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2º CICLO DE ESTUDOS
MESTRADO EM MEDICINA LEGAL

Tratamento involuntário de pessoas com transtorno mental em países de língua portuguesa: Análise e comparação da legislação

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M

2023

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Dissertação de Candidatura ao grau de Mestre em Medicina Legal, submetida ao Instituto de Ciências Biomédicas Abel Salazar da Universidade do Porto.

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Acknowledgments

Firstly, I want to thank Dr. Mariana Pinto da Costa, for all her availability and help throughout this study, for her corrections and assertive counselling. Without her support this work would not have been completed.

With the same sincerity, I would like to thank Dr. João Correia, for his support throughout the study and in all the interviews with the selected professionals, who contributed significantly to the success of this article.

I wish to express my deep gratitude to Judge Simas Santos, for his exceptional legal guidance and provision of extensive materials, with the constitutional frameworks of each CPLP countries in this study. His assistance has been invaluable.

I would also like to sincerely thank all professionals in Portuguese-speaking countries who provided key information and clarification about the reality of the compulsory treatment legislation in their countries, namely Nelson Caculo (Angola), Salvador André (Angola), Vinicius Belinati (Brazil), Gustavo Castellana (Brazil), Guido Palomba (Brazil), Aristides da Luz (Cape Verde), Edmundo Monteiro (East Timor), Flávio Mandlate (Mozambique), Vasco Cumbe (Mozambique), Marta Queirós (Portugal), Manuel Simas Santos (Portugal), Cleiser Vangente (São Tomé and Príncipe), Jerónimo Te (Guinea- Bissau).

Finally, my deepest thanks to every single person who contributed to this study, whether with corrections, suggestions, materials, their time, or their professional testimony. My thanks also go to all my friends and family who have supported me throughout this journey, always with a friendly word. You have been essential in getting this study this far.

Resumo

Contexto: O Internamento Involuntário é o internamento de uma pessoa com anomalia mental num estabelecimento adequado por decisão judicial. Constatando a importância do tema e a escassez de informação sobre a legislação do tratamento compulsivo nos países de língua portuguesa, tivemos como objetivo descrever as semelhanças e diferenças na legislação dos países da CPLP.

Objetivos: Descrever e analisar as semelhanças e diferenças na legislação sobre Internamento Involuntário nos países de língua portuguesa (abreviadamente designados por CPLP): Angola, Brasil, Cabo Verde, Timor-Leste, Guiné-Bissau, Guiné Equatorial, Moçambique, Portugal e São Tomé e Príncipe.

Métodos: Os dados obtidos nesta pesquisa foram retirados da legislação específica sobre saúde mental e internamento involuntário nos países de foco do autor. Foi efectuada uma análise exaustiva de toda a legislação, revistas científicas e planos nacionais de desenvolvimento nos países que não dispunham de legislação sobre tratamento involuntário.

Resultados: Os nove países pertencentes à comunidade dos países de língua portuguesa foram estudados nesta pesquisa. Apenas Brasil, Cabo Verde e Portugal dispunham de legislação específica sobre internamento involuntário. Os outros seis países analisados dispunham apenas de planos de desenvolvimento em matéria de saúde mental.

Conclusões: Nos três países analisados (Brasil, Cabo Verde e Portugal), foram utilizados procedimentos semelhantes para o internamento e tratamento de pacientes involuntários. No entanto, há também diferenças entre as legislações, incluindo quem são os indivíduos que podem ser internados; os locais de internamento; a avaliação bimestral do paciente e a variação acerca da definição de perturbação mental em cada país.

Palavras-chave: Internamento Involuntário; hospitalização; países de língua portuguesa; legislação; planos de desenvolvimento.

Abstract

Background: Involuntary treatment is the internment of a person with a mental disorder anomaly in an appropriate establishment by judicial decision. Noting the importance of the subject and the lack of information about the legislation of compulsory treatment in Portuguese-speaking countries, we aimed to describe the similarities and differences in the legislation of the CPLP countries.

Aims: To describe and analyse the similarities and differences in the legislation on involuntary treatment in Portuguese-speaking countries (abbreviated as the CPLP): Angola, Brazil, Cape Verde, East Timor, Guinea-Bissau, Equatorial Guinea, Mozambique, Portugal, and São Tomé and Príncipe.

Methods: The data obtained in this research were taken from the specific legislation on mental health and involuntary treatment in the countries of focus of the author. A thorough analysis of all legislation, scientific journals, and national development plans were carried out in countries lacking compulsory treatment legislation.

Results: The nine countries belonging to the community of Portuguese-speaking countries were studied in this research. Only Brazil, Cape Verde and Portugal had specific legislation on involuntary treatment. The other six countries analysed had only development plans on mental health.

Conclusions: Across the three countries analysed (Brazil, Cape Verde, and Portugal), similar procedures were used for the hospitalisation and treatment of involuntary patients. However, there are also some differences between the legislations, including who individuals can be hospitalised; the places for internment; the bimonthly patient assessment and the variation of definition of mental disorder in each country.

Keywords: Involuntary treatment; hospitalisation; Portuguese-speaking countries; legislation.

Summary

1. Introduction

Involuntary treatment (IT) in psychiatry involves the legal imposition of treatment, against one's will or in spite of their opposition (1), by judicial decision, to ensure the well - being and safety of the patient while also safeguarding others from potentially harmful behaviours (2). The use of coercive measures, which has shown an overall increase in recent years (3), remains a subject of clinical, legal, and ethical debate with conflicting perspectives in psychiatry (4). These measures violate various fundamental rights rooted in ethical principles, including autonomy, freedom of movement, and bodily integrity (1).

IT while offering potential benefits to individuals and communities, must carefully address and minimise associated harms, with proponents arguing that the clinical and societal advantages might justify its implementation. Paradoxically, it is argued that IT can be instrumental in the restoration of patient autonomy rather than its deprivation (5). It was also shown that individuals subjected to IT have a lower likelihood of experiencing violent or non- violent crimes (6). However, recent data has failed to demonstrate benefits in terms of long- term clinical improvement following IT and does not appear to rule out the possibility of worse compliance afterward (7, 8).

IT should only be applied when it is the sole means of ensuring that individuals with a treatable psychiatric condition receive the necessary and available therapeutic approach (5). While there has been global progress in psychiatric procedures and legislation, notable disparities still exist, particularly in regions such as Africa, where progress remains limited due to factors like stigma and political instability (9). Culture and social factors also play a significant role in the implementation of IT, with national legislations frequently reflecting their cultural context and constitutional rights (10). Therefore, because the criteria for implementing IT vary among countries, as do the rates of involuntary admissions, directly comparing practices represents a challenging task (11). The aim of this study has been to investigate and compare the fundamental requirements for proceeding with IT within each member of the Portuguese-speaking country community (CPLP) and to ascertain whether they are regulated by any national legislation.

2. Methods

2.1 Study design

A multi-method approach was employed to compare the compulsory treatment in CPLP countries where Portuguese serves as the primary official language.

2.1.1 Legislation and regulations

We conducted an extensive search, retrieval, and in-depth examination of published legislation, national regulations, as well as national plans and policies concerning population- level physical and mental health.

2.1.2 Key stakeholders contacts

A purposive sampling strategy was used to contact key stakeholders from each participating country, targeting experienced psychiatrists and mental health professionals. Stakeholders shared their perspectives on IT practices and legislation within their respective national contexts. Where psychiatrists were not available, other experienced mental health professionals were interviewed. All interviews were conducted by two of the authors (JS and JMC). The WHO resource book on mental health, human rights and legislation (14) was used as a foundational reference. This resource served as a guide and a consensus framework for evaluating the legal dimensions of mental health within the countries under investigation. Consultations with legal experts and academics specialising in jurisprudence were conducted to validate the suitability of our analytical framework.

2.2 Criteria for IT

In line with the WHO resource book on mental health, human rights and legislation (14), this study considered the following criteria for IT:

i) Clinical diagnosis of a mental disorder: IT typically requires the presence of a mental disorder as defined by internationally recognised classification systems (e.g., ICD-11 and DSM-5-TR). The type, severity, and criteria for involuntary admission may vary significantly across different jurisdictions, often sparking vital discussions and reflecting the values and priorities of each country.

ii) Exclusion of ineligible conditions: This involves identifying conditions that are not

considered for IT (e.g., intellectual disability; sexual preference). This process ensures that individuals with mental health conditions are not subjected to involuntary admissions unnecessarily, safeguarding their human rights.

iii) Need for treatment: The decision for IT should be backed by evidence of the individual's requirement for treatment, which is usually determined by the severity of the mental condition, incapacity to make informed decisions, and the likelihood that failure to admit the person will lead to significant deterioration or hinder the administration of appropriate treatment.

iv) Imminent danger to self, others, or patrimonial assets: This criterion applies when there is a concrete risk of harm posed by the individual to themselves, others, or patrimonial assets. This assessment is grounded in the principle that, in certain cases, the danger to public health and safety outweighs individual health concerns, impacting the overall well-being of the community.

v) Therapeutic purpose: IT should be integrated into a comprehensive treatment plan, ensuring that the individual's well-being remains the central focus throughout the process.

vi) Right to legal representation: Individuals facing IT have the right to legal counsel to protect their interests and ensure due process during any legal proceedings.

vii) Right to habeas corpus: This right enables the presentation of a detained individual before a court to assess the lawfulness of their confinement, serving as legal recourse against the state agent, typically a custodian, responsible for the detention.

viii) Legitimacy of requesting IT: This concerns the legal authority vested in certain parties to request IT, commonly including judges, family members, and psychiatrists usually.

ix) Facilities for treatment: Refers to the medical facilities where patients receive treatment, including general and psychiatric hospitals, or any other healthcare services, such as outpatient centres.

x) Review process: This involves periodic evaluations and assessments of the individual's condition and circumstances to ensure that the grounds for involuntary admission remain validated comply with relevant legal requirements. The review process serves as a safeguard against potential abuse and supports ongoing assessment and appropriate decision-making. The application of these criteria plays a pivotal role in ensuring a balanced approach to mental health legislation while safeguarding human rights and public safety.

3. Results

Brazil, Cape Verde, and Portugal are the only Portuguese-speaking countries that have

enacted specific legislation governing IT. The remaining countries - Angola, Guinea-Bissau, Mozambique, São Tomé and Príncipe, and East Timor - lack dedicated legislative frameworks concerning IT or provisions for managing specific disorders that require hospitalisation. Instead, these nations have implemented generalised health and development programs aimed at addressing systemic constraints within the healthcare sector and promoting access to comprehensive health services. These programs outline the government's strategic policies and interventions intended to enhance economic and public health.

Among the countries where IT is legislatively regulated, significant congruence is observed between Cape Verde and Portugal. The criteria for compulsory admission uniformly encompass the presence of a diagnosed mental health condition, non-compliance with treatment, and the inherent risk the individual may pose to themselves, others, or property. These two countries also include the possibility of involuntary community treatment as a reflection of the recent shift toward community care for individuals with severe mental conditions, ultimately aiming to prevent multiple hospital admissions. Despite the absence of national statutory regulations concerning IT, analogous practices concerning specific analysed variables can be found. Notably, there is a consensus regarding the prerequisite of a diagnosed psychiatric disorder as a condition for initiating IT among all CPLP countries. Additionally, there is unanimous preference for mental health facilities as the primary treatment setting, with Mozambique being the sole exception where alternative healthcare settings may also be utilised.

São Tomé and Príncipe has considerable variability in the criteria considered for compulsory treatment. In São Tomé, the option for IT remains viable even in cases where a patient remains clinically stable but refuses essential psychiatric medication. Conversely, in Mozambique, unlike the remaining countries, familial consent is a prerequisite for initiating IT; the absence of familial consent precludes the initiation of treatment, regardless of medical evaluations. The requirement of posing a risk to oneself, others, or property, often considered a key factor in determining the involuntary process, also shows significant variation between countries. Notably, Angola, Mozambique, and São Tomé and Príncipe, the three African countries with the highest poverty headcount ratios, do not adhere to this principle.

While the review process for IT is applicable in most CPLP countries, excluding Guinea-

Bissau, only Cape Verde and Portugal have predefined intervals for conducting these evaluations. In Portugal, a second assessment is mandatory, with a review occurring 5 days following the initial assessment and subsequently within a 2-month timeframe. In Cape Verde, the initial assessment is followed by a review after 10 days, and subsequently within a 2- month time frame.

Table 1 provides a comprehensive summary of all assessed parameters for each country pertaining to IT.

Table 1. Comparison between legislation of CPLP countries.

Country	Population[a], millions	Poverty headcount ratio[a,b], %	Legislation	Is a diagnosed psychiatric condition required for IT	Should the condition be treatable?	Should someone under IT pose a danger to themselves, others, or property?	Does someone under IT have a right to a legal representative?	Is the right to habeas corpus contemplated?	Where can IT be conducted?	Can IT be reviewed?	Should treatment be provided?	For countries with legislation, is there community IT?
Angola	36.78	31.1	No	Yes	Yes	No	Yes	Yes	Mental health facilities	Yes, without a set schedule	Yes	-
Brazil	215.16	5.8	Yes	Yes	Yes	Yes	Yes	Yes	Mental health facilities	Yes, without a set schedule	Yes	No
Cape Verde	0.58	4.6	Yes	Yes	Yes	Yes	Yes	Yes	Mental health facilities	Yes, with a set schedule	Yes	Yes
East Timor	1.4	24.4	No	Yes	Yes	Yes	Yes	Yes	Mental health facilities	Yes, without a set schedule	Yes	-
Guinea-Bissau	1.94	21.7	No	Yes	Yes	Yes	Yes	Yes	Healthcare facilities[c]	Yes, without a set schedule	Yes	-
Mozambique	33.9	64.6	No	Yes	Yes	No	Yes	Yes	Healthcare facilities	Yes, without a set schedule	Yes	-
Portugal	10.29	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Mental health facilities	Yes, with a set schedule	Yes	Yes
São Tomé and Príncipe	0.23	15.6	No	Yes	No	No	Yes	Yes	Mental health facilities	Yes, without a set schedule	No	-

Abbreviations: a, according to the most recent data available on The World Bank and International Monetary Fund platforms; b, the poverty headcount ratio is defined as the percentage of individuals living on less than 2.15 dollars a day; c, private healthcare facilities, only.

For all countries, habeas corpus plays a crucial role in preventing the abuse of state authority and ensuring the protection of citizens' rights, thereby upholding due process, and guarding against arbitrary or illegal detention. The specific criteria and procedures for granting habeas corpus may differ depending on the legal framework of each country. In the absence of specific legislation regulating IT, general legal frameworks are responsible for the protection of individual rights.

The right of the patient to have a legal representant in court was observed in all countries of CPLP. This could be analysed because of the Constitution of each country, which is the Magna Carta and has the greatest hierarchical power among all the other laws. The Constitution represents that every citizen must have their rights respected and may be represented by a legal representative or a private lawyer. In the case of IT, that it's an Involuntary interment – against the patient's will -, the patient has the right respected by law to reply against its interment by the legal representative.

4. Discussion

4.1 Key findings

Only three countries - Brazil, Cape Verde, and Portugal - have established legislation that specifically addresses involuntary treatment and adhere to the same commonly accepted principles and prerequisites governing involuntary treatment. These principles encompass the requirement of a diagnosed psychiatric condition, the condition being amenable to treatment, the individual posing a threat to themselves, others, or property, and the provision of therapeutic intervention.

Conversely, the remaining countries - Angola, Guinea-Bissau, Mozambique, São Tomé and Príncipe, and Timor-Leste - lack a legal framework that effectively safeguards the individual rights of those subjected to such coercive measures.

4.2 Strengths and limitations

This study reports the first comparative analysis of IT within Portuguese-speaking countries, encompassing a variety of low- and middle-income countries which is a key strength. Furthermore, it incorporates countries in Europe, Africa, Asia, and South America, thus enabling a comprehensive cross-continental comparison across nations with diverse geographical locations and varying socioeconomic circumstances.

Some limitations should also be noted. Firstly, the stakeholders contacted were selected through purposive sampling, potentially introducing limitations in the precision of the information gathered. However, it is crucial to underline that the professionals interviewed had extensive experience in the field of mental health and exhibited a profound understanding of the prevailing mental health practices in their respective countries. This suggests their capacity to offer valuable insights. Secondly, our study was specifically tailored to analyse a set of predefined criteria governing IT. Finally, we did not delve into factors that could potentially explain or provide a deeper understanding of our findings, such as cultural influences and hospitalisation rates.

4.3 Comparison with existing literature

Previous research examined the annual incidence of involuntary hospitalisation between 2008 and 2017 in 22 countries, including in Europe, Australia, and New Zealand and analysed the national legislation, demographic factors, and economic indicators within these countries, there are several yet largely unexplained variations (15). Notably, a higher annual incidence of involuntary hospitalisation was associated with several factors, including lower rates of absolute poverty, higher GDP, increased healthcare spending per capita, a larger proportion of foreign-born individuals in the population, and greater numbers of inpatient beds.

Of the 22 countries analysed (all HIC), Cyprus (only in relation to detention by police), Denmark, Greece (no, if patient lacks capacity; yes, otherwise), Italy, and Norway (no, if patient lacks capacity; yes,otherwise) do not explicitly preset the criterion of risk to itself, other or the

patrimony for IT. In our study, three countries did not present this criterion, Angola, Mozambique e São Tomé and Principe. In other words, this criterion seems to show clear variability between developed and developing countries.

Despite this diversity in legal frameworks, there are some commonalities among these countries. All CPLP countries generally agree on the necessity of a diagnosed psychiatric disorder as a condition for initiating involuntary treatment. Except for São Tomé and Príncipe, all countries demonstrated compliance with the requirement that each case of IT should be characterized by a therapeutic purpose. This contrasts with the results of a previous study that examined variations in mental health legislation among Commonwealth countries, where only a minority of acts (12 out of 32) appeared to comply with the same condition (16).

In Brazil, Cape Verde, and Portugal where legislation governing IT exists, there are notable issues related to the conceptualisation and legal framework of mental health conditions. On one hand, this legislation provides mental health professionals with flexibility in conducting individualized patient assessments, allowing them to move away from strict adherence to rigid criteria, which may not adequately capture clinical variations. On the other hand, this flexibility could potentially lead to overuse of IT, encompassing cases where less coercive measures could be employed. Striking the right balance is a nuanced challenge and necessitates clear consensus.

In terms of the review process for IT, the majority of CPLP countries, except for Guinea- Bissau, have established procedures. A smaller number of countries have set predefined intervals for conducting these evaluations, with Cape Verde and Portugal being the sole examples, demonstrating a structured and regulated approach to IT. Previous research examined the mental health legislation in five jurisdictions within developed countries, namely the Republic of Ireland, England and Wales, Scotland, Ontario, and Victoria, reporting a substantial alignment in the procedures utilised for admitting, detaining, and treating involuntary patients (5). However, similarly to our findings, variations emerged regarding the definition of mental disorders, the promptness of automatic review hearings following IT, and the role of supported decision-making within mental health legislation.

In our study Mozambique stands as a unique case within the CPLP, where the process of IT may be influenced by the patient's family. This phenomenon likely reflects the deep-seated

cultural influences on mental health in the country, with the family's paternalistic role aligning with the prevailing stigma associated with psychiatric conditions. In Africa, mental illness remains entwined with mystical beliefs, where supernatural ideas and witchcraft intersect with scientific understanding, despite government-led educational campaigns within local communities. In certain African nations, these challenges are exacerbated by a shortage of specialised professionals, leading to a reliance on foreign experts for support (16).

Countries worldwide have established various provisions within their national or regional mental healthcare systems for involuntary admission and treatment, aiming to safeguard the rights of individuals with severe mental illnesses. These principles and procedures governing these provisions can vary significantly due to differences in cultures, traditions, economies, and the availability of human resources. While Portuguese-speaking countries share the influence of Portuguese culture, they exhibit distinct socioeconomic development patterns. A noteworthy finding from our research is the correlation between a country's level of development and the protection of individual rights concerning IT.

We observed that the more economically developed CPLP countries, such as Brazil, Cape Verde, and Portugal, as indicated by their poverty headcount ratio, have enacted specific legislation addressing IT. In contrast, the less economically prosperous CPLP countries, encompassing Angola, Guinea- Bissau, Mozambique, São Tomé and Príncipe, and East Timor, provide fewer safeguards due to the absence of relevant legislation. This aligns with the data indicating that legislation fully safeguarding the rights of individuals with severe mental illness is implemented in only about one-third of countries worldwide, with the majority being high-income countries (12).

4.4 Implication of the findings for future practice and research

This study highlights the disparities within several CPLP members and calls upon countries without IT laws to develop appropriate legislation.

It is important to emphasize the critical distinction between legal IT and other forms of coercive intervention, where no jurisdiction regulates its application, and thus allowing room for abuse. Arguments in favor of IT for patients with mental disorders revolve around three main aspects: the protection of societal interests to safeguard others; the promotion of the patients' own health

interests; and considerations of patient autonomy (16). All forms of coercive practices might be considered, however, inconsistent with human rights-based mental healthcare (17). Therefore, IT remains a topic of ongoing debate, entailing complex ethical and legal considerations that often require a delicate balance between patient rights and public safety.

IT should only be contemplated when all other available alternatives have been exhausted, and therefore it should be regarded as a measure of last resort. Simultaneously, IT should be distinguished from involuntary placement, as both interventions raise distinct ethical questions and are viewed differently within the context of human rights (18). To illustrate this disparity, involuntary admission, as commonly practiced in São Tomé and Príncipe, does not necessarily guarantee the provision of a therapeutic approach, meaning that both concepts do not always align. The juxtaposition of a high prevalence of mental disorders and a shortage of resources for their treatment in sub-Saharan Africa underscores the importance of robust mental health literacy and the necessity for appropriate legislation to safeguard the most vulnerable individuals (19).

Our study findings reinforce the significance of striking a balance between the clinical imperative of compulsory treatment and the preservation of individual rights, irrespective of a country's economic development. This underscores the need for a collective endeavour to establish ethical and comprehensive legislation across all CPLP countries, aiming to protect the rights and well-being of individuals dealing with severe mental health conditions. Research suggests that involuntary measures, when determined through a transparent and carefully balanced evaluation process, are more likely to be appropriate, understood, and accepted (1).

Conclusions

The regulation and implementation of IT for individuals experiencing severe mental health conditions in Portuguese-speaking countries demonstrate a diverse array of approaches and practices. Notably, Brazil, Cape Verde, and Portugal have established dedicated legislation governing IT. In contrast, the remaining CPLP countries lack specific legislative frameworks and instead depend on generalized health and development programs to address healthcare system constraints and enhance access to comprehensive health services.

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APPENDIX

Appendix I – Presentations and publications linked with this study

1. Oral presentation at ICBAS (School of Medicine and Biomedical Sciences), presentation on December 14, 2023. Title of the presentation ‘Involuntary treatment of people with mental illness in Portuguese-speaking countries: Analysis and comparison of the legislation’.

2. Article published in 2024 in the IJLP - International Journal of Law and Psychiatry, with the title ‘Compulsory treatment in Portuguese-speaking countries: An analysis and comparison of the legal framework’ by Jessica Audrey Augusto Schmeling, João Martins-Correia, Mariana Pinto da Costa. (https://doi.org/10.1016/j.ijlp.2023.101950)

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