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RESEARCH

How does European mental health legislation promote autonomy for those in involuntary care? A comparative descriptive analysis of 27 countries

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Abstract

Purpose A growing emphasis on autonomy, manifest through the influence of recovery orientations, user involvement, and the broader shift towards patient-centered healthcare, has significantly influenced mental health care. The Convention on the Rights of Persons with Disabilities (CRPD) is a pivotal development in this regard, challenging longstanding practices in mental health care and particularly involuntary care. This study examined how European mental health legislation seeks to promote the autonomy of those subjected to involuntary care, by analyzing laws from 27 jurisdictions.

Methods Data was collected via a comprehensive survey between July 2023 and September 2024, completed by country representatives from the EU COST Action FOSTREN network. We examined the letter of the law as regards 16 autonomy-promoting provisions including the principle of least restriction, capacity-based criteria, supported decision-making, advance healthcare directives, treatment plans, rights to appeal, legal aid, advocacy services, and oversight mechanisms.

Results Most laws across the 27 jurisdictions were amended in the last eight years. All legislations included at least one measure related to the principle of least restriction, the right to appeal against involuntary status, and support to do so, such as legal aid. In contrast, mechanisms designed to support autonomous decision-making, such as Advance Healthcare Directives and Supported Decision-Making, were less frequently included as a right.

Conclusion While procedural legal safeguards are well established, there is significant variation in the adoption of other legal mechanisms to afford statutory rights to individuals in line with autonomy promoting approaches, including the CRPD.

Keywords Mental health legislation · Human rights · Convention on the Rights of Persons with Disabilities · Autonomy · Involuntary mental health care

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Introduction

Over the past decades, healthcare discourses have shifted from focusing on clinical expertise in decision-making towards an emphasis on the perspectives of those using services. Informed autonomous decisions are now considered a gold standard, founded on human rights and safeguarded in legislation. Within mental healthcare, the dynamics are somewhat different, particularly regarding people with severe mental health problems, for whom legislation permits involuntary care if specified criteria are met. Most laws still rely on criteria for involuntary care from the early 1900s, such as clinically defined "need for treatment" or "dangerousness" [1], but include a range of procedural safeguards to regulate, and minimize, restrictions on individual autonomy. Also, an increased emphasis on community-based services, user involvement, and personal recovery are put forward as means to promote human rights in mental health care [2], which are believed to protect personal autonomy.

Despite these developments, how to align involuntary mental health care with human rights frameworks, and even whether this is possible, remains contentious. The Convention on the Rights of Persons with Disabilities (CRPD), which came into force in 2008 and has been ratified by 187 countries plus the EU, states that people with disabilities, including mental health conditions, shall enjoy the same human rights as anyone else without exception [3]. Based on principles of equality and self-determination [4], the CRPD is chiefly about ascertaining the rights of people with disabilities [5], and places duties on signatory countries to provide programs that reinforce them, through providing community support, combating discrimination, promoting social participation etc. [6]. Some of the Convention's articles have implications for legislation surrounding involuntary care. For instance, Article 14 states that disability cannot justify the deprivation of liberty, which implies that using diagnosed or suspected mental illness as justification for differential treatment, a key criterion in most legislations, is considered discriminatory. Moreover, in their interpretation of the Convention's Article 12 "Equal Recognition before the Law", the CRPD Committee stated that everyone who can express their will and preferences, including those with mental disorders who might be considered dangerous, should be free to exercise their legal capacity to make decisions [7].

The interpretation of Articles 12 and 14 of the CRPD remains debated, with diverse perspectives on whether coercive interventions can ever be justified in mental health care [8–10]. Some interpret these articles as requiring complete abolition of involuntary care, while others propose that, while the use of involuntary care should be minimized and alternatives found, it should be permitted when used as a last resort for the shortest possible time, with strict regulations, safeguards and oversight mechanisms [11–13]. Proponents of this latter view argue that mental illness can potentially impair decision-making by affecting insight or volition, and lead individuals to reject treatment they might otherwise have chosen or that would have been beneficial to them, and that without this treatment they may suffer exacerbated harm and exclusion [14]. This view, which could be considered a version of "soft paternalism", suggests that involuntary treatment in psychiatric crises could save lives and secure health, and through that enhance autonomy in the longer term [13]. Countering this perspective, it has been argued that such an approach may lead to overuse of coercive care, prioritizing risk aversion over recovery [15]. Others again, including many researchers in the field, point to the evidence of adverse effects of coercive care on individuals [16, 17], combined with scarce evidence of effectiveness [18], to warn that the alleged benefits of soft paternalism do not seem to materialize.

Fistein and colleagues compared 32 Commonwealth mental health laws in 2009 and found great variation in how personal autonomy was protected, alongside trends towards broadening of diagnostic criteria, increased use of capacity tests, more emphasis on health over risk and on oversight and review systems [19]. The UN and WHO raised concern over such variation in how legislations safeguard autonomy in their joint 2023 guideline for how to align legislation with international human rights frameworks, and called for "a significant shift from biomedical approaches towards a support paradigm that promotes personhood, autonomy, and community inclusion" (WHO & United Nations, 2023, p. xvi) [20]. They also promoted integration of "stand-alone" mental health law and other laws permitting restrictions on those lacking decision-making capacity, in order to avoid differential treatment based on disability. While provisions for such "fusion law" have been proposed [21], stand-alone mental health legislations remain the norm [22].

There is growing attention to how mental health law across Europe align with international standards, including the CRPD [23], but there is little evidence to suggest that rates of involuntary care have decreased following the emphasis on autonomy [24, 25]. What is lacking in existing literature is systematic description of statutory adoption of specific autonomy-promoting mechanisms, such as advance healthcare directives, supported decision-making, and capacity-based criteria. A recent systematic review identified the need for such empirical work on potential impact of the Convention on national legislation [26]. Furthermore, it is argued that comparing mental health law across countries can clarify differing ethical positions and help promote discussions of how to enhance voluntariness [27]. To contribute to addressing gaps in the literature and

Table 1 Included survey items of autonomy promoting mechanisms in mental health laws

Survey item	Question	Definition	Relevance to autonomy and to the CRPD
Using the least restrictive option			
Principle of least restriction	Is the principle of the least restrictive environment applied to involuntary admissions? (Yes/No)	An obligation to use the treatment or the setting for treatment which meets the person's treatment needs while also imposing the fewest possible restrictions on that person's liberty.	Minimizes restrictions on personal liberty Article 14: Liberty and security of the person
Involuntary care as last resort	Does the law specify that involuntary admission/treatment should be only used as a last resort? (Yes/No)		Minimizes restrictions on personal liberty Article 14: Liberty and security of the person
Discharge when criteria for involuntary care no longer fulfilled	Does the law specify that patients must be discharged from involuntary admission as soon as they no longer fulfil the criteria for involuntary admission? (Yes/No)		Minimizes the duration of restrictions on personal liberty Article 14: Liberty and security of the person
Protecting decision making capacity and legal capacity			
Capacity based legislation			
Decision making capacity as criteria for involuntary care	Is a patient lacking decision-making capacity a legal criterion that must be met to allow involuntary admission? (Yes/No)	Decision making capacity means the ability to make (treatment) decisions, and this is usually assessed by checking that the person is able to understand and retain information, weigh it up to make a choice, and express this.	Protects autonomy of people with decision making capacity and protects the right to care for those without Article 12: Equal recognition before the law
Definition of capacity	Does the law define "competence" or "capacity"? (Yes/No. If yes, specify)		Clarifies threshold for determining who lacks decision-making capacity Article 12: Equal recognition before the law
Mechanisms for enhancing autonomy			
Provision for supported decision making	Does the law make provisions for Supported Decision Making? (Yes/No. If yes, specify)	That a person with a mental health condition is supported by others to make decisions. This can be structured support by clinical staff or others to facilitate that the person's will and preferences are respected in treatment decisions.	Creates opportunities for decisions to be based on one's will and preferences Article 12: Equal recognition before the law
Provision for treatment plan	Does the law require that a care/treatment plan is prepared for people who fulfil the criteria for involuntary admission? (Yes/No)	A formalized plan for the treatment of a person, tailored to their individual situation and needs.	Creates opportunities for one's treatment to be informed by one's will and preferences Article 25: Health
Provision for advance care directives	Does the law provide for use of "advance directives"? (Yes/No. If yes, specify definition and if legally binding)	Refers to a written statement by a patient when well, which sets out the way in which they want to be treated and/or treatment they do not want for their mental health condition, should they deteriorate.	Creates opportunities for one's treatment to be informed by one's will and preferences Article 12: Equal recognition before the law Article 17: Protecting the integrity of persons
Securing access to justice			
Provisions for appeal			
Provisions for appeal against involuntary status	Does the law provide for the right to appeal against involuntary care? (Yes/No. If yes, how often?)		Creates opportunity for a review of restrictions to liberty Article 13: Access to justice
Right to information about reasons for involuntary care	Does the law insist that patients must be informed of the reasons for involuntary care? (Yes/No)		Creates opportunity for self-advocacy Supports Article 21: Right to information, but not directly outlined

Table 1 (continued)

Survey item	Question	Definition	Relevance to autonomy and to the CRPD
Right to information about rights to appeal	Does the law insist that patients must be informed of the rights of appeal? (Yes/No)		Creates opportunity for informed decision on whether to appeal Article 21: Right to information; implied, but not directly stated
Provisions for appealing against proxy consent	Does the patient have the right to appeal a treatment decision to which a proxy consent has been given? (Yes/No)		Promotes the right to have one's will and preferences accounted for Article 12: Equal recognition before the law Article 13: Access to justice
Rights to advocacy			
Right to free legal aid	Do patients who are referred to or subjected to involuntary care have the right to free legal representation/free legal aid? (Yes/No)		Promotes financial access to appeal Article 13: Access to justice
Right to non-legal advocacy	Do patients have the right to non-legal advocacy services? (Yes/No. If yes, specify)	Services other than legal services, focused on establishing, protecting and maintaining a person's rights, including rights to choose and refuse treatment, proper communication and due process.	Promotes professional support to appeal Supports participation and self-advocacy, which aligns with the spirit of the UNCRPD
Oversight mechanisms			
Regular monitoring of involuntary care	Does the law include a provision for time-bound periodic reviews of involuntary care by an independent authority? (Yes/No)		Minimizes restrictions on personal liberty Article 14: Liberty and security of the person Article 16: Freedom from exploitation, violence, and abuse
Provisions for judicial/quasi-judicial review mechanism	Does the law set up a judicial or quasi-judicial body to review processes related to involuntary care or treatment and other restrictions of rights? (Yes/No. If yes, specify composition)		Minimizes restrictions by providing independent oversight, ensuring rigor and professional treatment Article 13: Access to justice

inform further discussions, we present a descriptive analysis of legislation governing the use of such care in 27 jurisdictions. Specifically, we aim to establish how recently laws have been revised; which legal provisions are in place to preserve/promote autonomy; and what safeguards and oversight mechanisms are in place. Our focus is on the letter of the law, examining which autonomy-promoting provisions are codified in legislation; we do not assess implementation, legislative intent, or actual practice.

Legal mechanisms to strengthen autonomy of relevance to the CPRD's ambitions have been conceptualized [20]. Next, we describe such mechanisms, with emphasis on those included in the present analysis.

Autonomy enhancing mechanisms

Using the least restrictive option A common legal principle is that voluntariness should always be the preferred option and, if this is not possible, the least restrictive option available should then be applied. Involuntary care should thus be the last resort and cease without delay when not strictly necessary. The CRPD goes further to mandate free and informed consent for all healthcare without discrimination, and therefore prohibits involuntary care based on disability, even when it seeks to address "dangerousness" or "need for treatment".

Protecting decision making capacity and legal capacity Some laws limit the scope of involuntary care to those lacking the capacity to make (treatment) decisions. Assessing capacity usually involves checking whether the person is able to understand information, report back, weigh the consequences of different alternatives and express a clear choice [24]. Jurisdictions adopting capacity-based law are often described as more aligned with the CPRD [29]. When someone lacks decision-making capacity, substitute decision-making, whereby clinicians, family members or others make decisions in the "best interest" of the person, is a common provision. However, because someone's "best interest" may not be identical to their "will and preferences", *substitute* decision making could prevent the person from exercising their legal capacity [30]. Instead, mechanisms for *supported* decision-making, which protects legal capacity, are promoted. This might, for example, include the individual appointing a trusted person to assist in making decisions

during episodes of impaired mental capacity. Individual treatment plans may be another mechanism for people to participate in planning their care and can be a statutory right. Advance healthcare directives (AHD) are another means to specify treatment preferences for future crises [31].

Securing access to justice Rights to appeal against legal decisions, including involuntary care, are commonplace. This might require "reasonable accommodations" to enable the person to fully participate [20], such as rights to adequate, timely and tailored information about the reason for their detention and appeal process. Also, legal representation or advocacy, and for such support to be free of charge, might be reasonable accommodation. To ensure due legal process, oversight mechanisms of involuntary care may include independent review or monitoring bodies, and mechanisms for redress.

Methods

We report on data from a large, descriptive study of mental health law and policy related to involuntary care conducted by the EU funded COST Action entitled *Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services* (FOSTREN). [28], [32]. Eight researchers, specializing in mental health law, psychiatry, sociology, and nursing, developed a comprehensive survey with 91 items to gather information covering legislation, policies, and service contexts. The survey was piloted and revised before distribution to FOSTREN management committee members, which consist of nominated representatives from 30 member countries. Further details on the survey development and pilot, data collection and planned analyses are published elsewhere [33].

To ensure clarity and consistency, we constructed a glossary of key terms, and we emphasized that our interest was *the letter of the law* because we were interested in legal provisions rather than how these were interpreted in practice. The present analysis reports from the section of survey concerned with legislation, and specifically 16 survey items relevant to autonomy, which we categorized as related to least restrictive principle, protection of autonomous decision-making, and access to justice. These are presented in Table 1, together with how they were defined, and their relevance to promoting autonomy and the CRPD. Survey items with dichotomous responses were coded as present/absent in the relevant legislation. For some survey items, respondents were asked to "specify" aspects of legal provisions. These textual responses underwent a two-phase analysis. First, DOA and EG summarized responses from all countries. Second, to enable categorization across countries, all data were synthesized, highlighting themes, similarities, and differences. At this stage, the authors identified additional details or clarifications required from some countries to ensure consistency in interpretations and solicited these as needed. To enhance validity, the two authors who had been least involved in the synthesis (JR and TL) reviewed findings, and amendments were then agreed among all authors. Finally, we performed member checking by sharing synthesized summaries with country representatives, and based on their feedback we finalized the categorization and textual analysis.

Results

For the present analysis, we obtained usable data for the following 27 countries: Austria (AUT), Belgium (BEL), Bulgaria (BUL), Croatia (CRO), Cyprus (CYP), Denmark (DEN), England & Wales (E&W), Estonia (EST), Finland (FIN), France (FRA), Germany, represented by Baden-Württemberg State as one of laws from the 16 states (GER), Greece (GRE), Ireland (IRL), Israel (ISR), Italy (ITL), Latvia (LAT), Moldova (MOL), Montenegro (MON), Norway (NOR), Poland (POL), Portugal (POR), Romania (ROM), Slovakia (SLK), Slovenia (SLE), Sweden (SWE), Switzerland (SWI), and Turkey (TUR).

As shown in Table 2, twenty countries have stand-alone mental health laws, while seven legislate for involuntary care through different parts of their overall legislation. The Italian and Romanian legislations were from 1978 and 2002, respectively, and fourteen countries had revised their laws since 2022. No jurisdiction had a "fusion law", that integrated the use of involuntary care in mental health care and other types of services.

Using the least restrictive option

The presence or absence of the 16 autonomy promoting items are shown in Table 3.

The principle of using the least restrictive option is specified in 17 legislations, 18 specify that involuntary admission must be the last resort, and 22 indicate that the person must be discharged when legal criteria are no longer met.

Protecting decision-making capacity and legal capacity

Capacity based legislation

We consider the laws in 11 jurisdictions as "capacity based", as they specify that involuntary care can only be applied to those with impaired capacity to make decisions. In the nine

Table 2 Laws regulating involuntary mental health care

Country	Is involuntary placement of people with mental disorders legislated for in stand-alone mental health law?	Year last amended
Austria	Yes	2023
Belgium	Yes	2024
Bulgaria	No, in general health law	2024
Croatia	Yes	2014
Cyprus	Yes	2007
Denmark	Yes	2024
England & Wales	Yes	2007
Estonia	Yes	2023
Finland	Yes	2025
France	Yes	2022
Germany	Yes	2023
Greece	No, in general health law	2022
Ireland	Yes	2018
Israel	Yes	2018
Italy	Yes	1978
Latvia	No, in general health law	2023
Moldova	Yes	2024
Montenegro	No, in general health law	2013
Norway	Yes	2017
Poland	No, in mental health act and Civil law	2023
Portugal	Yes	2023
Romania	Yes	2002
Slovak Republic	No, in general health law	2022
Slovenia	Yes	2019
Sweden	Yes	2022
Switzerland	Yes	2008
Turkey	No, in general health law	-

laws that define what capacity is, regardless of whether they evoke capacity as a criterion for involuntary care, this usually relates to the ability to consent to treatment, or more generally impaired judgement or understanding of reality. These definitions are sometimes provided in more general legislation (AUT, E&W, IRL, NOR). While some laws state that capacity must 'manifestly' be lacking (e.g. NOR), others refer to the person's judgement or assessment of reality as 'severely impaired' (ISR, SLOV) or simply to lack of 'discernment' (MOL, POR). Also, some laws relate capacity specifically to treatment (CRO, NOR, POL), while others emphasize the ability to exercise civil rights or perform specific activities (MOL, ROM). In Latvia, capacity is not applicable to health issues, but to financial matters only. In all countries the capacity criterion does not apply if the person is considered a risk to others or to their own life.

Supported decision making

Five countries reported that provisions for supported decision-making formed part of their legislation. Here, Ireland and Latvia seem to have the most comprehensive legislation. In Ireland, The Assisted Decision-Making (Capacity) Acts 2015, which came into force in 2022, provides a legal framework for supported decision-making by enabling individuals who may have difficulty making decisions to create legal agreements outlining how they wish to be supported. To safeguard the rights and interests of those who may require decision-making support, The Decision Support Service, established under the Act, regulates and registers support arrangements, supervises supporters, maintains a panel of experts and investigates complaints. Latvia has, under its Law on Social Services and Social Assistance 2023, established a supported decision-making service designed to assist adults with mental impairments in making independent decisions without influencing their will or choices.

In Austrian law, whether supported or substitute decision-making is offered depends on the person's condition: those lacking decision-making capacity receive assistance to make decisions if recovery is expected, and if it is not, substituted decisions are made by a legal guardian. Doctors must consult relatives or others close to the person and experienced professionals to support the person in regaining capacity but must respect the person's objections to such involvement or information disclosure.

The Israeli Commission for Equal Rights of Persons with Disabilities makes provisions for supported decision-making by facilitating assistance from another person. Those receiving mental health care in Portugal can also appoint a "trusted person" to assist them in exercising their rights. The content of some of these laws has insufficient detail to clearly distinguish them from provisions for substitute decision-making by a legal representative, appointed guardian or next of kin that is included in 15 jurisdictions. Legal provisions for advocacy services (outlined below) may also be understood to serve as decision-making support.

Treatment plans and advance healthcare directives

Individualized treatment plans are required in nine countries. Eleven mandate various forms of directives in advance of acute situations. In some countries, such provisions involve authorizing named individuals to advocate for their wishes or making substitute decisions in case of incapacity (CRO, E&W, ISR). In Croatia, where the nomination must be notarized, it is specified that this authority may be revoked if the nominated person is deemed unfit to protect the person's needs.

AHDs may also take the form of a living will (GER, POR, SWI), by which a person specifies in advance their consent, preferences or refusal of medical procedures. AHDs may be formulated in less formal documents to inform future treatment decisions. This often takes the form

Table 3 Presence of autonomy promoting provisions in laws regulating involuntary mental health care in 27 European countries

	AUT	BEL	BUL	CRO	CYP	DEN	E&W	EST	FIN	FRA	GER	GRE	IRL	ISR	ITL	LAT	MOL	MON	NOR	POL	POR	ROM	SLK	SLE	SWE	SWI	TUR	Total
Using least restrictive option																												
Principle of least restriction	✓			✓		✓	✓	✓			✓				✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	17
Involuntary care is last resort	✓	✓		✓		✓		✓	✓	✓	✓				✓	✓	✓	✓	✓		✓	✓	✓	✓	✓			18
Discharge when criteria for involuntary care no longer fulfilled	✓	✓	✓		✓	✓		✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		22
Protecting decision making capacity and legal capacity																												
Capacity based legislation																												
Decision-making capacity as criteria for involuntary care		✓				✓		✓		✓	✓	✓		✓					✓		✓					✓	✓	11
Definition of capacity	✓			✓			✓	✓			✓		✓				✓		✓			✓						9
Mechanisms for enhancing autonomy																												
Supported decision making	✓												✓	✓		✓					✓							5
Treatment plan is necessary						✓			✓		✓						✓	✓	✓			✓			✓	✓		9
Advance care directives	✓			✓*		✓	✓				✓*		✓	✓*	✓				✓		✓*					✓*		11
Securing access to justice																												
Provisions for appeal																												

Table 3 (continued)

	AUT	BEL	BUL	CRO	CYP	DEN	E&W	EST	FIN	FRA	GER	GRE	IRL	ISR	ITL	LAT	MOL	MON	NOR	POL	POR	ROM	SLK	SLE	SWE	SWI	TUR	Total
Provisions for appeal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	27
Information about reasons for involuntary care	✓	✓		✓		✓	✓	✓		✓	✓			✓		✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	19
Information about right to appeal	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	23
Provisions to appeal proxy consent	✓	✓		✓				✓			✓	✓								✓						✓		8
Rights to advocacy																												
Rights to free legal aid	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	23
Rights to non-legal advocacy	✓	✓				✓	✓				✓			✓		✓	✓	✓		✓				✓	✓			12
Oversight mechanisms																												
Regular Monitoring of involuntary status	✓						✓				✓		✓	✓			✓	✓	✓	✓	✓	✓	✓					12
Provisions for Judicial/Quasi-judicial review mechanism	✓			✓		✓	✓			✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	19
Total	14	9	4	10	2	12	10	10	4	7	15	7	9	11	6	7	11	11	13	10	12	11	7	9	8	10	6	

*Legally binding

of a treatment plan, into which the person must have input (e.g. AUT, DEN, SWI). In Austria, the person may request such a plan, which can include preferred medication and outpatient treatment, avoiding restrictions in crises, and contact requests. Danish law requires that during admission the person is consulted about their treatment preferences, including the use of coercion.

In Ireland, individuals with mental capacity can create an advance healthcare directive through the Decision Support Service. Similarly, in England & Wales, the Mental Capacity Act 2005 provides a statutory framework for making advance decisions to refuse treatment. However, authority afforded by mental health legislation takes precedence in both these jurisdictions, and advance statements can thus be overridden. This is also the case with other forms of AHDs; whether or not they are legally binding, healthcare professionals are encouraged to respect them whenever possible, but they may be set aside in case of imminent danger. In Ireland, if a specific pre-decided treatment request is not adhered to, the reasons for this must be documented by the designated healthcare representative. Where directives are legally binding, such as crisis plans in Switzerland, service users' opinion at the time of treatment may overrule them. In Italy and Portugal, while living wills are legally binding in some general health laws, this does not apply when the person meets criteria for involuntary admission.

Securing access to justice

Provisions for appeal

The right to appeal against involuntary care, usually to a court or independent review body, is specified in all countries. Nineteen regimes specify the right to receive information about the reasons for involuntary status, and 23 make it mandatory that the person is informed about their right to appeal. In four countries (CYP, FIN, ITA, SWE), the person can appeal, but the law does not specify their right to information about this. Seventeen regimes place limits on the number of appeals; some permit one appeal in the period for which the legal decision applies (e.g. BUL, GRE, TUR), while in others several appeals are permitted in each period (e.g. E&W, LAT, NOR, SWI). Additionally, eight countries allow proxy consent to be appealed.

Rights to advocacy

In 22 jurisdictions those subjected to involuntary care have the right to free legal aid to support an appeal. Twelve countries additionally afford rights to non-legal advocacy services, including publicly funded individual advocacy services (DEN, E&W, SLE). In England & Wales, this involves support by a non-legal Independent Mental Health Advocate, who helps people to understand their rights, express their views about their care, and make complaints or appeals. Similar roles are held by Patient Advisors in Denmark and Mental Health Rights Representatives in Slovenia. In other countries, advocacy is legislated through the right to nominate a trusted representative to defend rights and provide support (e.g. AUT, SWE).

Oversight mechanisms

Twelve laws specify that involuntary status should be subject to periodic monitoring, and 19 countries have judicial or quasi-judicial review bodies for involuntary hospitalization. The composition of these bodies vary; legal practitioners and healthcare professionals, usually psychiatrists, are included in most countries, while some (DEN, E&W, IRL, MOL, NOR, ROM) include lay people.

Discussion

To explore how autonomy of those in involuntary care is legislated across Europe, we examined legislation from 27 countries. We found that most legislations had been amended during the period in which patient rights, recovery and other autonomy enhancing approaches to mental health care have become prominent, and only the Italian legislation was last amended prior to the launch of the CRPD in 2006. All the 16 items we included as autonomy-promoting mechanisms are incorporated in law somewhere, but there is large variation among countries, with a spread of 2–15 items.

Which legal provisions and safeguards are in place to preserve/promote autonomy?

All legislations specified at least one measure related to the least restrictive approach. Around a third of countries had capacity-based laws, which protected those with decision-making capacity against involuntary care, although the criteria are usually written so that the autonomy it entails is set aside if the person is assessed to represent a risk. None had, however, developed "fusion law" to avoid differential treatment due to mental health diagnoses [21]. There may be change ahead on this front, as Northern Ireland has passed fusion legislation but not yet implemented it [34], and it was also proposed in Norway as a Green Paper [35].

It is worth noting that legislations classified as capacity based had different definitions and thresholds for determining if a person lacks capacity. These ranged from "manifest" lack of capacity to statements of lack of "discernment" or "significantly impaired" understanding of reality. For other

countries, such as Italy, the legislation of which we did not consider as capacity based, clinical guidance of how to apply the law suggests that one should assess capacity for those refusing treatment. This could mean that clinicians take a person's capacity into account, even if this is not specified as a criterion in law [36].

We also found significant variation in whether those subjected to involuntary care are afforded legal rights to treatment plans, AHD and supported decision-making, which may assist the person in making decisions in line with their will and preferences. Over half the countries had at least one of these as mandatory requirements. Individual treatment plans were codified in statute in a third of the countries. This does not mean, of course, that such treatment plans are not available as part of clinical practice elsewhere. Ireland has the most comprehensive system for such advance decision-making through The Assisted Decision-Making (Capacity) Act (2015) that enshrined AHD practices in law [31], and has set up a specific agency to assist in its implementation. It is worth noting that it took eight years from passing the law in Parliament until it took effect in 2023.

Supported decision-making was included in a small number of laws. It could be difficult to discern from the law texts, however, if this was distinct from substitute or shared decision-making, which is relevant to assess how these statutes protect legal capacity as conceived by the CRPD Committee. Moreover, these mechanisms may be overruled in situations of imminent risk, potentially rendering them relatively weak rights.

The rights to appeal and representation to ensure due legal process were almost uniformly part of legislations, although there was some variation regarding specifics. Most legislations mandate that individuals be informed of the reason for their admission and their right to appeal. The right to free legal aid was also common. Beyond these provisions, safeguards were more varied. For example, only half of the countries have legislated rights to non-legal advocacy, although several countries report that non-legal advocacy services are in place and widely accessible, even if not a statutory right. An area of concern is that five countries have neither a requirement to monitor involuntary status nor independent judicial review bodies to oversee the use of involuntary care, leaving significant protection gaps.

Implications and need for further research

Legislation texts are complex, often built upon existing legal frameworks and tailored to national contexts, which can make comparisons problematic. Our respondents reported classification challenges when responding to the survey items. As mentioned, terminology used to describe treatment plans and AHD making made it hard to differentiate between them, to ascertain what rights were afforded, and to translate this into the concepts underlying the promotion of autonomy. Similarly, it was hard to ascertain if legal provisions related to supported or substitute decision-making, or whether the specified threshold for impaired mental state meant that particular regimes could be classified as capacity based. Future conceptual work that can help capture such fine-grained classifications across contexts is recommended.

We also noted that in their initial response many country representatives reported on how the law is commonly practiced or commented on discrepancies between law and mental health practice. This went in both directions, either autonomy-enhancing law not implemented in mental health practice (e.g., AHDs), or, most commonly, autonomy-promoting provisions being widespread in practice even if it was not a statutory right (e.g., informal, non-legal advocacy services). This divergence suggests that the presence of legal provisions is not sufficient to ensure protection of autonomy. Research examining involuntary hospitalization rates across 22 countries found that variations in rates were not explained by differences in legal framework characteristics such as criteria for involuntary hospitalization, procedural safeguards, or statutory patient rights. Instead, higher rates were significantly associated with service capacity (hospital bed availability, healthcare spending per capita) and socioeconomic factors (GDP per capita, the proportion of foreign-born individuals in the population, and lower absolute poverty) [25]. Recent comprehensive analyses of European mental health laws show, much like our study, variability in the conceptualization of legal criteria related to involuntary care and in the presence of safeguards, and highlight the need for harmonization and rights-based reform in light of the CRPD. [23]. Clinical and professional factors may also explain the implementation gap. Across Europe, there is substantial professional dissatisfaction with involuntary care legislation [37], and considerable variation in attitudes toward coercion across individuals, professional groups, and service contexts [38]. These variations in professional perspectives influence how clinicians apply legal criteria. In complex risk assessments, clinical decision-making tends to favor involuntary care [39]. Additionally, 'defensive practice', driven by concerns about liability, can lead to unnecessary coercive interventions [40]. Assessments of decision-making capacity may be influenced by multiple factors ranging from personal clinical opinions to bed availability, ultimately shaping whether legal safeguards are invoked or bypassed in practice [41]. These studies underscore that while documenting what is legislated provides a baseline to fully understand whether and how autonomy is protected, additional examination of implementation context, broader health system factors, service capacity and actual clinical practice is needed.

Specifically, we propose a number of areas for future investigation to understand how the right to autonomy may be strengthened for those subjected to involuntary care. First, future research should assess the processes that led to legal change within and across jurisdictions where many autonomy-promoting mechanisms are in place. Next, studies should examine the barriers and reasons why other jurisdictions have not introduced such autonomy-promoting measures. Identifying these barriers could inform targeted strategies for legal reform. Research examining legislative intent and debates could clarify whether observed provisions were deliberately designed to promote autonomy, and if so if this was in response to the CRPD. Additionally, implementation studies are needed to understand potential implementation gaps [42] between law and practice, including resource availability and how mechanisms like treatment plans and AHDs are utilized when legally mandated. Finally, our study was limited to autonomy-promoting measures within laws governing involuntary care, thus excluding broader healthcare and civic rights, such as access to primary healthcare, housing, and welfare entitlements, which significantly impact mental health service users' overall autonomy. Future analyses designed to take this broader legal and policy context into account to provide a more comprehensive understanding of autonomy protection are needed.

Given that most of the legislations were amended in the last 15 years, the opportunity to align national legislation to the autonomy agenda in general and the CRPD in particular has been there. Even so, there was great variation in whether and which of the autonomy-related items were incorporated. This might suggest, as noted in other studies [4, 43, 44], that the CRPD has not impacted legislation as intended. Our findings suggest that while procedural safeguards are well established, autonomy-promoting mechanisms developed to support individuals' will and preferences, where they exist, may be overridden by clinical assessment of risk, reflecting ongoing tensions regarding how to balance autonomy with other considerations in involuntary care. However, variation in legislation does not necessarily translate to variation in autonomy protection in practice. As outlined above, implementation depends on multiple factors including attitudes toward coercion, service infrastructure, resource availability, and clinical decision-making practices. Additionally, because the Convention concerns international and not national law, there is no direct mechanism to compel immediate national legislative changes [5]. These factors further point to a need for implementation research examining why legally mandated autonomy protections succeed in some contexts but not others, and for understanding why countries fail to act on a Convention they have signed up to regarding the protection of the autonomy of those receiving healthcare against their will.

Strengths and limitations

This was a descriptive comparative study examining the letter of the law across 27 European jurisdictions. We did not assess legislative intent, implementation in practice, or resource availability. The high number of included countries enable the observation of trends, even if, given the heterogeneity of mental health legislation, countries not represented here might have different regimes. The transnational and transdisciplinary research teams who collaborated on design, execution, and data analysis meant a range of perspectives were included. The involvement of respondents from all countries enhanced data quality. While the study focused on the letter of the law, we acknowledge that the binary classification of autonomy promoting mechanisms (present/absent) may oversimplify complex legal provisions and, given the challenges referred to above, we cannot rule out that some items should have been classified differently despite our thorough checks.

Conclusion

This analysis of mental health legislation surrounding involuntary care across 27 European jurisdictions reveals that most laws have been revised after the adoption of CRPD. Procedural safeguards, like rights to appeal and support for such appeal, are almost universally legislated for, and all but one jurisdiction explicitly mandates the principle of the least restrictive option.

Mechanisms to support autonomous decision-making, such as advanced directives and supported decision-making, are incorporated less frequently and with considerable variation across countries, and can usually be overridden. This suggests that the translation into law of the principles of the CRPD and other initiatives to enhance autonomy for those subjected to involuntary care still has some way to go. Future research is needed to understand the processes that lead to adoption of autonomy-promoting mechanisms in mental health laws, identify barriers to adoption in other jurisdictions, and examine the role of broader social, policy and legal contexts.

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Author contributions DOA and JR conceptualized the study. DOA and EG analyzed and synthesized the data. DOA wrote the first draft of the manuscript. JR and EG contributed to writing the manuscript draft. TL reviewed and made contributions to the manuscript draft.

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Data availability No datasets were generated or analysed during the current study.

Declarations

Competing interests The authors declare no competing interests.

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