International Journal of Law and Psychiatry 64 (2019) 184–197

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy

Involuntary psychiatric admission: Comparative study of mental health legislation in Brazil and in England/Wales

Emanuele Seicenti de Brito[a], Carla Aparecida Arena Ventura[b,*]

[a] CAPES Foundation, Ministry of Education of Brazil, Brasília DF 70.040-020, Brazil
[b] University of São Paulo at Ribeirão Preto College of Nursing WHO Collaborating Centre for Nursing Research Development, 3900 Bandeirantes Av, Campus Universitário, Ribeirão Preto 14040-902, Brazil

ARTICLE INFO

Keywords:
Human rights
Mental health
Patients rights
Involuntary admission
Comparative study

ABSTRACT

Involuntary admission is a controversial measure that can lead to violation of various human rights. On the opposite, involuntary admissions may contribute for the recovery of those with severe mental disorders who represent a danger to themselves or others. From this perspective, legislation must define and limit the circumstances in which this may occur preventing human rights violations. In this context, this descriptive-comparative study aimed at analyzing the similarities and differences between the mental health' laws related to involuntary psychiatric admission in Brazil and England/Wales. Data were collected through bibliographic and documentary research. The analysis was based on the World Health Organization's Checklist on Mental Heallth Legislation, using the comparative method. Results showed that the Brazilian legislation meets 52 (31.32%) of the 166 WHO standards, while legislation in England/Wales meets 90 (54.2%). In addition, the law from England/Wales establishes clearer and detailed procedures for "involuntary admissions" and has "oversight and review mechanisms" more effective than Brazil; the legislation presents a medium compliance of "competence, capacity and protection", and Brazil does not address these issues in its legislation; Brazilian legislation establishes a larger list of "fundamental rights", but does not provide "penalties" for the breach of those rights, while England/Wales meets WHO criteria in relation to this issue. The main similarities between Brazil and England/Wales refer to standards that require review: "voluntary patients", "emergency treatment", "economic and social rights", "civil issues" and "protection of vulnerable groups." Both jurisdictions also have the same level of compliance regarding "clinical and experimental research", and "special treatments, seclusion and restraint". This study may bring light for a reflection from competent authorities on the need to have audits for national mental health legislations, carried out by multidisciplinary committees, as recommended by WHO.

1. Introduction

People with mental disorders are considered a vulnerable group in society and face stigma, discrimination, and marginalization, resulting in a greater likelihood that their human rights will be violated. Because of their mental disorder, they can be subject to unwanted interference in their lives, such as involuntary admission to psychiatric facilities. Involuntary admission is a controversial measure that can lead to the

* Corresponding author.
E-mail addresses: emanuele600@usp.br (E.S.d. Brito), caaventu@eerp.usp.br (C.A.A. Ventura).

https://doi.org/10.1016/j.ijlp.2019.04.005
Received 7 February 2018; Received in revised form 15 March 2019; Accepted 10 April 2019
Available online 17 April 2019

violation of various human rights,[1] as it invades the right to liberty, privacy, integrity, the right to maximum preservation of capacity, the right to be treated in the least restrictive environment possible, the right to living independently and being included in the community. It also brings the risk of abuse for political, social, and other reasons (Hunt & Mesquita, 2006; World Health Organization, 2005).

The absence of these rights negatively impacts the lives of these persons who are subject to stigma and discrimination, abuse, restrictions in the exercise of civil and political rights, restrictions in the ability to participate in public affairs and also barriers in access to education and work. Thus, persons with mental disorders meet the main criteria of vulnerability, requiring special attention in development policies (Drew et al., 2011).

The United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD) is the most up-to-date international legal instrument specifically tailored to stipulate the rights of persons with disabilities, including those with serious mental disorders (Szmukler, 2019). Further careful consideration may need to be given to the application of the UN-CRPD in the context of mental health, as it presents challenging ethical questions (Duffy & Kelly, 2017a, 2017b).

According to the Committee on the Rights of Persons with Mental Disabilities General Comment, involuntary admissions are not permitted. Both conventional mental health and "capacity-based" law are deemed to violate the convention (Szmukler, 2019). Legislation from different countries base "involuntary care on the presence of mental illness and associated risk" (Kelly, 2016). When addressing this theme, Kelly (2016) argues that "denial of care (especially to the most distressed) on the basis of the CRPD would be grossly inconsistent with the fundamental aims and purpose of the CRPD, as people with disabilities are entitled to all levels and modalities of care that are available to everyone, without distinction of any description". Considering that a minimum level of physical and mental health is necessary to ensure the ability to enjoy and benefit from other rights, involuntary treatment has been seen as a means to restore the right to health and other human rights of persons with mental disorders (Gable & Gostin, 2009).

On the other hand, there is a growing discussion on recovery, criticizing these measures and suggesting the abolition of this practice for constituting violations of human rights regardless of circumstances. As these measures are still used in all countries, legislation needs to define and limit the circumstances where this can occur (Erdmane, 2010; Latif & Malik, 2012; Zhang, Mellsop, Brink, & Wang, 2015).

The formulation of mental health laws and policies is a key strategy to promote human rights, the development of community services, and to protect persons with mental disorders who do not or cannot avail themselves of voluntary treatment and are more likely to continue to experience rights violations including homelessness, imprisonment and victimization (Drew et al., 2011). Changes in mental health legislation may also stimulate awareness and education campaigns, through the establishment of legal and supervisory mechanisms to prevent human rights violations. These policies and laws should be established in conformity with international human rights standards, which require the active involvement of people with mental disorders in the policy decision process.

Historically, the development of policies and laws excluded people with mental disorders, which facilitated a situation where their needs were not adequately addressed (Drew et al., 2011). One aspect of mental health laws used in developed countries is to address the question of how a person with a severe mental disorder, susceptible to harm himself and others, can be hospitalized with their human rights respected?

In this context, this study aimed to analyze the similarities and differences between the mental health laws relating to involuntary psychiatric admission in Brazil and England/Wales.

Considering the international standards established by different Human Rights Conventions, governments are implementing laws and policies on mental health. In Brazil, since the end of the 1980s, the initiatives aiming for changes in the care to persons with mental disorders increased with the promulgation of ordinances and the creation and implementation of services to substitute hospitalization in institutions with asylum characteristics. The movement of psychiatric reform was consolidated in the country with Law n. 10216 in 2001 which implemented a model based on a network for mental health care in the country, prioritizing community engagement.

Other countries passed through a process of reforms in their mental health services, among them England and Wales (Mental Health Act 1959, Mental Health Act 1983, Community Care Act 1990, Mental Capacity Act 2005, Mental Health Act 2007), which actually have a Network for Mental Health Care with services at all complexity levels and with policies focused on prevention and primary care linked to Basic Health Unities and the community. These legislations establish the need for a strong investment in secondary care through several types of services offered to the population. These policies are created in conformity with the Community Care Act 1990, which establishes that the treatment and rehabilitation of patients with mental disorders should occur in the community.

Both jurisdictions are characterized by the purpose to assure the right to health to their populations, through the principle of universalization of access, integrality, and quality of health services. They went through reform movements in their mental health services, with the same purpose: to include users in the social context, excluding the hospital-based model of mental health practices. England and Wales have consolidated legislation, with healthcare provided with quality and based on scientific evidence and with international recognition (Brazilian Psychiatry Association, 2006).

The study uses comparative analysis, which is widely used in the social sciences and which has been used in the health sciences as a valuable method of rethinking concepts, services, and practices, finding references in the search for new pathways. In this context, an

[1] The terms human rights, right to health, mental health and mental disorder are mentioned several times in this paper. Therefore, we present below the definitions adopted for these terms in this article:

Human Rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, right to health, and many more. Everyone is entitled to these rights, without discrimination (United Nations, 2018).

Right to Health is one of a set of internationally agreed human rights standards and is inseparable or 'indivisible' from these other rights. This means that achieving the right to health is both central to, and dependent upon, the realization of other human rights, to food, housing, work, education, information, and participation (World Health Organization, 2017).

The right to health, as established in international human rights instruments, covers both physical and mental health. Just as it is difficult to deal with the right to health without considering other human rights, mental health and physical health cannot be considered separately in the context of human rights - a minimum level of physical and mental health is necessary to ensure the ability to enjoy and benefit from other human rights.

Mental Health is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"(World Health Organization, 2014).

Mental Disorder: There are many different mental disorders, with different presentations. They are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behavior, and relationships with others.

Mental disorders include depression, bipolar affective disorder, schizophrenia, and other psychoses, dementia, intellectual disabilities and developmental disorders including autism (World Health Organization, 2018). WHO Resource book does not advocate a particular definition; it only aims to make lawmakers and others involved in the process of drafting legislation aware of the various choices and advantages and disadvantages of different approaches to definitions (World Health Organization, 2005, p. 20). In this article, the term mental disorder is used as it is present in the analyzed legislation.

understanding and a comparison of standards in Brazil and England/Wales on the rights of people with mental disorders involuntarily admitted to psychiatric facilities is important as a parameter to characterise the evolution of the right to mental health in both countries, and should serve as a reference in the search for new pathways to mental health in Brazil.

1.1. The World Health Organization's (WHO) checklist on mental health legislation

The history of psychiatry supports the importance of legislation in the area of mental health in order to protect the rights of persons with mental disorders (Duffy & Kelly, 2017a,b). WHO also recognized the role of law in this process, and, in 2005 published the WHO Resource Book on Mental Health. The book seeks to guide governments in the development of mental health legislation centered on human rights. It features an attached Checklist on Mental Health Legislation with the objective of assisting countries in reviewing the comprehensiveness and adequacy of existing mental health legislation and guiding them in the process of drafting new laws.

Therefore, the checklist aims at helping individual countries to assess whether key elements are included in the legislation, and ensure that the general recommendations contained in the Resource Book are examined and considered by them (World Health Organization, 2005).

The list comprises 175 individual patterns grouped into 27 categories (A-AZ). Despite being very detailed, it is not an absolute set of rules, nor is it a comprehensive list. Some problems suggested by WHO that fall within the mental health legislation may be covered by other forms of legislation or policy already in place. The list provides a useful framework though, explicitly rooted in human rights issues, which should be considered in the context of national mental health laws (Kelly, 2011).

Several comparative studies and analyses of legislation worldwide have used the checklist (Dlouhy, 2014; Fistein, Holland, Clare, & Gunn, 2009; Gray, McSherry, O'Reilly, & Weller, 2010; Kelly, 2011; Shao, Xie, Good, & Good, 2010.; Duffy & Kelly, 2017a,b).

The Resource Book was published before the approval of the United Nations Convention on the Rights of Persons with Disabilities. Thus, it is not totally in accordance with the Convention's content, as it discusses involuntary treatment, lack of competence, and emergency treatments. After the approval of the above mentioned Convention, WHO implemented the WHO QualityRights initiative, which comprises different tools for the evaluation of services and training modules on the human rights of persons with mental disabilities. The QualityRights instruments are not directly linked to the legislation of countries, such as the WHO Checklist. Therefore, in spite of the Checklist limitations, this tool was chosen as it is a useful and detailed instrument to analyze mental health legislation in different countries.

2. Material and methods

This is a descriptive-comparative study between the mental health laws that relate to involuntary admission in Brazil and England/Wales.

The research process followed three stages: i) data collection, ii) analysis and iii) comparison of the data.

i) Data collection

An analysis was carried out on aspects of mental health services and on current mental health legislation. The following techniques were used for data collection:

Bibliographic research: This was executed through scientific databases in the areas of health, law, and multidisciplinary areas, allowing access to a large collection of publications on the subject of the research, including scientific articles, books, and theses.

Documentary research: Documents included in this research were specific laws of the jurisdictions in the study, documents from the Ministry of Health and the Department of Health of England, as well as World Health Organization reports, the Disability Rights Commission, and the Care Quality Commission. The last two are from English organizations that publish reports periodically on mental health in the country.

The main legislation in Brazil on Mental Health is the Law 10.216 of 2001, which redirected the care model in mental health and addresses the rights of people with mental disorders. Since its enactment, it has approved several pieces of legislation on psychiatric hospitalization and on mental health in general.

In England and Wales, the Mental Health Act of 1983 (MHA), revised in 2007, is the legislation that has the greatest effect on people with mental disorders. This legislation allows patients with mental disorders to be admitted to hospitals, detained, and treated against their will, or allows them to receive care in the community under community treatment orders or guardianship. This can only be done if the patient is putting their own health or safety or others at risk. The person must have, or appear to have, a mental disorder (Abdalla-Filho & Engelhardt, 2003; Care Quality Commission, 2016).

The MHA includes safeguards for people's rights when they are being detained or treated by professionals. It does this by providing rules and requirements for professionals to follow. The MHA Code of Practice, which is the statutory guidance for mental health professionals and services, explains how this should be done in practice.

Tables 1 and 2 list the current mental health legislation related to involuntary admission in Brazil and in England/Wales used in this study.

ii) Analysis

The World Health Organization's Checklist on Mental Health Legislation was used for the analysis. The list comprises 175 individual patterns grouped into 27 categories (A-AZ).[2] Some adjustments were necessary and nine standards which related to offenders with mental disorders were excluded because this study aims to focus only on the involuntary admission.

2.1. Strategies for assuring trustworthiness

Strategies for assuring trustworthiness were used to enhance the value of the research findings. Thereby, two researchers with a background in law and experience in the development of comparative legislation studies analyzed the legislation from both countries, based on

[2] In this study, a modified version of the WHO Checklist adapted by Kelly, 2011 was used. Each alphabet letter corresponds to a legislative issue. A- Preamble and objective; B- Definitions; C– Access to mental health care; D- Rights of users of mental health services; *E*- Rights of users of mental health services; F- Competence, capacity, and guardianship; G- Voluntary admission and treatment

Rights of families or other carers; H– Non-protesting patients; I- Involuntary admission (when separate from treatment) and involuntary treatment (where admission and treatment are combined); *J*- Involuntary treatment (when separate from involuntary admission); K- Proxy consent for treatment; L- Involuntary treatment in community settings; M- Emergency situations; N- Determinations of mental disorder; O– Special treatments; P- Seclusion and restraint; Q- Clinical and experimental research; R- Oversight and review mechanisms; S- Police responsibilities; U- Discrimination; V- Housing; W- Employment; X- Social security; Y- Civil Issues; *Z*-Protection of vulnerable groups; AZ- Offenses and penalties.

For each component included in the checklist it is necessary to answer three questions: a) is the question covered by the legislation? b) If so, is it fully covered? c) Or it is not covered?

Table 1
List of the Brazilian documents used in this study.

Year	Document	Topic/Aim
1999	Law No. 9.867	Allows the development of psychosocial support programs for patients with mental disorders in monitoring community service.
2000	Ordinance MS/GM No. 106	Creates and regulates the functioning of the Therapeutic Residential Services.
2000	Resolution CFM No. 1.598	Standardizes medical care to patients with mental disorders.
2001	Law No. 10.216	Redirected the care model in mental health and addresses the rights of people with mental disorders.
2002	Ordinance MS/GM No. 251	Establishes the systematic and annual evaluation and supervision of the hospital network specialised in psychiatry, as well as general hospitals with wards or psychiatric beds, establishing classification criteria as to the size of the establishment and enforcing the assessment requirements set by the Ministry of Health in relation to the therapeutic process and Brazilian Health Regulatory Agency (ANVISA) for analysis of sanitary surveillance.
2002	Ordinance MS/GM No. 336	Adds new parameters to those set by the 1992 ordinance for the outpatient area, expanding the scope of substitute day care services, establishing different sizes from population criteria, and targeting specific new services for the drugs and alcohol area, and for childhood and adolescence. It also creates its own funding mechanism, in addition to municipal financial allocations from the CAPS network.
2002	Resolution CFM No. 1.640	Regulates the therapeutic use of electroconvulsive therapy (ECT).
2002	Ordinance MS/GM No. 2.391	Regulates the control of involuntary and voluntary psychiatric hospitalizations in accordance with the provisions of Law 10.216/2002, and the communication reporting procedures of admissions to public attorneys by health facilities, whether or not they are members of the SUS.
2003	Law No. 10.708	Establishing the “Back Home” program which stipulates psychosocial rehabilitation aid for patients suffering from mental disorders discharged from hospital.
2004	Ordinance MS/GM No. 52	Creates the Hospital Care Restructuring Program Annual Psychiatric SUS, reaffirming the policy guidelines for the progressive reduction of beds.
2010	Resolution CFM No. 1.952	Adopts guidelines for a comprehensive care model for mental health in Brazil and modifies the CFM Resolution n° 1.598/2000.
2011	Ordinance MS/GM No. 3.088	Establishes the Psychosocial Care Network for people with mental disorders and needs arising in the SUS from the use of crack, alcohol and other drugs.
2013	Resolution CFM 2.057	Consolidates the various resolutions in the Psychiatry area and reaffirms the universal principles of protection for human beings, protection of the private medical acts of psychiatrists and the minimum security criteria for hospitals or psychiatric care of any nature, also setting the anamnesis model and expert script in psychiatry.

Table 2
List of the England and Wales documents used in this study.

Year	Document	Topic/Aim
1983	Mental Health Act (MHA)	The legal framework for compulsorily treating people with mental health conditions where it is in the interests of their health or safety or the safety of others to do so, alongside the safeguards required to protect their rights while receiving such treatment.
2005	Mental Capacity Act (MCA)	The legal framework for people who need to make decisions on behalf of someone else who lacks capacity. It sets out who can take decisions, in which situations, and how they should go about this. This ensures that they act in the person's best interest and that they empower people to make their own decisions wherever possible.
2005	Deprivation of Liberty Safeguards	The part of the MCA that provides safeguards which protect the rights of people who are deprived of their liberty so that they can be given necessary care or treatment. The safeguards apply specifically to care homes and hospitals.
2007	Mental Health Act (MHA)	An act to amend the Mental Health Act 1983 and the Mental Capacity Act 2005 in relation to mentally disordered persons.

the WHO Checklist. A law professor and a mental health professor validated the relevance of the analyzed data. A native English-speaking professor read the article. At the end, the paper has been professionally proofread.

iii) Comparison of the data

For the comparison step of the data of the two countries, we used the comparative method, considered valuable for the evaluation of the concepts, services, and practice for the comparison of the data of the two countries (Conill et al., 1991). Applying the comparative method in the context of the human sciences is to seek to explain them, to account for the similarities and differences (Schneider, Cláudia, & Schmitt, 1998).

There are two times that are relevant in the context of the comparative method: analog time, related to the identification of similarities between phenomena; and the contrastive moment during which the differences are identified in the cases studied (Schneider et al., 1998).

This study followed these two moments: First, the similarities between the rules for involuntary hospitalization services were identified to establish the differences. Then, an attempt was made to determine how one system can contribute to another.

3. Results: Analysis of the legislation on mental health in Brazil and England/wales

The Brazilian legislation meets 52 (31.32%) of the 166 WHO standards, while the laws of England/Wales meet 90 standards (54.2%).

Table 3 shows the standards embraced by the laws of Brazil and England/Wales, according to the World Health Organization's Checklist on Mental Health Legislation.

The law of England/Wales broadly covers nine standards: Definitions (B) and Determinations of mental disorder (N), Involuntary admission and treatment (IJK and L), Consent (K), Police responsibilities (S), Offenses and penalties (AZ). Brazilian law covers the first four but not comprehensively. The topics relating to police responsibilities, offenses, and penalties have not been addressed by Brazilian legislation.

The patterns on “clinical and experimental research” (Q) and “special treatments, seclusion, and restraint” (O, P) were addressed in both countries, but not fully and comprehensively.

The Mental Health Act in England/Wales includes, but not comprehensively, WHO standards in relation to “competence, capacity, and guardianship”. It does not address the procedures for appeals against disability decisions/incompetence and periodic decision revisions (F4). It does not provide a systematic review of the need for a guardian (F7).

Table 3
Standards covered by the laws of Brazil and England/Wales.

	Brazil	England/Wales
Areas of high compliance with WHO standards		➢ Definitions and Determinations of mental disorder (B and N) ➢ Involuntary admission and treatment (I J K and L)Consent (K) ➢ Police responsibilities (S) ➢ Offenses and penalties (AZ)
Areas of medium compliance with WHO standards	➢ Definitions and Determinations of mental disorder (B and N) ➢ Fundamental principles (A, D) ➢ Involuntary admission and treatment (I J K and L) ➢ Special treatments, seclusion, and restraint (O, P) ➢ Clinical and experimental research (Q)	➢ Competence, capacity, and guardianship (F) ➢ Oversight and review mechanisms (R) ➢ Special treatments, seclusion, and restraint (O, P) ➢ Rights of families or other carers (E) ➢ Clinical and experimental research (Q)
Areas of low compliance (or any compliance) with WHO standards	➢ Rights of families or other carers (E) ➢ Competence, capacity, guardianship, and consent (F, K) ➢ Voluntary Patients (G, H) ➢ Emergency treatment (M) ➢ Oversight and review mechanisms (R) ➢ Police responsibilities (S) ➢ Economic and social rights (C, V) ➢ Employment, social security, and civil issues (W, X, Y) ➢ Protection of vulnerable groups (Z) ➢ Offenses and penalties (AZ)	➢ Fundamental principles (A, D) ➢ Voluntary Patients (G, H) ➢ Emergency treatment (M) ➢ Economic and social rights (C, V) ➢ Employment, social security, and civil issues (W, X, Y) ➢ Protection of vulnerable groups (Z)

These standards are not covered by Brazilian law.

Standards in relation to oversight and review mechanisms (R) and rights of families or other carers (E) have not been addressed fully by the law of England/Wales. These issues are also not covered by Brazilian law.

Brazil and England/Wales have not addressed adequately in their legislation the following WHO standards: Voluntary patients (G, H); Emergency Situations (M); Economic and social rights (C, V); Employment, security, and civil social issues (W, X and Z) and Protection of vulnerable groups (Z).

4. Discussion

Legislation in England/Wales meets 90 (54.2%) of the 166 standards set by WHO. The areas of high coverage include clear definitions of mental disorder, robust procedures for admission and involuntary treatment (although access to information in certain phases remains less than ideal), and clarity about the offenses and penalties for those who violate the law. The following are areas of medium compliance: competence, capacity and consent, monitoring and review mechanisms, and rules governing special treatment, isolation, and containment, as well as more specific issues such as the rights of families and clinical and experimental research.

Among the areas of low coverage are the legislative commitments to protect and promote the rights of people with mental disorders, the definition and treatment of voluntary patients, patients' protection for vulnerable groups (children, women, minorities), procedures in emergency situations. The largest deficit refers to the protection of economic and social rights in mental health legislation.

Legislation in Brazil meets 52 (31.32%) of the 166 standards established by the WHO. There are no areas of high compliance. Medium areas of compliance would be definitions and mental disorder determinations, fundamental principles, admission and involuntary treatment, and clinical and experimental research. Important issues such as competence, capacity, guardianship, and consent, which were highlighted in the CRPD, were not addressed by Brazilian law. The same holds true for offenses and penalties, the responsibility of the police, and emergency situations. Low coverage areas include monitoring and review mechanisms, special treatments, seclusion and restraints, voluntary patients, economic, social, and pension rights.

For discussion, the WHO standards were divided into three groups: 1) *Rights of persons with mental disorders in the legislation of Brazil and England/Wales*, covering the following standards: Definition and determination of mental disorder, Fundamental principles, Economic and social rights. 2) *Involuntary admission in the legislation of Brazil and England/Wales* covering the following standards: Involuntary admission and treatment, Emergency situations, Special treatments, Seclusion and restraint, Oversight and review, Competence, Capacity, and Consent, and 3) *Other relevant issues* covering: Voluntary patients, Rights of families or other carers, Clinical and experimental research, Protection of vulnerable groups, Responsibilities and police offenses and penalties.

4.1. Rights of persons with mental disorders in the legislation of Brazil and England/wales

4.1.1. Definition and determination of mental disorder

The section on “Definitions” (B) in the legislation is important because it presents the interpretation and meaning of the terms used. In this sense, the definitions must be clear and unambiguous for those who need to understand and implement the law, and also for the public who might be affected by it, for patients, families, and also for the courts when they need to make decisions based on the formulated definitions (World Health Organization, 2005).

The law of England/Wales includes clear definitions of mental disorders, stating that “mental disorder means any disorder or disability of the mind; and mentally disordered shall be construed accordingly”.[3] It lists the categories of disorders and defines specific terms, as suggested by WHO. Brazilian law adopted the term “mental disorder”, without defining it and other terms used in the legislation.

With respect to the level of qualification required to diagnose mental disorder (N), the Resource Book guides that legislation should “set the level of experience and qualifications required to determine mental disorder, and outline professional groups authorized to do so (World Health Organization, 2005, p. 82).” In relation to the determination of mental disorder” (N), the Laws of Brazil and England/Wales meet all WHO criteria, with a strong emphasis placed on medical diagnosis.

[3] England/Wales: MHA 2007, Section 1; amending MHA 1983, section 1 (2).

4.1.2. Fundamental principles

WHO emphasizes that the rights of mental health service users should be protected formally in mental health legislation, although some of these rights are not specific to people with mental disorders, such as the rights to information and confidentiality. This special and additional protection is necessary due to the history of human rights abuses, and also the specific characteristics of mental disorders (World Health Organization, 2005).

The preambles of the MHAs of 1983 and 2007 in England/Wales make no mention of human rights and therefore fail to agree with most of the WHO standards in relation to the "preamble and objectives" (A). Brazilian law also lacks a preamble mentioning human rights but has greater compliance with WHO standards with regard to the preamble and the objectives.

Brazilian law has greater coverage of this issue than the law of England/Wales does. Law 10.216/01 specifies the rights of people with mental disorders to:

I - have access to the best treatment from the health system, commensurate with their needs;

II - be treated with humanity and respect and in the exclusive interest of benefiting their health in order to achieve their recovery by their reintegration in the family, in work, and in the community;

III - be protected against any form of abuse and exploitation;

IV - have guaranteed confidentiality of the information provided;

V - be entitled to medical presence at any time, to clarify whether or not their hospitalization is involuntary;

VI - have free access to the available media;

VII - receive detailed information about their illness and its treatment;

VIII - be treated in a therapeutic environment by the least intrusive means possible;

IX – preferably, to be treated in community mental health services (Brazil, 2001).

Among the fundamental principles described in Section 8 of the MHA 2007 are: – (a) respect for patients' past and present wishes and feelings, respect for diversity generally including, in particular, diversity of religion, culture, and sexual orientation (within the meaning of section 35 of the Equality Act 2006), (c) minimizing restrictions on liberty, (d) involvement of patients in planning, developing, and delivering care and treatment appropriate to them, (e) avoidance of unlawful discrimination, (f) effectiveness of treatment, (g) views of carers and other interested parties, (h) patient wellbeing and safety, (i) and public safety.[4]

Both jurisdictions include rights to respect, dignity, and to be treated in a humane way (D1),[5] but do not meet the WHO requirements regarding access to information and right to privacy. Some of these issues are covered by other laws but are not addressed in the mental health legislation. In Brazil, the mental health legislation provides guaranteed access to information, "unless this could cause harm to the patient or to others".[6] Thus, the access to this right has restrictions which contradict general human rights standards such as the International Covenant on Civil and Political Rights (ICCPR) and the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI principles). In these cases, treatment goals may conflict with the exercise of other rights. As an example, the Personal Health Information Protection Act (PHIPA) of 2004 in Ontario, Canada, governs the rules pertaining to the collection, use, and disclosure of personal health information by Health Information Custodians. Changes are needed to ensure that family members and caregivers providing support to, and often living with, an individual with a mental illness or addiction have access to the personal health information necessary to provide that support, however, to prevent further deterioration in the health of that individual, and to minimize the risk of serious psychological or physical harm (Chan & O'Brien, 2011).

The laws of both jurisdictions analyzed in this study also specify the right to be protected from cruel, inhuman, and degrading treatment (D).[7] However, the laws do not set out the minimum conditions to be maintained in mental health facilities for a safe, therapeutic and hygienic (D5) environment.

The MHAs of England/Wales make no explicit reference to educational activities, professional qualifications, leisure, and recreational activities, and religious or cultural needs of people with mental disorders (D8).

In Brazil, the law provides that the services to carry out psychiatric care in an in-patient regime should provide: facilities for educational, recreational and leisure activities, and patient engagement in proper occupation according to their cultural tradition, and vocational rehabilitation measures to promote their reintegration into the community.[8]

The inclusion of human rights references in all documents relating to the rights of people with mental disorders mainly serves the purpose of emphasising the notion of the full value of individuals and the principle of non-discrimination, reiterating the fact that a person having a mental disorder does not lack the essence of humanity, and that their human rights should be respected (Erdmane, 2010).

4.1.3. Economic and social rights

This category includes the patterns Housing (V), Employment (W), Social security (X), Civil Issues (Y).

For Housing (V), the WHO resource book suggests that legislation could incorporate provisions for giving persons with mental disorders priority in State housing schemes and subsidized housing schemes. Such provisions may not be possible in some countries, but, at the very least, people with mental disorders should not be discriminated against in the allocation of housing. Legislation can also mandate governments to establish a range of housing facilities such as halfway homes and long-stay supported homes. Legislation should include provisions to prevent geographical segregation of persons with mental disorders. This may require specific provisions in appropriate legislation to prevent discrimination in location and allocation of housing for persons with mental disorders (World Health Organization, 2005).

With respect to employment (W), World Health Organization (2005) emphasizes that legislation could include provisions for the protection of persons with mental disorders from discrimination and exploitation in employment and equal employment opportunities. It could also promote reintegration into the workplace for people who have experienced a mental disorder, and ensure protection from dismissal from work solely on account of mental disorder. Legislation could also promote "reasonable accommodation" within the workplace, whereby employees with mental disorders are to be provided with a degree of flexibility in their working hours in order to be able to seek mental health treatment.

Regarding social security (X), the payment of disability grants can represent a huge benefit for people with mental disorders and should be encouraged through legislation. Where pensions are provided, disability pensions for persons with mental disorders should be paid at a similar rate as pensions granted to persons with physical disabilities. The social security legislation needs to be flexible enough to allow people with mental disorders to get back into employment, especially part-time employment, without losing the benefits of their disability pension (World Health Organization, 2005).

[4] Section 8 (2B). Mental Health Act 2007.

[5] England/Wales: MHA 2007, Section 8; amending MHA 1983, section 118(2B). Brazil: Lei 10.216/01 Article 2°.

[6] Article 14, Resolution CFM No. 1.598/2000

[7] England/Wales: MHA 2007, Section 8; amending MHA 1983, section 118(2B). Brazil: Law 10.216/01 Article 2°.

[8] Article 10, Resolution CFM No. 2.057/13

Civil issues (Y) of persons with mental disorders involve the right to exercise all civil, political, economic, social and cultural rights as recognized in the human rights documents (Universal Declaration of Human Rights, The International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights).

Legislation in England/Wales and Brazil allows hospitalization of people with mental disorders and thus raises questions related to certain civil rights such as the right to freedom. Nevertheless, the laws are substantially less clear about other aspects of mental health care, many of which relate to economic and social rights (e.g., the right to health care) (Kelly, 2011). Some of the main shortcomings identified relate to legal guarantees in mental health legislation of rights relating to access to mental health care (C), housing (V), employment (W), social security (X), and other civil matters (Y) in relation to people with mental disorders. This raises the question of the importance of using mental health legislation instead of general legislation to resolve these issues among individuals with mental disorders.

Brazil and England/Wales have general legislation, regulations, and systems related to equality, housing, several other civil matters, and social security, which are relevant to all individuals, regardless of whether they have a diagnosis of mental disorder (Kelly, 2011). Strong evidence in the history of psychiatry, however, suggests that the human rights of people with mental disorders require additional protection (Gostin & Gable, 2004; Kelly, 2011), and the WHO Resource Book presents these rights in a detailed checklist of mental health legislation, while recognizing that countries can address some issues through general legislation or regulations, rather than mental health legislation (Kelly, 2011).

4.2. Involuntary admission in the legislation of Brazil and England/Wales

4.2.1. Involuntary admission and treatment

WHO emphasizes that a key issue for mental health legislation in this area is to describe circumstances in which involuntary hospitalization and involuntary treatment are appropriate, and to establish adequate procedures. To ensure that rights are adequately protected, this section of legislation usually requires a fairly detailed exposition of the legal proceedings and therefore requires a significant amount of detail (World Health Organization, 2005, p. 62).

Legislation in England/Wales meets most of the criteria for involuntary admission, it does not meet the requirements for the provision of information (I7), periodic reviews, and regular intervals of involuntary and voluntary admission to long-term care by an independent authority (I9), and for the accreditation of establishments for the admission of involuntary patients (I3). This requirement is covered by Brazilian law in the resolution of the Federal Council of Medicine nº 1.598/2000.[9]

Despite the efforts that have been made, Brazilian law has several shortcomings regarding admission and involuntary treatment, thus running the risk of abuse of this feature; it should be used only in extreme situations.

Important aspects are included in the Brazilian legislation, such as the requirement of a statement of the therapeutic purpose of admission (I1C) and the implementation of the principle of the least restrictive environment (I4).[10] The biggest gaps relate to the right to review and appeal in reaction to the hospitalization. Involuntary hospitalization should be reviewed systematically and periodically by a review body responsible for the clinical health of the patient. In addition, patients and their families should have the right to appeal to a review body, court, or tribunal against the imposition of involuntary hospitalization (World Health Organization, 2005).

The resource book also deals with the "involuntary treatment in community settings" (L). These provisions are generally considered less restrictive than a hospital, "although highly restrictive living conditions and intrusive medical interventions that can be part of community systems are more restrictive than a short stay in hospital." (World Health Organization, 2005, p. 76).

Some countries have community treatment systems that include involuntary medical treatment. This is the case the Therapeutic Communities (CT) in Brazil. Decree No. 3088, 2011, enables the health services of the CT as to provide ongoing health care, of a transitional residential character, for up to nine (09) months for adults with stable clinical needs arising from the use of crack, alcohol and other drugs.

In this regard, World Health Organization (2005) warns that legislation on community treatment "should only be introduced in the context of accessible and quality community mental health services that emphasize voluntary care and treatment as the preferred option. There is a significant risk that due to compulsory community supervision, mental health services would start to use the obligation to provide community-based care instead of focusing on making such services acceptable by users and investing efforts and resources in the voluntary involvement of the same users "(p. 77).

Thus, it can be seen that Brazilian law does not meet the requirement that all the criteria and safeguards required for involuntary inpatient treatment should also be included for involuntary treatment based in the community (L2).

The Mental Health Act of 2007 introduced involuntary treatment in the community, and individuals undergoing treatment in the community enjoy all the criteria and safeguards necessary for involuntary hospital treatment (L2).[11]

Although after its introduction, the uptake of Community Treatment Orders (CTO) was initially higher and over the years seems to be stable, CTOs are still subject to controversy. There is a conflict between the power to coerce patients to treat in the community and the principles of autonomy and preventing harm to patients. A study that examined national data to explore the use of CTOs in England finds that about 5500 patients are subject to CTOs at any one time. Each year, 4500 patients are made subject to a CTO each year and 2500 are fully recalled, and two-thirds of recalls end in revocation. The low rate of CTO discharges by mental health tribunals suggests that they are not used inappropriately (Gupta, Akyuz, & Baldwin, 2018).

In this context, there are differences in CTOs' practice between services and individuals. Some authors argue for the importance of CTO in the management of risks, enabling patients to be cared for and treated in a less restrictive environment (Brophy, Campbell, & Healy, 2003). However, it is difficult to evaluate the extent to which the use of CTOs allows psychiatric services to continue to function with reduced bed provisions. The success or failure of CTOs is linked to appropriate application and implementation (Gupta et al., 2018). In spite of the fact that CTOs may be effective with certain groups of people with mental disorders, there is a need for clearer professional guidelines in order to assist professionals in the decision process (Brophy et al., 2003).

4.2.2. Emergency situations

For admissions in emergency situations (M), the resource book indicates some central issues: to constitute an emergency, we must first show that the time required to follow substantive procedures would cause sufficient delay and result in injury to the person involved or other people. In an emergency, hospitalization and involuntary treatment should be allowed following the assessment and advice of a qualified general practitioner or another appropriate professional.

Emergency treatment should be for a limited time (usually no more than 72 h) and substantive procedures for admission and involuntary treatment, if required, should be initiated as soon as possible and

[9] Article 19, Resolution CFM No. 1.598/2000.

[10] Art. 4°, § 1° Lei 10.216/01

[11] MHA 2007, Section 32 a 36

completed within this period (World Health Organization, 2005, p. 81).

It also suggests a specific procedure that includes a treatment plan, immediate information to the legal family members or representatives on the use of emergency powers, and the right to appeal to a mental health court and judicial courts against involuntary hospitalization and emergency treatment (World Health Organization, 2005).

Legislation in Brazil and England/Wales allows emergency treatment for patients lacking capacity if the treatment is necessary immediately and if there is a high probability of immediate danger of harm to the patient or others (M1).[12] The MHA of 2007 outlines procedures for admission and treatment in emergency situations (M2)[13]; and provides considerable detail on the roles of mental health professionals, including the doctor in charge (M3).[14] Brazil does not fulfill these WHO standards.

None of the jurisdictions fulfills the remaining WHO requirements in relation to the procedures for admission and treatment after the end of the emergency (M5); they do not explicitly prohibit treatments such as ECT, psychosurgery, sterilization, or participation in clinical or experimental trials for people regarded as emergency cases (M6); and they do not specify the rights of patients, families, and personal representatives to appeal against emergency admission (M7).

Where the time limit for emergency admission (M4) is concerned, the MHA of 1983 (England/Wales) allows admission for assessment for up to 28 days,[15] a significantly greater period than the 72 h recommended by WHO (M4). Brazil does not define a time limit for admissions in emergency situations.

4.2.3. Special treatments, seclusion, and restraint

Brazil and England/Wales require informed consent for medical procedures and also allow such procedures to be carried out without consent if waiting for informed consent would endanger the patient's life (O2, O2a). None of the laws prohibits full-scale irreversible treatments for involuntary patients. The MHA of 2007 introduces several safeguards,[16] and Brazilian law prohibits psychosurgery and any intrusive and irreversible treatments performed on involuntary and compulsory patients, but with exceptions.[17]

Regarding psychosurgery, both jurisdictions meet the demanding criteria of an independent body to ensure that there is informed consent for psychosurgery or other irreversible treatments for those receiving involuntary treatment (O3a).[18]

Where ECT is concerned, in England/Wales, there is a requirement for informed consent for involuntary patients, except for those who are capable of giving consent, in which case a second opinion (O4) is required.[19] In Brazil, informed consent is also required, and for situations where the patient is unable to give informed consent, this can be obtained from the relatives or guardians. When this is not possible, the doctor who indicates and/or performs ECT becomes responsible for the procedure and must report the procedure to the technical director of the institution and register it in the medical records.[20]

The England/Wales Mental Health Act does not prohibit unmodified ECT (without anesthesia) (O5) or ECT for minors (O6). In Brazil, the law provides that ECT can only be performed with anesthesia[21] and that its use in children under 16 years should be done only in exceptional circumstances.[22] None of the jurisdictions referred to sterilization (O1, O1a).

Both of the MHAs do not address the issue of unmodified ECT. Kelly (2011) argues that unmodified ECT (without anesthesia) is no longer practiced in England/Wales, which reduces the need to have this issue reflected in the mental health legislation. The same position is maintained with respect to sterilization. No jurisdiction prohibits sterilization and WHO points out that such a ban is necessary only in countries where such interventions are occurring unjustifiably as a treatment for mental disorders (World Health Organization, 2005).

The adherence or not to the WHO criteria on the prohibition of unmodified ECT and sterilization also depends on the specific legal traditions of each country. In jurisdictions such as Brazil, with a high level of adherence to human rights standards, the use of unmodified ECT represents a violation of Article 5 of the Universal Declaration of Human Rights that “no one shall be subjected to torture or to cruel treatment or punishment, inhuman or degrading treatment” (United Nations, 1948) and therefore it is not necessary to require the mention of that prohibition in the mental health legislation. Similarly, in jurisdictions that emphasize common law, as in England/Wales, unmodified ECT may be contrary to common law and therefore does not require specific mention. The same arguments can be applied to “sterilization as a treatment for mental disorder” (O1). None of the jurisdictions provides detailed guidance on “seclusion and restraint” (P). In England/Wales, there is a Code of Practice that deals with isolation and containment, but the Code is for guidance purposes only and, although the medical team has the duty to take it into account, the law does not impose a legal duty to comply with the Code (Kelly, 2011).

4.2.4. Oversight and review

Modern legislation contains safeguards to protect the human rights of persons with mental disorders. World Health Organization, 2005, p. 67) classifies these entities in two categories: (i) oversight and review of the processes regarding people who are admitted/treated involuntarily; and (ii) oversight and review of the well-being of people with mental disorders, within and outside mental health facilities.

These entities should be independent and make decisions exclusively on the basis of the merit of the situation and not influenced by political pressures or from health services suppliers.

The Resource Book still guides about the composition, powers, and resources of these authoritative bodies. It is also necessary to decide whether to have a body with national jurisdiction or to have a number of review bodies functioning at local, district or regional levels based on existing administrative boundaries.

Legislation in England/Wales meets some, but not all, WHO standards in relation to inspection and oversight (R). The mental health review tribunals assess involuntary admissions (R1a (i))[23] and community treatment orders (R1),[24] deal with appeals against involuntary hospitalization (R 1a (ii)),[25] and review the case of involuntary patients, but not the long term voluntary patients (R1a (iii)).

The law affirms the importance of the Care Quality Commission (CQC), which aims to verify whether the patients' human rights are being protected and how the mental health service providers are applying the safeguards of law and the principles and rules of Code of Practice while a person is being treated.

The CQC regularly inspects facilities (2a (i)), maintains adequate statistics (2a (iii)), publishes results regularly (2a (vi)), makes recommendations accordingly (2a (v)), is properly structured (2b), and

[12] England/Wales: MHA 2007, Section 35 (1) amending MHA 1983, section 64G. Brazil: Resolution CFM n° 2.057/2013, article 14.

[13] MHA 1983, as amended by the MHA 2007, part. II

[14] MHA 2007, section 9(9); amending MHA 1983, section 34(1), and section 12(7)(a), amending MHA 1983, Section 64(1).

[15] MHA 1983, section 2(2)(a).

[16] MHA 1983, as amended by the MHA 2007, section 57.

[17] Resolution CFM 2.057/2013, article 19.

[18] Brazil: Resolution CFM 2.057/2013, article 25. England/Wales: MHA 1983, as amended by the MHA 2007, section 57(2).

[19] MHA 1983, as amended by MHA 2007, section58A.

[20] Resolution CFM 1.640/02, article 3°, § 1°, and 2°.

[21] Resolution CFM 1.640/02, article 6°. Resolution CFM 2.057/2013, article 25.

[22] Resolution CFM 1.640/02, article 9°, §2°. Resolution CFM 2.057/2013, article 23.

[23] MHA 1983, as amended by MHA 2007, part V.

[24] MHA 2007, section 37(3), amending MHA 1983, section 68(1).

[25] MHA 1983, as amended by the MHA 2007, section 66.

has clear authority (2c). It does not provide guidance on minimizing invasive treatments (2a (ii)) and does not keep a record of institutions and accredited professionals (2a (iv)). Although the CQC holds consultations, reviews, and investigations, it does not define the procedures for detailed complaints (R3a R3b- (vi)) (Kelly, 2011).

Overall, WHO standards for monitoring and evaluation are met in part, but not in their entirety, England/Wales having a larger gap on procedures for submissions, investigations, and complaints resolutions (R3a R3b- (VI)). The absence of a robust complaints procedure reduces the degree of supervision and evaluation.

In Brazil, the deficits in relation to the monitoring and review mechanisms are even greater, the legislation has poor coverage of WHO standards. The law determines that there should be a Revision Commission for Involuntary Psychiatric Hospitalizations (R 1, R 1a (i), R 1a (iv)),[26] which should be multidisciplinary. At least one member should be a psychiatrist or a general practitioner certified in Psychiatry, of a higher professional level in the mental health area. This person should not belong to the medical staff of the facility where the hospitalization occurs. In addition, there should be a representative of the State Prosecutor. It is considered "relevant and desirable" that representatives of human rights associations, users of mental health services, and families are also part of the Commission, (1b). Just as in England/Wales, the Commission shall review the cases of involuntary patients, but not the cases of long-term voluntary patients (1a (iii).

Brazilian law does not cover any of the standards relating to appeals to a higher court against the decisions of the Revision Commission (1c) and nor does it not meet the standards for the establishment of a control and supervisory body to protect the rights of people with mental disorders in and out of mental health facilities.

The protection of the right of appeal and review were intensified in international recommendations and principles. The establishment of legal mechanisms and supervision to protect the rights of people with mental disorders is required under Articles 13 and 16 of the CRPD. According to the recommendations of the Council of Europe, a person has the right to appeal against decisions taken by the court or any other competent authority on their involuntary hospitalization in psychiatric facilities. In relation to both decisions, the person also has the right to a review by a court at reasonable intervals (Erdmane, 2010).

Lack of supervision is considered by Drew et al. (2011) to be a significant result of the occurrence of violations of human rights. Thus, the commitment of governments to establish mechanisms for the implementation of adequate monitoring is essential.

4.2.5. Competence, capacity, guardianship, and consent

For competence and capacity, the resource book indicates some key issues: "legislation may need to define capacity and competence, state the criteria for determining them, lay down the procedure for assessing them and identify the actions that need to be taken when a lack of capacity and/or competence is identified. Generally, capacity refers specifically to the presence of mental abilities to make decisions or to engage in a course of action, while competence refers to the legal consequences of not having the mental capacity. The presence of a major mental disorder does not in and of itself imply incapacity in decision-making functions and is therefore not the overall determining factor of capacity or competence. Despite the presence of a disorder that may affect capacity, a person may still have the capacity to carry out some decision-making functions. Considering that capacity may fluctuate from time to time, and may improve partially or fully in time, it needs to be related to the specific decision or function to be accomplished. Determination of incapacity may be made by a health professional, but a judicial body would determine incompetence" (World Health Organization, 2005, p. 42). Capacity is the test for competence, and people should not be judged as lacking competence only because they are incapable of making specific kinds of decisions at a specific time.

On the other hand, in cases of involuntary patients who are capable and choose to refuse treatment, their rights can be negatively affected, especially the deprivation of the right to liberty and their right to health. This situation can hence result in individuals being denied interventions for treatable mental illness, which can impact the duration of untreated psychosis as well as social and psychological outcomes (Duffy & Kelly, 2017a, 2017b).

In England/Wales, the Mental Capacity Act has been in place since 2005. The Act is responsible for good coverage of the WHO standards of competence, capability, and protection. However, the laws of England/Wales do not have procedures for periodic reviews of decisions in relation to guardianship, incapacity, and incompetence (F4), and systematic review of the need for a guardian (F7).

In Brazil, this issue does not receive any coverage in mental health legislation. It is an important problem to be solved, not only due to non-compliance with respect to the standards of the WHO Resource Book but also according to the development in 2006 of the CRPD. The CRPD commits signatory countries to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity" (Article 1). Among the eight general principles of the CRPD, is respect for people's individual autonomy and independence, and also their full and effective participation and inclusion in society (Article 3). Brazil signed the CRPD in 2007 and ratified it in 2008, while the United Kingdom signed in 2007 and ratified it in 2009. After ratification, the pressure undoubtedly increases for countries to explicitly address issues such as competence, capacity, and consent of individuals with mental disorders.

Flyn and Arstein-Kerslake (2014) state that the key difference between safeguards in the support model and those which have existed in substitute decision-making regimes is that safeguards for support are based on the core principle of respect for the individuals' will and preferences, no matter what level of decision-making ability they hold. For example, in a support model, there needs to exist an adjudication mechanism for challenging support people if they fail to respect the will and preference of the individual. In contrast, adjudication in most current substituted decision-making regimes focuses on "protecting" the individual and discovering what is in her "best interest," with little importance placed on his/her will and preference.

Article 12 (3) of the CRPD recognizes that decision-making is a process of communication and that the decision-making capacity is a variable human attribute. The vast majority of persons, whether or not with a mental disorder, are more or less able to reason and understand the content and the consequences of a course of action, depending on the amount of information they receive, how the information is received, the context in which the information is received, the time provided to process information, and the opportunities to discuss the information with trusted people. This is especially true in relation to health information. In the area of mental health, the complexity of communication processes can be burdened with the side effects of medication and other treatments and the cyclical and volatile nature of the condition (Weller, 2011).

For the development of a supported decision-making culture in mental health, it is necessary to implement a number of strategies, including the development of training programs and practical guidance to ensure that persons with disabilities, medical and support staff fulfill their respective roles in the communication process (Weller, 2011).

On the recognition of the legal capacity of persons with mental disorders in the CRPD, Dhanda (2008) argues that the CRPD recognizes that a disabled person may need support to exercise their legal capacity, but getting support is no reason to conclude that the capacity does not exist. This paradigm of interdependence that allows the coexistence of autonomy and support is an important development that the Convention has used to establish a system of rights for people with disabilities.

[26] Ordinance GM n° 2.391/2002, article 10.

By recognizing autonomy with support, the CRPD gives a voice to people with disabilities, making them an integral part of society and thus according space to the disability perspective on the world. In this context, the role of the support person is to help the person with mental disability to articulate her/his current will and preferences (Scholten & Gather, 2017, p. 3).

However, there are some adverse consequences of the support decision model, such as on the well-being and autonomy of persons with mental disorders (Scholten & Gather, 2017). According to Scholten & Gather (2017, p. 4), "autonomy is more than simply having the ability to do what one wants at a given point of time; and, similarly, well being is more than merely one's present experience of happiness or the satisfaction of one's present desires. As an illustration of this, consider a person who suffers from a severe psychotic episode. In many such cases, there is little reason to think that unresevedly respecting the person's current treatment choices will protect or further her interest in either autonomy or well-being". These authors argue that, in such cases, respecting treatment rejections will adversely affect the well being and autonomy of persons with mental disorders.

Therefore, one can point out some internal inconsistencies in the CRPD related to negative and positive rights, as "it does not clarify under which circumstances, which rights should prevail over others. In some cases, involuntary treatment might clearly limit the autonomy of the person, but it might promote their social inclusion, health, and standard of living as well" (Pozón, 2016, p. 304).

In addition, supported decision making can complicate the distribution of responsibility for treatment decisions and the allocation of decision support, aggravating the problem of undue influence. In this regard, "it is a well-known fact that families and friendships are not always harmonious and that even relatives and friends with good intentions may in good faith unconsciously project their own interests onto those of the patient. Although the problem of undue influence affects both the competency model and the exclusive supported decision-making model, the problem is more serious in the latter" (Scholten & Gather, 2017, p. 4).

4.3. Other relevant issues

4.3.1. Voluntary patients

Although the MHA of England/Wales gives emphasis to treatment in the least restrictive environment (G1), the legislation meets only one of the five WHO criteria for "admission and voluntary treatment" (G).

While Brazil meets three of the five criteria, and stipulates that voluntary patients should, at admission, be informed that they will lose the right to leave if they fall under the conditions for involuntary detention (G5) and patients with physical health problems (G3) need to be met in a manner equivalent to how they are met.

WHO distinguishes voluntary patients from non-protesting patients. The concept of voluntary "precludes the use of coercion; and implies that there are choices available and that the individual has the ability to exercise that choice "(World Health Organization, 2005, p. 59). "Non-protesting" patients would be those unable, due to their mental health status, to give consent to admission, but who do not refuse mental health interventions (for example, people with severe mental disabilities) (World Health Organization, 2005).

Including these patients in the legislation seeks to ensure that they are not processed incorrectly as involuntary or voluntary patients. This helps to prevent a potentially huge increase in the number of people incorrectly admitted as involuntary patients (World Health Organization, 2005).

Compliance with the WHO standards in relation to non-protesting patients (H) is limited in both jurisdictions: while the MCA of 2005 (England/Wales) lays down rules on admission (H1) and treatment (H2) of these patients, these provisions are drastically limited (Kelly, 2011). In Brazil, the legislation does not specifically provide for non-protesting patients. The greater compliance with WHO guidelines on voluntary patients is especially important because the vast majority of people accessing psychiatric care should do so voluntarily (Kelly, 2011).

In this context, in England, safeguards are also known as the "Bournewood safeguards", after a case involving a 'non-protesting' patient was judged by the European Court of Human Rights. In the Bournewood case, an autistic man with severe learning difficulties was informally admitted to Bournewood Hospital. The European Court of Human Rights found that he had been deprived of his liberty unlawfully, because of the lack of legal procedure that offers sufficient guarantees against arbitrary detention and quick access to a court. The Department of Health has committed to introducing new legislation to close the "Bournewood gap" (Dow, 2008), such as the MCA.

4.3.2. Rights of families or other carers

The mental health legislation needs to ensure that families have access to the support and services they need to care for a person with a mental disorder, and should encourage the involvement of family members in different aspects of the mental health services, the legal processes, and the involuntary admission and appeal (World Health Organization, 2005).

The legislation of England/Wales meets many of the standards regarding the "rights of families or other carers" (E),[27] with the exception of encouraging family members and other attendants to be involved in the formulation and implementation of individualized treatment plan of the patient (E2).

Brazil meets only one of the WHO criteria on this topic, which deals with the involvement of security of family or other attendants to engage in development policy plans, legislation and planning mental health services (E5).[28]

It is common for families to assume the main responsibility in the care of people with mental disorders and, therefore, the law needs to recognize their important role in the involuntary hospitalization process.

The literature indicates that the inclusion of the family in therapy, makes the treatment more effective for the individual, removes the guilt of the family about the disease and the disease process, and includes the family as relevant subjects in the rehabilitation and social reintegration (Brito, Badagnan, & Ventura, 2015; Hirdes & Kantorski, 2005).

4.3.3. Clinical and experimental research

Article 7 of the ICCPR (1966) prohibits clinical and experimental research without informed consent. Already, Principle 11 (15) of MI Principles states that "clinical trials and experimental research shall never be carried out on any patient without informed consent, unless a patient who can not give informed consent may be admitted to a clinical trial or receiving experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose" (United Nations, 1991).

In addition, according to article 15 of the CRPD, no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

In this context, WHO includes specific standards for countries that allow clinical and experimental research with the consent of patients.

Regarding "clinical and experimental research" (Q), Brazilian law stipulates that research, clinical trials, and experimental treatments cannot be performed on any patient with a mental disorder without their informed consent (Q1).[29] It also stipulates that if the person is

[27] MHA 1983, section 132(4); MHA 1983 section 132A(3), amended by MHA 2007, schedule 3, paragraph 30; MHA 1983, section 11(4); MHA 2007, section 8, amending MHA 1983, section 118(2B).

[28] Law 10.216/01, Artigo 3°.

[29] Resolution CFM n° 2.057/13, article 28.

unable to give informed consent, proxy consent is obtained from the legal representative or family member (Q2a).[30]

Legislation in England/Wales does not provide detailed guidance on experimental research (Q1), but for those who do not have the capacity to consent, the MCA of 2005 enables the research subject to have certain safeguards,[31] including the requirement of consent of the appropriate authority (Q2a)[32] and that the research can not be conducted if the same research could be carried out on persons able to consent (Q2b),[33] and that the research is necessary to promote the health of the individual and the population represented (Q2b).[34] Brazilian law in turn, does not meet this latter requirement (Q2b).

4.3.4. Vulnerable groups

The CRPD (2006) has specific articles addressing the rights of women and children with disabilities. Accordingly the article 6 states parties to "recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take: measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms; appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in that Convention" (United Nations, 2006).

Article 7 states that "states parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right" (United Nations, 2006).

According to Resource Book (2005), specific legislation for minors, women, and minorities affected by mental disorders would be unnecessary if the practice was non-discriminatory and showed that these vulnerable groups received adequate treatment and services and was non-discriminatory. However, in reality, these groups are discriminated against and suffer injustice. Although the extent of these problems varies from country to country, no country is immune to discrimination against vulnerable groups, and therefore the protection of the rights of these groups in mental health legislation is relevant to all countries.

Brazil and England/Wales do not meet adequately the WHO standards regarding protection for minors. Brazilian law does not meet any of the standards, while the MHA of 2007 (England/Wales) includes "minimize restrictions on freedom" as a "fundamental principle" (Z1, minors).[35] It emphasizes the importance of facilities appropriate to age (Z2b, minors)[36]; and requires that one takes into account the views of children on issues affecting them (Z4, minors).[37] The legislation does not prohibit all irreversible treatments for children (Z5, minors), although there are specific safeguards for certain treatments (such as ECT) in the MHA of 2007.[38]

Where "women" are concerned Brazil and England/Wales include as fundamental principles, respect for diversity in general, including the diversity of gender, religion, culture, and sexual orientation[39] and protection against discrimination[40] (Z1, women). None of the jurisdictions meets any of the other WHO standards in relation to women.

In respect of "minors", Brazil and England/Wales include as fundamental principles, respect for diversity in general, including the diversity of gender, religion, culture and sexual orientation and protection against discrimination[41] (Z1, minors). None of the jurisdictions meets any of the other WHO standards regarding the protection of minorities.

4.3.5. Police responsibilities

The WHO Resource Book considers it important that the legislation will help to ensure a constructive and helpful role for the police with respect to people with mental disorders. At the same time, the police forces have the immediate responsibility of maintaining public order. They also have the "duty to protect and respect the rights of people who are vulnerable because of a mental disorder and to act in a caring and compassionate manner" (World Health Organization, 2005, p. 97).

The legislation should also address police powers to enter private property to arrest a person and to take them to a place of safety when there are reasonable grounds to suspect that the person is a danger to himself and others; to take a person subject to involuntary admission to a designated mental health facility; to take an involuntary patient absent without the permission of the mental health establishment, back to that establishment. Responses to requests for help in emergency situations may impose restrictions on the activities of the police to ensure protection against arrest and illegal detention of people with mental disorders (World Health Organization, 2005).

The legislation in England/Wales meets all the standards related to police responsibilities.[42] Brazilian legislation has no mention of this issue, although in practice the use of police force is seen in cases of involuntary admission (Brito, 2011).

4.3.6. Offenses and penalties

"A law is written to guide and direct people in terms of what a democratically constituted legislature, after consultation and debate, has deemed necessary and appropriate for the country. When a law is transgressed, the criminal justice system of a country has the power to take actions to prosecute and punish offenders. This gives legislation a special position relative to, for example, a country's policy or strategic plans" (World Health Organization, 2005, p. 86).

The law must specify the appropriate punishment for different offenses and may indicate the severity of the penalties for certain transgressions, taking into account the fact that not all transgressions are equally serious. In many countries, unless they are given specific guidance by the law, the courts may be unable to act effectively when the law is transgressed, so the potential of the law to promote mental health cannot be fully realized (World Health Organization, 2005).

Legislation in England/Wales is compliant with WHO standards regarding "offenses and penalties" (AZ).[43] In spite of this, Brazilian legislation does not provide any guidance on punishment for those who infringe the rights of people with mental disorders. This reduces its effectiveness, since it provides a guarantee of many rights but does not have punishments applicable to cases of disrespect for these rights.

[30] Law n° 10.216/01, article 11.
[31] MCA 2005, sections 30–34.
[32] MCA 2005, section 32.
[33] MCA 2005, section 31(4).
[34] MCA 2005, section 31(5).
[35] MHA 2007, section 8, amending MHA 1983, section 118(2B)(c).
[36] MHA 2007, section 31(3), amending MHA 1983, section 131.
[37] MHA 1983, section 131(2).
[38] MHA 2007, section 58A, amending MHA 1983, section 58.
[39] Brazil: Law 10.216/01, article 1°. England/Wales: MHA 2007, section 8, amending MHA 1983, section118(2B)(b).
[40] Brazil: Law10.216/01, article 1°. England/Wales: MHA 2007, section 8, amending MHA 1983, section 118(2B)(e).
[41] Brazil: Law 10.216/01, article 1°. England/Wales: MHA 2007, section 8, amending MHA 1983, section 118(2B)(e).
[42] MHA 1983, as amended by MHA 2007, sections 135–136.
[43] MHA 1983, as amended by MHA 2007, part IX.

Table 4
Summary of similarities and differences in the laws of Brazil and England/Wales.

Main similarities	Main differences
Legislations cover, but not comprehensively, the issue of clinical and experimental research and special treatment, isolation, and restrictions. Legislation does not address adequately the themes: voluntary patients, emergency situations, economic and social rights, employment, social security, civil affairs, and vulnerable groups.	Involuntary admission related procedures are more detailed in the legislation of England and Wales. England/Wales legislation provides definitions of key terms used in the legislation, while Brazilian law does not cover these standards. Legislation in England/Wales lists the offenses and penalties in cases of disrespect of mental health law. Brazilian law is more detailed in establishing the fundamental rights of people with mental disorders but does not deal with offenses and penalties.

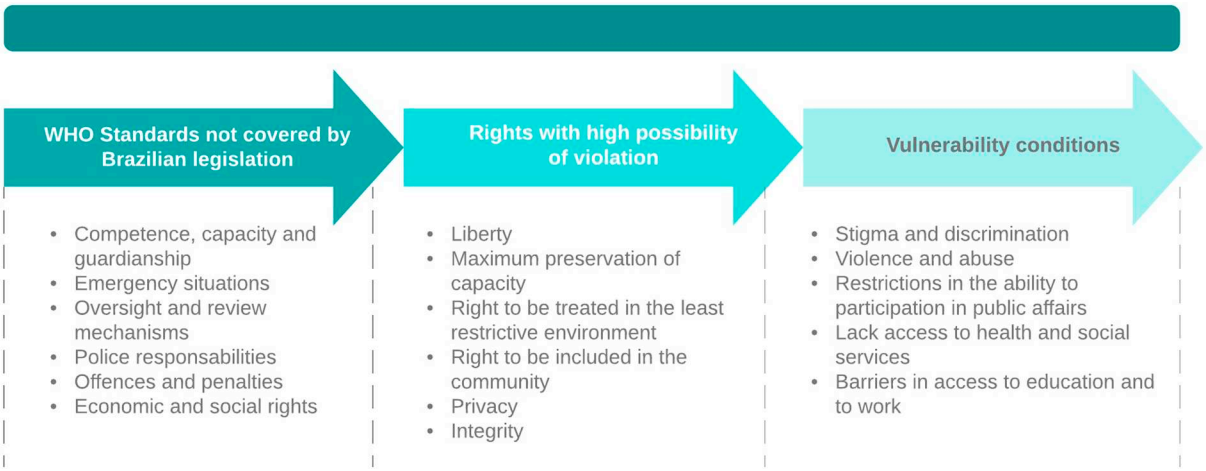

Fig. 1. Relationship between standards not covered by Brazil legislation, human rights, and vulnerability conditions.

4.4. Similarities and differences in the laws of Brazil and England/Wales on involuntary admission

Brazil and England/Wales underwent a reform processes in their legislation and mental health services, seeking the reintegration of persons with mental disorder in the social environment, excluding the hospital-centered model of its mental health practices. Brazilian law has several shortcomings regarding involuntary hospitalization, while the laws of England/Wales have more detail on the procedures, reviews, and violations of the law. This law is closely linked to clinical practice, even listing the types of mental disorders and defining specific terms (Abdalla-Filho & Engelhardt, 2003).

Oversight committees such as the Care Quality Commission (CQC) are good examples to be followed by Brazil, in the pursuit of ensuring human rights of people with mental disorders who are hospitalized involuntarily. Established by the MHA of 1983, the CQC has a duty to monitor services exercising their powers and performing their functions when patients are subjected to involuntary admissions, community treatment orders or guardianship. The team visits and interviews people whose rights are restricted by the MHA, and requires actions of service providers when they become aware of cases of interest. They also have the duty to provide a second opinion by an appointed doctor and to analyze complaints. As one of several UK organizations that form the National Mechanism of the UK for the prevention of torture, inhuman or degrading treatment, they are also required to work proactively to implement actions when practices are seen during visits that flout human rights standards.

Thus, the law of England/Wales could be used as a reference by the Brazilian legislator in the improvement of the legislation in relation to the specific procedures for involuntary admission, external audit, and the inclusion of definitions of key terms of legislation, offenses and penalties imposed by those who disregard the rights guaranteed by mental health legislation and law enforcement responsibilities in relation to people with mental disorders.

Brazilian legislation, in turn, is closer to listing the fundamental rights of people with mental disorders. However, it fails to define the penalties when the rights are not respected.

Both jurisdictions need to review their legislation in the following areas: voluntary patients, emergency situations, economic and social rights, civil issues, and the fundamental rights of vulnerable groups which are often restricted in detention, such as the right to privacy, the maximum preservation of legal capacity and the right to physical and mental integrity. These issues have received special attention from the CRPD and other international human rights instruments, but they are not adequately addressed in the relevant laws. With the ratification of the CRPD by both jurisdictions, it is necessary to review the legislation in respect of these essential rights to the effective exercise of citizenship by people with mental disorders.

Table 4 summarises the main similarities and differences found in the analyzed legislation.

Failure to address or the inappropriate approach to some specific patterns can directly impact the health of people with mental disorders and impinge on their citizenship. We can mention as an example, Brazil and the gap in the standards of competence, capability, and protection. By failing to legislate on competence, capability, and protection, the country contributes to the increased possibility that people with mental disorders have their right to autonomy, decision making, and maximum preservation of capacity, disrespected. The absence of these rights has an impact on the lives of these people who are subject to stigma and discrimination, abuse, restrictions on the exercise of civil and political rights, restrictions in the ability to participate in public affairs, and also barriers in access to education and to work.

Figs. 1 and 2 present the WHO Checklist components which are not covered by the legislation of Brazil and England/Wales, human rights and vulnerability conditions of persons with mental illness who do not exercise their rights.

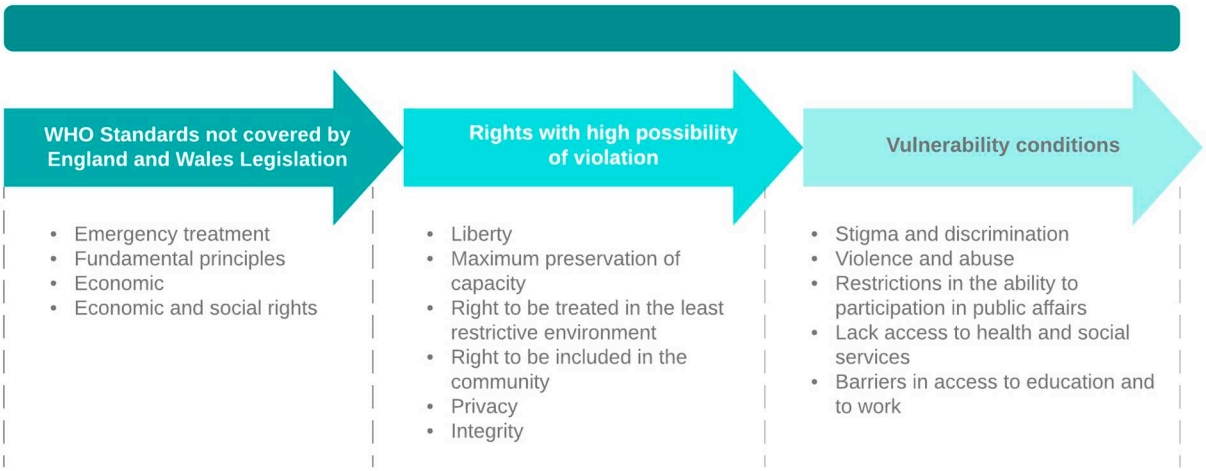

Fig. 2. Relationship between standards not covered by England/Wales legislation, human rights, and vulnerability conditions.

5. Conclusions

The formulation of mental health laws is critical to the promotion of human rights of a vulnerable population group, in this case people with mental disorders. It can be said that because of the present disorder, such persons could be subject to be admitted to psychiatric facilities arbitrarily, and their rights restricted.

Brazil and England/Wales have sought, through the implementation of laws and programs, the reintegration of persons with mental disorder in society, limiting the possibilities for involuntary commitment and ensuring greater oversight in cases requiring hospitalization.

Through this research, we attempted to analyze the similarities and differences between the legislation on mental health related to involuntary psychiatric hospitalization in Brazil and England/Wales, since the understanding and comparison of these standards can act as a reference in the search for new avenues for mental health. From the comparative analysis of the laws it follows that:

- The England/Wales legislation provides clearer procedures and more details on “involuntary hospitalization” and has “control mechanisms” that are more effective than those in Brazil;
- Despite the gaps in the procedures for appeals against disability decisions and the review of the need for a guardian, the MCA has good coverage of “competence, capacity and protection”, a subject of high importance, especially after the ratification of the CRPD, and that Brazil does not address in its legislation;
- Brazilian law has a longer list of “fundamental rights”, but does not provide for “penalties” for breaches of those rights. The England/Wales legislation amply covers this area;
- The main similarities between Brazil and England/Wales refer to standards that require review: “voluntary patients”, emergency “economic and social rights”, “civil matters”, and “vulnerable”;
- Both jurisdictions have the same level of coverage for “clinical and experimental research”, and “special treatment, isolation, and restrictions.”

In short, the analysis of mental health legislation presented in this paper suggests that international human rights documents, such as the WHO Resource Book, are important tools which can guide the construction of legislation. It is also necessary that the formulation of mental health laws and policies is articulated in international human rights documents such as the CRPD.

As a limitation of this study, it is important to mention the analysis by two individuals and not by a multidisciplinary evaluation committee made up of representatives from a diverse range of groups able to offer different answers for each item on the checklist, as recommended by the World Health Organization. In addition, the analysis focuses on the legal content and is not directed at measuring its applicability or evaluating its results. In sum, although the range of issues found in this study which can be improved in both jurisdictions, one may affirm that mental health legislation is in a process of constant development aiming at consolidating the rights of persons with mental disorders in these countries.

Funding

This research is part of a doctoral dissertation and is supported by a grant from CAPES Foundation Fellow (grant number BEX 5170/14-1).

Acknowledgements

The authors would like to thank Ann Gallagher and Robert Jago for reviewing the article and two anonymous referees for International Journal of Law and Psychiatry for their helpful comments on an earlier version of this paper.

References

Abdalla-Filho, E., & Engelhardt, W. (2003). The practice of forensic psychiatry in England and Brazil: A brief comparison. *Revista Brasileira de Psiquiatria, 25*(4), 245–248.

Brazil (2001). Law 10.216, from 6th of Abril, 2001. *Official Journal of the Brazilian Republic Federation* (April 9, 2001: 3 (section 1)).

Brazilian Psychiatry Association (ABP). Guidelines for a comprehensive care model in mental health in Brazil. (2006). http://www.abpbrasil.org.br/diretrizes_final.pdf> (Acesso em: 20 mar. 2014).

Brito, E. S. (2011). *O Direito Humano à Saúde Mental: compreensão dos profissionais da área.* University of Sao Paulo.

Brito, E. S., Badagnan, H. F., & Ventura, C. A. A. (2015). The care integrated to family and community in the view of professionals from a psychiatric hospital. *Journal of Nursing UFPE on Line, 9*(4), 8088–8096.

Brophy, L., Campbell, J., & Healy, B. (2003). Dilemmas in the case Manager's role: Implementing involuntary treatment in the community. *Psychiatry, Psychology and Law, 10*(1), 154–163.

Care Quality Commission (2016). Monitoring the mental health act in 2014/2015. London http://www.cqc.org.uk/sites/default/files/20161122_mhareport1516_web.pdf.

Chan, B. W. Y., & O'Brien, A. M. (2011). The right of caregivers to access health information of relatives with mental illness. *International Journal of Law and Psychiatry, 34*, 386–392.

Conill, E. M., et al. (1991). Organização dos serviços de saúde: a comparação como contribuição. *Cadernos de Saúde Pública, 7*(3), 328–346.

Dhanda, A. (2008). Constructing a new human rights lexicon: Convention on the rights of persons with disabilities. *Sur. Revista Internacional de Direitos Humanos, 5*(8), 42–59. https://doi.org/10.1590/S1806-64452008000100003.

Dlouhy, M. (2014). Mental health policy in Eastern Europe: A comparative analysis of seven mental health systems. *BMC Health Services Research, 14*(1), 1–8. https://doi.org/10.1186/1472-6963-14-42.

Dow, J. (2008). Mental health act 2007. *Journal of Integrated Care, 16*(2), 33–37.

Drew, N., Funk, M., Tang, S., Lamichhane, Chávez, J., Katontoka, E., ... Lawrence

Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: An unresolved global crisis. *Lancet, 378*, 1664–1675.
Duffy, R. M., & Kelly, B. D. (2017a). Concordance of the Indian mental healthcare act 2017 with the World Health Organization's checklist on mental health legislation. *International Journal of Mental Health Systems, 11*, 48.
Duffy, R. M., & Kelly, B. D. (2017b). Rights, laws and tensions: A comparative analysis of the convention on the rights of persons with disabilities and WHO resource book on mental health, human rigths and legislation. *International Journal of Law and Psychiatry, 54*, 26–35. https://doi.org/10.1016/j.ijlp.2017.07.003.
Erdmane, A. (2010). Liberty behind closed doors: Involuntary placement and medical treatment in psychiatric institutions from the human rights perspective. *Vienna Journal on International Constitutional Law, 4*, 90.
Fistein, E. C., Holland, A. J., Clare, I. C. H., & Gunn, M. J. (2009). A comparison of mental health legislation from diverse commonwealth jurisdictions. *International Journal of Law and Psychiatry*. https://doi.org/10.1016/j.ijlp.2009.02.006.
Flyn, E., & Arstein-Kerslake, A. (2014). The support model of legal capacity: Fact, fiction, or fantasy? *Berkeley Journal of International Law, 32*(1), 124–143.
Gable, L., & Gostin, L. O. (2009). Mental health as a human right. *Swiss human rights book* (pp. 249–261). (Rüffer & rub).
Gostin, L. O., & Gable, L. (2004). The human rights of persons with mental disabilities: A global perspective on the application of human rights principles to mental health. *Maryland Law Review, 63*(20), 20–121.
Gray, J. E., McSherry, B. M., O'Reilly, R. L., & Weller, P. J. (2010). Australian and Canadian mental health acts compared. *The Australian and New Zealand Journal of Psychiatry, 44*(12), 1126–1131. https://doi.org/10.3109/00048674.2010.520009.
Gupta, S., Akyuz, E. U., Baldwin, T., & Curtis, D. (2018). Community treatment orders in England: Review of usage from national data. *BJPsych Bulletin, 42*, 119–122.
Hirdes, A., & Kantorski, L. (2005). A família como um recurso central no processo de reabilitação psicossocial. *Revista de Enfermagem da UERJ, 13*, 160–166.
Hunt, P., & Mesquita, J. (2006). Mental disabilities and the human right to the highest attainable standard of health. *Human Rights Quarterly, 28*, 332–356.
Kelly, B. D. (2011). Mental health legislation and human rights in England Wales and the Republic of Ireland. *International Journal of Law and Psychiatry*. https://doi.org/10.1016/j.ijlp.2011.10.009.
Kelly, B. D. (2016). Mental health, mental illness, and human rights in India and elsewhere: What are we aiming for? *Indian Journal of Psychiatry, 58*(Suppl. 2), S168–S174. https://doi.org/10.4103/0019-5545.196822.
Latif, Z., & Malik, M. (2012). Mental health legislation in Ireland: A lot done, more to do. *The Journal of the American Academy of Psychiatry and the Law, 40*(2), 266–269.
Pozón, S. R. (2016). The convention on the rights of persons with disabiities and mental health law: A critical review. *ALTER, European Journal of Disability Research, 10*, 301–309. https://doi.org/10.1016/j.alter.2016.07.001.
Schneider, S., Cláudia, E., & Schmitt, J. (1998). O uso do método comparativo nas ciências sociais. *Cadernos de Sociologia, 9*, 49–87.
Scholten, M., & Gather, J. (2017). Adverse consequences of article 12 of the UN convention on the rights of persons with disabilities for persons with mental disabilities and an alternative way forward. *Journal of Medical Ethics, 0*, 1–8.
Shao, Y., Xie, B., Good, M. J. D., & Good, B. J. (2010). Current legislation on admission of mentally ill patients in China. *International Journal of Law and Psychiatry, 33*(1), 52–57. https://doi.org/10.1016/j.ijlp.2009.10.001.
Szmukler, G. (2019). "Capacity", "best interests", "will and preferences" and the UN convention on the rights of persons with disabilities. *World Psychiatry, 18*, 34–41. https://doi.org/10.1002/wps.20584.
United Nations (1991). *UN principles for the protection of persons with mental illness and the improvement of mental health care.* New York: United Nations, Secretariat Centre.
United Nations (2006). *Convention on the rights of persons with disabilities.* Geneva: United Nations.
United Nations. Human rights. (2018). http://www.un.org/en/sections/issues (depth/human-rights/).
Weller, P. J. (2011). *The convention on the rights of persons with disabilities and the social model of health: New perspectives.* (New Perspectives).
World Health Organization (2005). *WHO resource book on mental health, human rights and legislation.* Geneva: World Health Organization.
World Health Organization (2014). Social determinants of mental health. http://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?equence=1.
World Health Organization (2017). Human rights and health. fact sheet. december 2017. http://www.who.int/mediacentre/factsheets/fs323/en/>.
World Health Organization (2018). Mental disorder. *Fact Sheet*. April 2018 http://www.who.int/mediacentre/factsheets/fs396/en/.
Zhang, S., Mellsop, G., Brink, J., & Wang, X. (2015). Involuntary admission and treatment of patients with mental disorder. *Neuroscience Bulletin, 31*, 99–112.