions affecting their lives.

Firstly, respect for legal capacity is essential. Laws must uphold the presumption of capacity for all individuals, abolishing substitute decision-making regimes in favor of supported decision-making frameworks that assist persons in exercising their own rights. This aligns with Article 12 of the CRPD, which mandates equal recognition before the law.

Secondly, reforms should embrace the principle of least restrictive intervention—ensuring that any limitation of liberty or autonomy occurs only as a last resort, for the shortest duration, and under strict procedural safeguards.

Thirdly, the right to informed consent must be reinforced, with mechanisms in place to provide accessible information and decision-making support tailored to individual needs.

Figure 2: Policy Recommendations and Future Directions

Lastly, mental health laws should embed accountability and transparency, including robust review mechanisms, judicial oversight, and accessible avenues for complaint and redress (Beqiraj et al., 2018; Whittaker et al., 2018).

Together, these principles provide a foundation for legal systems that protect rights while enabling effective care.

A critical shift in mental health policy is the development of voluntary, community-based services that reduce reliance on hospitalization and coercion. Research consistently shows that community care models improve outcomes, enhance autonomy, and promote social inclusion.

Policies should prioritize funding and scaling up a continuum of community services including outpatient care, crisis intervention teams, supported housing, and rehabilitation programs. Community services are often more flexible, culturally sensitive, and responsive to individual preferences.

Moreover, integrating mental health into primary care systems can enhance accessibility, reduce stigma, and facilitate early intervention. Collaborative care models involving multidisciplinary teams are particularly effective.

Crucially, the expansion of voluntary services must be accompanied by training for mental health professionals on human rights principles, trauma-informed care, and de-escalation techniques to reduce coercive practices.

Governments and stakeholders should also invest in data collection and monitoring systems to assess service quality, equity, and user satisfaction, fostering continuous improvement (Delmon, 2017; Nyarku et al., 2018).

Peer support—assistance and guidance provided by individuals with lived experience of mental health conditions—has emerged as a vital component of modern mental health care. Peer workers offer unique empathy, reduce isolation, and empower service users, promoting recovery-oriented care.

Policy frameworks must incorporate formal recognition and funding for peer support programs, ensuring they are integrated into mental health systems and adequately resourced (Gillard et al., 2017; Gopalan et al., 2017).

Supported decision-making (SDM) mechanisms are equally transformative. SDM respects the legal capacity of persons with disabilities by providing tailored assistance in understanding information, weighing options, and communicating decisions. This approach replaces substitute decision-making and aligns with international human rights mandates.

To implement SDM effectively, policies should support; Training for facilitators skilled in communication, mediation, and advocacy. Development of legal recognition for SDM agreements and frameworks that clarify rights and responsibilities. Public awareness campaigns to reduce stigma and promote understanding of SDM (Brooks et al., 2017; Sapag et al., 2018). Research and evaluation to refine practices and document outcomes.

SDM mechanisms empower individuals to participate fully in healthcare decisions, fostering autonomy and dignity.

Legal reforms must aim to minimize the use of coercion in mental health care while safeguarding rights. This requires comprehensive legislative and policy action.

Key measures include; Repealing or amending laws that authorize involuntary detention and treatment based solely on disability or diagnosis. Laws should limit coercion to exceptional circumstances that meet strict criteria related to immediate risk, and even then, only as a last resort. Mandating procedural safeguards such as timely judicial review, independent advocacy, and the right to appeal decisions (Fox-Decent and Pless, 2017; Naclerio, 2017). These mechanisms ensure that deprivation of liberty or forced treatment is subject to oversight and can be challenged. Establishing advance directives and psychiatric wills as legally binding instruments that enable individuals to express treatment preferences in anticipation of crisis, thus respecting autonomy even during impaired capacity. Regulating the use of restrictive practices (e.g., seclusion, restraint) with stringent conditions, monitoring, and penalties for misuse. Promoting alternatives to coercion, including crisis respite centers, mobile crisis teams, and mediation services.

Additionally, mental health laws should incorporate anti-discrimination provisions to protect persons with psychosocial disabilities from bias and ensure equality before the law.

Moving forward, reform efforts must prioritize a participatory approach, involving persons with lived experience in policy design, implementation, and evaluation. This inclusivity enhances legitimacy and responsiveness.

International cooperation can foster the sharing of best practices and the development of global standards consistent with human rights treaties.

Technological innovation, including digital tools for peer support and decision-making assistance, holds promise for expanding access and empowerment but requires careful ethical and legal oversight.

Finally, ongoing research and evaluation are critical to understand the impact of reforms, identify gaps, and guide continuous improvement.

Rights-based mental health law reform necessitates a holistic strategy that centers on autonomy, dignity, and inclusion (Dew et al., 2018; Latonero, 2018). Strengthening voluntary, community-based services alongside investment in peer support and supported decision-making fosters empowerment and recovery. Legal measures must curtail coercion, enhance safeguards, and enshrine respect for informed consent. Through these concerted efforts, mental health systems can evolve from coercive, paternalistic models to ones grounded in respect for human rights and person-centered care—ensuring that all individuals receive compassionate, equitable, and effective support (Carney, 2017; Flanagan et al., 2017).

CONCLUSION

The analysis of mental health law reform reveals complex legal and ethical tensions inherent in involuntary treatment regimes. Central findings highlight the ongoing conflict between protecting individual autonomy and ensuring safety, underscoring the difficulty in balancing these competing imperatives. Capacity assessments, while essential, remain fraught with challenges related to validity and consistency, often influencing the legitimacy of overriding consent. Procedural safeguards and legal remedies play a crucial role in protecting rights, yet disparities in access and implementation persist. Furthermore, concerns regarding discrimination and stigma emphasize the need for reforms that address systemic biases affecting marginalized populations.

Given these tensions, there is a compelling call for integrated legal frameworks that fully respect human rights while enabling effective mental health care. Such frameworks should embed principles from international human rights instruments, especially the United Nations Convention on the Rights of Persons with Disabilities (CRPD), prioritizing supported decision-making over substitute models. They must also ensure procedural fairness, transparency, and accountability through robust oversight mechanisms and accessible legal remedies.

Fundamentally, mental health law reforms must emphasize the dignity, autonomy, and non-discrimination of persons with psychosocial disabilities. Recognizing individuals as rights holders with inherent worth necessitates shifting away from coercive practices toward person-centered, voluntary care models. This transition requires legal reforms coupled with investments in community-based services, peer support, and capacity-building initiatives. By centering these values, future mental health systems can foster inclusion, reduce stigma, and promote recovery.

In conclusion, aligning mental health laws with rights-based principles is essential to uphold justice and equity. Integrated, rights-respecting legal frameworks that balance autonomy with protection will better serve individuals' needs while honoring their fundamental human rights. This approach lays the foundation for transformative mental health care reforms that respect and empower all persons.

REFERENCES

[1] Alden, D.L., Friend, J., Lee, P.Y., Lee, Y.K., Trevena, L., Ng, C.J., Kiatpongsan, S., Lim Abdullah, K., Tanaka, M. and Limpongsanurak, S., 2018. Who decides: me or we? Family involvement in medical decision making in Eastern and Western countries. *Medical Decision Making*, *38*(1), pp.14-25.

[2] Allen, S. and Hawkins, A.J., 2017. Theorizing the decision-making process for divorce or reconciliation. *Journal of Family Theory & Review*, *9*(1), pp.50-68.

[3] Alston, B., 2017. Towards supported decision-making: Article 12 of the convention on the rights of persons with disabilities and guardianship law reform. *Law in Context*, *35*(2), pp.21-43.

[4] Barnett, P., Matthews, H., Lloyd-Evans, B., Mackay, E., Pilling, S. and Johnson, S., 2018. Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis. *The Lancet Psychiatry*, *5*(12), pp.1013-1022.

[5] Barstow, C., Shahan, B. and Roberts, M., 2018. Evaluating medical decision-making capacity in practice. *American family physician*, *98*(1), pp.40-46.

[6] Beaupert, F., 2018. Freedom of opinion and expression: From the perspective of psychosocial disability and madness. *Laws*, *7*(1), p.3.

[7] Beqiraj, J., Garahan, S. and Shuttleworth, K., 2018. Ombudsman schemes and effective access to justice: A study of international practices and trends.

[8] Biddulph, S., Nesossi, E. and Trevaskes, S., 2017. Criminal justice reform in the Xi Jinping era. *China Law and Society Review*, *2*(1), pp.63-128.

[9] Bignami, F., 2016. Regulation and the courts: judicial review in comparative perspective. In *Comparative Law and Regulation* (pp. 275-304). Edward Elgar Publishing.

[10] Braithwaite, J., Churruca, K., Long, J.C., Ellis, L.A. and Herkes, J., 2018. When complexity science meets implementation science: a theoretical and empirical analysis of systems change. *BMC medicine*, *16*, pp.1-14.

[11] Brooks, H., Harris, K., Bee, P., Lovell, K., Rogers, A. and Drake, R., 2017. Exploring the potential implementation of a tool to enhance shared decision making (SDM) in mental health services in the United Kingdom: a qualitative exploration of the views of service users, carers and professionals. *International Journal of Mental Health Systems*, *11*, pp.1-12.

[12] Carney, T., 2017. Supported decision-making in Australia: Meeting the challenge of moving from capacity to capacity-building?. *Law in Context*, *35*(2), pp.44-63.

[13] Cate, F.H., 2016. The failure of fair information practice principles. In *Consumer Protection in the Age of the'Information Economy'* (pp. 341-377). Routledge.

[14] Chan, H.Y., 2018. *Advance directives: rethinking regulation, autonomy & Healthcare decision-making*. Cham, Switzerland: Springer International Publishing.

[15] Cocanour, C.S., 2017. Informed consent—It's more than a signature on a piece of paper. *The American Journal of Surgery*, *214*(6), pp.993-997.

[16] Cokely, E.T., Feltz, A., Ghazal, S., Allan, J.N., Petrova, D. and Garcia-Retamero, R., 2018. Decision making skill: From intelligence to numeracy and expertise. *Cambridge handbook of expertise and expert performance*, *2018*, pp.476-505.

[17] Crawford, A. and Evans, K., 2017. Crime prevention and community safety.

[18] Cullors, P., 2018. Abolition and reparations: Histories of resistance, transformative justice, and accountability. *Harv. L. Rev.*, *132*, p.1684.

[19] Davidson, G., Brophy, L., Campbell, J., Farrell, S.J., Gooding, P. and O'Brien, A.M., 2016. An international comparison of legal frameworks for supported and substitute decision-making in mental health services. *International Journal of Law and Psychiatry*, *44*, pp.30-40.

[20] Delmon, J., 2017. *Public-private partnership projects in infrastructure: an essential guide for policy makers*. Cambridge university press.

[21] DePiñeres, T., Raifman, S., Mora, M., Villarreal, C., Foster, D.G. and Gerdts, C., 2017. ‘I felt the world crash down on me’: Women’s experiences

being denied legal abortion in Colombia. *Reproductive health*, *14*, pp.1-9.

[22] Dew, A., Dowse, L., Athanassiou, U. and Trollor, J., 2018. Current representation of people with intellectual disability in Australian mental health policy: The need for inclusive policy development. *Journal of Policy and Practice in Intellectual Disabilities*, *15*(2), pp.136-144.

[23] Diadori, P., 2017. A mixed method review and quality criteria analysis: Towards improving decision aids and informing care models in prenatal testing.

[24] Dirth, T.P. and Branscombe, N.R., 2018. The social identity approach to disability: Bridging disability studies and psychological science. *Psychological bulletin*, *144*(12), p.1300.

[25] Dove, E.S., Kelly, S.E., Lucivero, F., Machirori, M., Dheensa, S. and Prainsack, B., 2017. Beyond individualism: Is there a place for relational autonomy in clinical practice and research?. *Clinical ethics*, *12*(3), pp.150-165.

[26] Duffy, R.M. and Kelly, B.D., 2017. Rights, laws and tensions: A comparative analysis of the Convention on the Rights of Persons with Disabilities and the WHO Resource Book on Mental Health, Human Rights and Legislation. *International journal of law and psychiatry*, *54*, pp.26-35.

[27] Fistein, E.C., Clare, I.C., Redley, M. and Holland, A.J., 2016. Tensions between policy and practice: a qualitative analysis of decisions regarding compulsory admission to psychiatric hospital. *International journal of law and psychiatry*, *46*, pp.50-57.

[28] Flanagan, J., Boltz, M.P. and Grace, P.J., 2017. Practice Nursing: Caring. *Nursing Ethics and Professional Responsibility in Advanced Practice*, p.293.

[29] Fox-Decent, E. and Pless, A., 2017. The Charter and Administrative Law Part I: Procedural Fairness. *Evan Fox-Decent & Alexander Pless, The Charter and Administrative Law Part I: Procedural Fairness, in ADMINISTRATIVE LAW IN CONTEXT, 3rd ed (Colleen Flood & Lorne Sossin, eds., Forthcoming)*.

[30] Freckelton, I., 2018. Involuntary detention decision-making, criteria and hearing procedures: An opportunity for therapeutic jurisprudence in action. In *Involuntary detention and therapeutic jurisprudence* (pp. 293-337). Routledge.

[31] George, M.A., 2016. Expressive ends: Understanding conversion therapy bans. *Ala. L. Rev.*, *68*, p.793.

[32] Gillard, S., Foster, R., Gibson, S., Goldsmith, L., Marks, J. and White, S., 2017. Describing a principles-based approach to developing and evaluating peer worker roles as peer support moves into mainstream mental health services. *Mental health and social inclusion*, *21*(3), pp.133-143.

[33] Gold, M.R., Realmuto, L., Scherer, M., Kamler, A. and Weiss, L., 2018. Community priorities for hospital-based prevention initiatives: results from a deliberating public. *Journal of Public Health Management and Practice*, *24*(4), pp.318-325.

[34] Gopalan, G., Lee, S.J., Harris, R., Acri, M.C. and Munson, M.R., 2017. Utilization of peers in services for youth with emotional and behavioral challenges: A scoping review. *Journal of adolescence*, *55*, pp.88-115.

[35] Gross, A.J. and Thomas, C., 2017. The New Abolitionism, International Law, and the Memory of Slavery. *Law and History Review*, *35*(1), pp.99-118.

[36] Hailemariam, M., Fekadu, A., Prince, M. and Hanlon, C., 2017. Engaging and staying engaged: a phenomenological study of barriers to equitable access to mental healthcare for people with severe mental disorders in a rural African setting. *International journal for equity in health*, *16*, pp.1-12.

[37] Haque, A.A., 2017. *Law and morality at war*. Oxford University Press.

[38] Hardesty, G.D., 2018. Emerging from Crisis: The Paris Climate Agreement and the New Development Paradigm.

[39] Hem, M.H., Molewijk, B., Gjerberg, E., Lillemoen, L. and Pedersen, R., 2018. The significance of ethics reflection groups in mental health care: a focus group study among health care professionals. *BMC medical ethics*, *19*, pp.1-14.

[40] Hobbins, J., 2017. Between autonomy and paternalism: crisis managers' constructions of citizens' responsibilities in the context of crises

and Contingencies. *Journal of Contingencies and Crisis Management*, *25*(4), pp.269-278.

[41] Ibrahim, I.A., Brown, R.D. and Truby, J., 2017. Big data analytics and its impact on basin water agreements and international water law: A study of the Ramotswa aquifer. *University of Pennsylvania Journal of International Law*, *73*, p.101.

[42] Janus, E.S., 2018. Beyond Strict Scrutiny: Forbidden Purpose and the "Civil Commitment" Power. *New Criminal Law Review*, *21*(3), pp.345-378.

[43] Kritsotaki, D., Long, V. and Smith, M. eds., 2016. *Deinstitutionalisation and after: post-war psychiatry in the western world*. Springer.

[44] Latonero, M., 2018. Governing artificial intelligence: Upholding human rights & dignity. *Data & Society*, *38*.

[45] Leenes, R., Palmerini, E., Koops, B.J., Bertolini, A., Salvini, P. and Lucivero, F., 2017. Regulatory challenges of robotics: some guidelines for addressing legal and ethical issues. *Law, Innovation and Technology*, *9*(1), pp.1-44.

[46] Liang, D., Mays, V.M. and Hwang, W.C., 2018. Integrated mental health services in China: challenges and planning for the future. *Health policy and planning*, *33*(1), pp.107-122.

[47] Luchtman, M.J.J.P. and Vervaele, J.A.E., 2017. Comparison of the legal frameworks.

[48] Mahomed, F., 2016. Stigma on the basis of psychosocial disability: A structural human rights violation. *South African Journal on Human Rights*, *32*(3), pp.490-509.

[49] McLean, S.A. ed., 2016. *First do no harm: law, ethics and healthcare*. Routledge.

[50] McSwiggan, S., Meares, S. and Porter, M., 2016. Decision-making capacity evaluation in adult guardianship: a systematic review. *International Psychogeriatrics*, *28*(3), pp.373-384.

[51] Merry, S.E. and Levitt, P., 2017. The vernacularization of women's human rights. *Human rights futures*, pp.213-36.

[52] Mezzina, R., Rosen, A., Amering, M. and Javed, A., 2018. The practice of freedom: Human rights and the global mental health agenda. In *Advances in psychiatry* (pp. 483-515). Cham: Springer International Publishing.

[53] Milat, A.J. and Li, B., 2017. Narrative review of frameworks for translating research evidence into policy and practice. *Public Health Res Pract*, *27*(1), p.e2711704.

[54] Mustapha, A.Y., Chianumba, E.C., Forkuo, A.Y., Osamika, D. and Komi, L.S., 2018. Systematic review of mobile health (mHealth) applications for infectious disease surveillance in developing countries. *Methodology*, *66*.

[55] Naclerio, M.A., 2017. Accountability through procedure: Rethinking charter school accountability and special education rights. *Colum. L. Rev.*, *117*, p.1153.

[56] Nyarku, K.M., Kusi, L.Y., Domfeh, H.A., Ofori, H., Koomson, I. and Owusu, J.A., 2018. Moderating the service quality-customer loyalty relation through customer satisfaction, gender and banking status: Evidence from mobile money users in University of Cape Coast, Ghana. *International Journal of Academic Research in Business and Social Sciences*, *8*(6), pp.704-733.

[57] Ogungbenle, H.N. and Omowole, B.M., 2012. Chemical, functional and amino acid composition of periwinkle (Tympanotonus fuscatus var radula) meat. *Int J Pharm Sci Rev Res*, *13*(2), pp.128-132.

[58] Papadimos, T.J., Marcolini, E.G., Hadian, M., Hardart, G.E., Ward, N., Levy, M.M., Stawicki, S.P. and Davidson, J.E., 2018. Ethics of outbreaks position statement. Part 1: Therapies, treatment limitations, and duty to treat. *Critical care medicine*, *46*(11), pp.1842-1855.

[59] Phillips, J.M., 2018. From Containment to Resilience: A Genealogy of the Governance of Mental Abnormality in Canada.

[60] Prado, M.M. and Trebilcock, M.J., 2018. *Institutional bypasses: a strategy to promote reforms for development*. Cambridge University Press.

[61] Purser, K. and Purser, K., 2017. Substitute decision-making. *Capacity Assessment and the Law: Problems and Solutions*, pp.129-148.

[62] Richardson, G., 2018. Involuntary treatment: Searching for principles. In *Involuntary detention and therapeutic jurisprudence* (pp. 55-73). Routledge.

[63] Sapag, J.C., Sena, B.F., Bustamante, I.V., Bobbili, S.J., Velasco, P.R., Mascayano, F., Alvarado, R. and Khenti, A., 2018. Stigma towards mental illness and substance use issues in primary health care: Challenges and opportunities

for Latin America. *Global Public Health*, *13*(10), pp.1468-1480.

[64] Scull, A., 2018. *Social order/mental disorder: Anglo-American psychiatry in historical perspective*. Routledge.

[65] Sinha, A., 2018. Defining detention: the intervention of the European Court of Human Rights in the detention of involuntary migrants. *Colum. Hum. Rts. L. Rev.*, *50*, p.176.

[66] Sokolowski, M., 2018. *Dementia and the advance directive: Lessons from the bedside*. Springer.

[67] Stoyanova, V., 2018. The disjunctive structure of positive rights under the European Convention on Human Rights. *nordic journal of international law*, *87*(3), pp.344-392.

[68] Stuen, H.K., Landheim, A., Rugkåsa, J. and Wynn, R., 2018. Responsibilities with conflicting priorities: a qualitative study of ACT providers' experiences with community treatment orders. *BMC health services research*, *18*, pp.1-11.

[69] Szmukler, G. and Kelly, B.D., 2016. We should replace conventional mental health law with capacity-based law. *The British Journal of Psychiatry*, *209*(6), pp.449-453.

[70] Taylor, B.J., 2017. Decision making, assessment and risk in social work.

[71] Tomossy, G.F. and Weisstub, D.N., 2017. The Reform of Adult Guardianship Laws:: The Case of Non-Therapeutic Experimentation. In *Human Experimentation and Research* (pp. 335-361). Routledge.

[72] Tõnurist, P. and Surva, L., 2017. Is volunteering always voluntary? Between compulsion and coercion in co-production. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations*, *28*, pp.223-247.

[73] Tran, N.T., Baggio, S., Dawson, A., O'Moore, É., Williams, B., Bedell, P., Simon, O., Scholten, W., Getaz, L. and Wolff, H., 2018. Words matter: a call for humanizing and respectful language to describe people who experience incarceration. *BMC international health and human rights*, *18*, pp.1-6.

[74] Turnpenny, A., Petri, G., Finn, A., Beadle-Brown, J. and Nyman, M., 2018. Mapping and understanding exclusion: institutional, coercive and community-based services and practices across Europe.

[75] Usher, R. and Stapleton, T., 2018. Overview of the Assisted Decision-Making (Capacity) Act (2015) Implications and opportunities for occupational therapy. *Irish Journal of Occupational Therapy*, *46*(2), pp.130-140.

[76] Whittaker, M., Crawford, K., Dobbe, R., Fried, G., Kaziunas, E., Mathur, V., West, S.M., Richardson, R., Schultz, J. and Schwartz, O., 2018. *AI now report 2018* (pp. 1-62). New York: AI Now Institute at New York University.