International Journal of Law and Psychiatry 99 (2025) 102069

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

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

‘If someone had stopped to talk to me’: A human rights analysis of Spain's mental health system

María Laura Serra [*]

University of Valladolid, Valladolid, Spain

ARTICLE INFO

Keywords:
Mental health law
Psychiatric care
Lived experiences
Coercion
CRPD compliance

ABSTRACT

This study explores the gap between Spain's mental health legal framework and the lived experiences of users and survivors of psychiatry, including persons with psychosocial disabilities. Employing a socio-legal methodology, it critically contrasts domestic legislation with qualitative data from interviews, uncovering systemic issues that perpetuate coercive practices such as inadequate judicial oversight and the routine use of coercion and isolation. The findings highlight a significant failure to protect patient autonomy and dignity. This research advocates for comprehensive legal and structural reforms to align Spain's mental health care system with international human rights standards. It underscores the need for a person-centered, rights-based approach that prioritises autonomy, informed consent, and dignity, ultimately promoting a mental health care environment that fully upholds human rights.

1. Introduction

Significant concerns persist regarding the human rights of individuals engaging with the Spanish mental health system, highlighting a critical dissonance between the intent of legal protections and the lived experiences of service users and survivors of psychiatry, including persons with psychosocial disabilities. This issue reflects a broader global challenge, as mental health is increasingly recognised as a global priority by international health organisations (Mahdanian, Laporta, Drew Bold, Funk, & Puras, 2023). While Spain's legal framework—underpinned by international instruments such as the Convention on the Rights of Persons with Disabilities (CRPD)—is designed to protect the rights of individuals with psychosocial disabilities, the implementation of these rights remains deeply flawed.

These complexities and challenges are not unique to Spain. Evidence shows that despite significant advancements in mental health service delivery worldwide, stigmatising attitudes and human rights violations persist in mental health settings. This underscores the persistent gap between policy and practice, even in high-income countries with advanced human rights laws, as revealed by Hoffman, Sritharan, and Tejpar (2016).

Drawing from these insights and scholars such as Perlin (2012) and Bartlett (2003), who critique the persistence of coercion within psychiatric systems—highlighting the failure of legal frameworks despite their theoretical emphasis on autonomy and consent—this paper situates these concerns within the specific context of Spain's mental health system. It aims to advocate for moving away from coercive and paternalistic approaches towards models that fully integrate human rights principles and recognise all individuals with mental health conditions, regardless of their decision-making abilities, as rights holders. It critically analyses domestic laws to highlight the gap between legal intent and practical application. This gap is further explored through the lived experiences, whose narratives reveal the human rights challenges they face within a system that routinely prioritises control over care.

As Mahdanian et al. (2023) note, the relationship between mental health and human rights is “complex and bidirectional”. The authors' argument is that human rights violations can negatively impact mental health while protecting human rights can improve mental health outcomes. In light of this, this study adopts a socio-legal approach, blending an analysis of the legal frameworks with qualitative data drawn from interviews with psychiatric service users and stakeholders. The analysis is structured around two key themes: first, the limitations of judicial oversight in involuntary treatment cases, and second, the broader issue of coercion within psychiatric care, encompassing both formal and informal practices. By doing so, it fills a critical gap in the literature by providing an in-depth socio-legal analysis that assesses the human rights situation of users and survivors of psychiatry, including persons with psychosocial disabilities. This highlights the need for comprehensive

---

[*] Corresponding author at: Department of Civil Law, Faculty of Law, University of Valladolid. Plaza de la Universidad s/n, 47002 Valladolid, Spain.
E-mail address: marialaura.serra@uva.es.

https://doi.org/10.1016/j.ijlp.2025.102069
Received 29 September 2024; Received in revised form 16 January 2025; Accepted 31 January 2025

reforms to align Spain's mental health care legal system with international human rights standards and advocates for a shift towards person-centred, rights-based care.

1.1. Context and background

Mental health is a multifaceted process influenced by various factors intrinsically linked to the fulfilment of human rights. The World Health Organization's (WHO), 2022 report underscores mental health's integral role in overall well-being, extending beyond the mere absence of mental disorders. Spain's mental health system, however, faces several challenges, including concerns over human rights violations. Inconsistencies within the system reveal a tension between theoretical commitments to human rights and the lived experiences of psychiatric service users and survivors, including persons with psychosocial disabilities, particularly in terms of autonomy, consent, coercion, and dignity.

The COVID-19 pandemic has further brought mental health to the forefront of political discourse in Spain, sparking criticism from many mental health advocates regarding the approach of political parties and policymakers towards necessary legal reforms. Considering Spain's evolving perspective on mental health law and the apparent changing stance on this issue, there is an urgent need to ensure the active participation of users and survivors of psychiatric services, including people with psychosocial disabilities, in shaping the future of mental health law reforms. Their involvement is essential not only for addressing specific concerns about consent or autonomy but also for dismantling the systemic coercion and violations of dignity that persist within the system.

Spanish jurisprudence, particularly the rulings of the Constitutional Court concerning involuntary admission under Articles 17 (right to liberty) and 24 (right to a fair trial) of the Spanish Constitution, offers valuable insights into the procedural and doctrinal aspects of mental health regulation. Scholars such as Cabañas García (2012) and Martínez Navarro (2023) further examine these issues from a constitutional and procedural perspective. While their research underscores significant legal foundations, this study aims to focus on the socio-legal realities encountered in psychiatric settings, highlighting the lived experiences and rights of users of psychiatric services, including persons with psychosocial disabilities.

Spain's legal landscape concerning mental health is complex, underpinned by several key legislations and policies but lacking a standalone mental health law. Law 8/2021 (*Ley 8/2021, de 2 de junio, por la que se reforma la legislación civil y procesal para el apoyo a las personas con discapacidad en el ejercicio de su capacidad jurídica*) has made progress by recognising legal capacity for all individuals, regardless of their decision-making abilities, replacing the substituted decision-making regime with a support system. Nevertheless, despite this reform, systemic issues such as involuntary treatment, coercion and disregard for dignity in care practices remain entrenched. This gap between legal reform and practical implementation reveals inconsistencies in the Spanish legal framework, particularly regarding the rights of users of psychiatric services, including persons with psychosocial disabilities.

For instance, the Law on Patient Autonomy of 2002 (*Ley 41/2002, de 14 de noviembre, básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica*), regulates patient autonomy and informed consent within healthcare. However, significant concerns persist.[1] Article 8, while promoting informed consent, allows for verbal consent in general circumstances and mandates written consent only in high-risk scenarios. The Law remains vague on what constitutes a "risk scenario", merely referring to "risks or inconveniences of notable and foreseeable negative impact on the patient's health". This ambiguity raises questions about the adequacy of consent, particularly for users of mental health services, including those with psychosocial disabilities. Article 9 further complicates the matter by outlining situations in which informed consent can be bypassed, such as public health risks or perceived immediate threats to a patient's physical or mental integrity or when the patient is deemed incapable of making decisions.

Although these provisions aim to protect patients, they risk undermining autonomy and decision-making rights by permitting non-consensual treatment under broadly defined conditions. Qualitative interview analysis highlights persistent ambiguities and inconsistencies in respecting patient autonomy and consent, especially in the practical application of legal safeguards.

In summary, while Law 41/2002 attempts to respect patient autonomy and informed consent, its provisions must be critically examined and aligned more closely with the standards set by the CRPD (particularly Articles 12, 17, and 25) to ensure the rights of all users of the mental health system are upheld. Without such alignment, the Law risks perpetuating coercive practices that directly violate the principles of autonomy and dignity it seeks to protect.

Inconsistencies within the Spanish legal framework become even more evident when analysing the Civil Procedure Law (*Ley 1/2000 de 7 de enero de Enjuiciamiento Civil*), which allows for involuntary admission into psychiatric units. While the Law introduces safeguards, including the requirement for judicial authorisation, it continues to facilitate coercive practices, further undermining individual autonomy and dignity. The new Law 8/2021 replaces the substituted decision-making system with a support system, requiring every effort to determine the person's likely decision based on their life history, beliefs, and values. However, in practice, this system often vacillates, leading to decisions that prioritise 'best interests' over respect for individual autonomy — leaving room for coercive measures.

The first significant tension arises from its application to healthcare practices. Although Law 8/2021 specifically references existing regulations concerning involuntary treatment and informed consent (for instance, art. 249 & art. 287.1), practical gaps persist in cases where a patient's will cannot be determined. This reform in civil legislation was designed to ensure supported decision-making, but in healthcare settings, including mental health, the "best interest" criterion remains valid, particularly in psychiatric admissions. Article 763 mandates judicial authorisation for involuntary admissions due to mental disorders (*trastorno psíquico*). While this article might appear to safeguard patient rights, exceptions—especially due in emergencies—allow admissions without prior judicial authorisation, creating opportunities for systemic coercion that undermine autonomy and dignity. Although urgent internments are subject to subsequent review, this creates a window wherein individuals' rights may be compromised and clashing with the CRPD's standards on equality, liberty and security.

Additionally, Article 763 requires attending psychiatrists to submit periodic reports to the court regarding the ongoing need for admission, with these reports issued every six months unless otherwise specified. Although this introduces a layer of legal oversight, concerns remain about how well it protects the autonomy of those undergoing involuntary treatment. The Law stipulates that the court must hear the individual affected before their internment is authorised or ratified. Although the CRPD calls to end all types of forced treatment, this can be considered an attempt to align the CRPD's emphasis on participation and respect for the voices of persons with disabilities. However, in practice, this provision's effectiveness depends on the individual's ability to participate meaningfully and the court's willingness to consider their views genuinely.

Prados García (2023) provides a compelling critique, suggesting that Article 763 should be repealed to fully align with the CRPD's requirements for supported decision-making and non-coercion. While her proposal raises important questions regarding legislative reform, this analysis concentrates on the practical implications of Article 763 as

---

[1] It should be noted that this Law allows medical consent to be replaced when "the patient has judicially modified capacity", which should be interpreted as no longer applicable since the enactment of Law 8/2021.

presently enforced in psychiatric care. Nevertheless, her contributions underscore the pressing need for Spain's legal framework to align more closely with CRPD standards on legal capacity and non-coercion.

The CRPD Committee (2022) and the UN High Commissioner for Human Rights (OHCHR) together with the WHO (2023) advocates for abolishing involuntary treatment and hospitalisation for individuals who need mental health support, including persons with psychosocial disabilities, calling for a reassessment of such provisions and for healthcare systems based on free and informed consent. This advocacy highlights the inherent conflict between involuntary admissions, as permitted by Article 763, and the human rights model embedded in the CRPD (see Degener, 2017). The Committee on the Rights of Persons with Disabilities, 2019 has called for Spain to move away from coercive practices and align its legal frameworks with human rights standards, emphasising community-based care models prioritising autonomy and decision-making capacity. Despite these international recommendations, coercive practices persist within the Spanish mental health system, most notably in the form of involuntary confinement and the use of coercion and restraints.

The issue of coercion and restraints in mental health services is particularly evident in Spain, where the state and the public prosecutor's office confirms the existence of coercion in the mental health system. In January 2022, the State Attorney General's Office issued Instruction 1/2022, which provides guidelines that limits the use of restraints to last resort, requiring judicial oversight and documentation. This instruction is a step towards addressing the overuse of restraints; however, it applies only to cases of involuntary confinement. As such, there remains a significant risk of overuse, inconsistent application, and challenges in ensuring proper documentation and accountability across all psychiatric services.

The introduction of Instruction 1/2022 highlights ongoing concerns about the state's reliance on coercive measures in mental health care. Despite the intent to regulate these practices, the instruction falls short of addressing coercion in voluntary settings and continues to expose individuals to the potential for rights violations. Consent represents one of the primary challenges for the reform of laws and policies to achieve compliance with the CRPD (particularly Articles 12 and 25), as the autonomy and rights of users of psychiatry, including people with psychosocial disabilities, have been and continue to be disregarded, undervalued and nullified in the specific context of mental health.

In response to these ongoing legal challenges and criticisms, Spain has introduced two significant strategic frameworks: the Mental Health Strategy 2022–2026 and the Disability Strategy 2022–2030. While these strategies signal a shift towards aligning mental health care with human rights standards, they are not without shortcomings. The Mental Health Strategy endorses individualising treatment plans and implementing community-based care models, aligning with the CRPD's goals in theory, most notably Article 19 (living independently and being included in the community). However, it lacks specific protocols for implementing these goals, particularly concerning resource constraints and the legal framework for involuntary treatment. The strategy's ambiguous stance on involuntary treatment, especially its relationship with Article 763 and the Law on Patient Autonomy, raises concerns about whether it can effectively reconcile the tension between legal obligations and the need to minimise coercive interventions. It proposes to align care with the patient's will and minimise involuntary interventions. However, it does not address how this will be reconciled with existing laws that permit broader circumstances for non-consensual treatments.

Similarly, the Disability Strategy 2022–2030, while addressing the need for legal reforms to align mental health care with human rights, lacks detailed plans for how these changes will be operationalised. The absence of clear guidance on how to resolve the inconsistencies between Law 8/2021 and current legal practices—particularly concerning consent and coercion—remains a significant oversight. Although the strategy acknowledges the need for reform, it does not offer concrete steps to ensure that Spain's legal framework complies fully with international human rights standards.

Although Spain's autonomous communities (*Comunidades Autónomas*) hold considerable competence over health and social services, this study focuses on the national-level regulations—namely Article 763 of the Civil Procedure Law and Instruction 1/2022—that shape Spain's mental health system. Consequently, this article does not examine the potential variations among the autonomous communities. Future research targeting regional frameworks could yield a more nuanced understanding of how these laws and policies are implemented locally, including variations in resource allocation, oversight, and service delivery.

In conclusion, while Spain's legal and strategic frameworks reflect an intention to align mental health care with human rights standards, significant gaps persist. The legal inconsistencies surrounding autonomy and consent in mental health services risk perpetuating coercive practices that violate the rights of users of psychiatry, including persons with psychosocial disabilities. The following sections will provide a qualitative analysis of these issues, drawing on the lived experiences of mental health service users to identify the root causes of these gaps and propose concrete reforms to bridge the divide between Law and practice.

2. The gap between law and lived experience

A comprehensive understanding of the implications of Spain's mental health laws requires an examination of the lived experiences of those who navigate this system. While legal frameworks such as Law 8/2021 and the Law on Patient Autonomy aim to protect individual rights, the realities faced by users of mental health services reveal significant discrepancies between the Law's intentions and its practical implementation. This section explores how failures in the legal framework—particularly concerning autonomy, consent, coercion, and dignity—create systemic challenges that undermine the rights of individuals with psychosocial disabilities.

The data collected for this study, although corresponding to experiences before the implementation of recent Disability Strategy and Mental Health Strategy, provides crucial insights into the persistent challenges within the system. These challenges are not isolated but rather interconnected, reflecting how the erosion of autonomy and informed consent often leads to coercive practices that ultimately violate individual dignity. By merging a thematic analysis with legal framework discussions, this section aims to provide a coherent examination of how personal narratives underscore the broader legal and systemic challenges. Such an integrated approach seeks to highlight the tangible impacts of legal structures on individual experiences, advocating for a nuanced understanding and subsequent reform of the mental health system.

This analysis examines key themes—such as involuntary treatment, coercion, and the complexities of autonomy and consent—not as isolated issues but as interconnected elements of a broader systemic failure. Testimonies from users and survivors of psychiatry expose a pervasive pattern of neglecting individual rights, calling for urgent reforms to align Spain's mental health care practices with international human rights standards.

3. Method section

This paper is part of an individual research project under a *Maria Zambrano* scholarship, co-funded by the EU Next Generation Fund and the University of Valladolid, focusing on human rights within the Spanish mental health system. The research aims to provide a socio-legal context for developing public policies and legal changes that respect and guarantee human rights.

With this purpose in mind, the project explored three key questions: (1) What barriers do users or survivors of psychiatry, including persons with psychosocial disabilities, face within Spain's mental health system? (2) How can Spain ensure the protection of human rights for these individuals in the regulation of mental health? (3) What tools do justice and health and social care practitioners require to effectively support their rights during psychiatric treatment?

This article focuses primarily on the first question, presenting a qualitative inquiry into the lived realities of users or survivors of psychiatry, identifying the barriers they face, and examining how these barriers shape their interactions with Spain's mental health system. The data collection and analysis centred on these challenges and systemic inadequacies, which were then examined alongside the relevant legal and policy framework, aided by semi-structured interviews with stakeholders and key informants.

3.1. Data collection and participants

To explore and make visible the lived experiences of users and survivors of psychiatry, including persons with psychosocial disabilities, the study relied on qualitative data collection, focusing on oral history interviews. This method enabled a deeper understanding of how legal frameworks are experienced and perceived by those directly affected by Spain's mental health system.

A total of 38 interviews were conducted across seven of Spain's autonomous communities. Specifically, 9 participants were from Castilla y León, 8 from Cataluña, 6 each from Canary Islands and Comunidad de Madrid, 5 from Andalucía, 2 from Navarra, 1 from Extremadura, and 1 participant preferred not to disclose their region. Of the participants, 80 % identified as women and 20 % as men.

Recruitment efforts targeted individuals with direct experiences of the mental health system. To ensure a broad representation of perspectives, specific outreach was made to organisations representing users and survivors of psychiatry, including persons with psychosocial disabilities. An open call for participation was also published on social media to reach individuals outside of formal organisations.

Participants received detailed information sheets about the study's objectives, and informed consent was obtained before participation. Within the consent form, participants had the option to remain anonymous or be identified by their real names in the study's publications. The Research Ethics Committee of Valladolid East Health Area (CEIm) of the University Clinical Hospital of Valladolid approved the study, ensuring adherence to ethical standards.

Data collection occurred from September 2022 to November 2023 through interviews primarily in person, supplemented by some videoconference sessions. While some interviews addressed recent developments, the majority of participants' personal experiences took place prior to the implementation of Law 8/2021. This temporal context indicates that certain legal changes, including Instruction 1/2022, may not have substantially altered the participants' experiences at the time of their narratives.

The oral history interviews were audio-recorded and transcribed verbatim, with minor adjustments for readability. The study adopted an inductive approach to analysis and knowledge construction, working from the ground of the stories upward (Bochner and Riggs, 2014), allowing themes to emerge organically from the narratives rather than imposing a predefined structure. This approach ensured that the interconnectedness of issues was preserved. The transcripts were analysed using thematic coding, which involved both open and focused coding processes to identify recurring patterns and categories. Themes such as autonomy, coercion, consent, and dignity were not treated as discrete categories but were instead examined in terms of how they intersect and reinforce each other in participants' lived experiences.

The coding process was grounded in a critical research paradigm (Leavy, 2017), which prioritises the experiences and perspectives of marginalised individuals, such as persons with psychosocial disabilities. This methodological approach was explicitly chosen to challenge dominant discourses and highlight power imbalances, particularly those embedded in legal and medical systems. As a result, the analysis not only focuses on individual narratives but also critiques the broader social structures that sustain coercive practices in mental health care.

3.2. Stakeholder interviews

In addition to oral history interviews, semi-structured interviews were conducted with key stakeholders, including psychiatrists, nurses, prosecutors, and government officials. These interviews provided a complementary perspective on how legal frameworks, such as the Civil Procedure Law and *Instrucción 1/2022*, are interpreted and applied by professionals within the mental health system. The inclusion of these stakeholders was crucial for understanding the systemic nature of coercion and the practical challenges in upholding autonomy and consent within clinical and legal contexts.

Fourteen stakeholders were interviewed, including four psychiatrists, three nurses, five prosecutors, and two government teams (each comprising multiple public officials) from the Ministry of Health and the National Mechanism for the Prevention of Torture (MNP in Spanish) from the National Ombudsman office. These interviews helped to contextualise the personal narratives within the broader legal and institutional framework, providing insight into the power dynamics that shape mental health care practices.

3.3. Ensuring rigour and reflexivity

Given the topic's sensitive nature, reflexivity was a key component of the research process. As a researcher, I was continuously mindful of my own position and potential biases, especially given the power imbalances often present between researchers and participants in qualitative studies. This reflexive approach was essential in ensuring that the analysis remained focused on the voices and experiences of the participants rather than imposing an external framework.

To ensure rigour, multiple strategies were employed, including having an advisory group board composed of three academics in Philosophy of Law, Civil Law, and Human Rights, one psychiatrist, and two survivors of psychiatry and activists. Likewise, triangulation of data sources (e.g., oral history interviews, stakeholder interviews, and document analysis) and peer debriefing were implemented. These strategies enhanced the validity of the findings, ensuring that the thematic analysis accurately reflects the complex interplay between legal frameworks and lived experiences.

4. Personal narratives in the context of legal frameworks

Despite Spain's formal commitment to international human rights standards, particularly the CRPD, a persistent gap exists between the rights enshrined in Law and the lived experiences of psychiatric service users, including those undergoing both voluntary and involuntary treatments. This gap manifests in various ways, from failures in securing informed consent and respecting patient autonomy to the continued reliance on coercive measures that undermine dignity. By examining both voluntary and involuntary treatment contexts through the lived experiences of service users, this section explores how systemic issues in Spain's mental health system—such as inconsistencies in judicial oversight, medical paternalism, and the marginalisation of patient voices—continue to perpetuate these human rights violations.

To address these themes effectively, this section is divided into two parts. First, it will examine how the superficial nature of judicial oversight, particularly through brief and perfunctory judicial interviews, undermines the autonomy of psychiatric service users, including persons with psychosocial disabilities. The presence of psychiatrists during these reviews further skews the process, creating power imbalances that erode the objectivity of judicial decisions. The second part will explore the systemic use of coercive practices in mental health care, including mechanical restraints, forced medication, and isolation, which severely undermine patient autonomy and dignity. While these issues are distinct, the theme of autonomy permeates both areas, as individuals' capacity for self-determination is restricted in both legal and clinical settings.

4.1. Judicial oversight and autonomy: A critical disconnect

The 2021 report from the State Attorney General's office —the most recent to provide comprehensive data on this issue— documented a total of 57,592 resolved cases related to involuntary treatment (FGE, 2021). However, the report lacks clarity on whether this figure solely encompasses cases that were involuntary from the outset or if it also includes instances where voluntary admissions were subsequently converted to involuntary ones. This ambiguity reflects broader issues of transparency in reporting involuntary hospitalisation across various jurisdictions. For instance, Sheridan Rains et al. (2019) highlight significant variability in how European countries report and handle cases of voluntary admissions converted to involuntary ones, complicating accurate data representation. Despite these uncertainties surrounding data collection, the State Attorney General's office expresses concern in the report regarding procedural adequacy and the effectiveness of judicial oversight in cases of involuntary treatment.

A full exploration of how the legal ground of Article 763 —focusing on individuals "who are not in a position to decide for themselves"— shapes experiences is beyond the scope of this article. However, one interesting consideration is that interviews revealed that, for participants, the legal foundation underpinning involuntary treatment, such as Article 763, was largely irrelevant to their lived experiences. Instead, they focused on the impact of the treatment itself, often describing feelings of disempowerment and a lack of control. Research by Henderson et al. (2004) similarly found that service users often experience the procedural aspects of involuntary treatment as disempowering, with little recourse to assert their preferences or challenge the legal basis of their detention. Likewise, Foureur and Galmiche (2019) found that patients placed greater emphasis on maintaining their integrity and the need for human interaction, rather than on the legalities surrounding their consent.

Under Article 763, judicial authorisation is required for involuntary treatment and must be sought from the court in the jurisdiction where the individual resides. This authorisation should be obtained prior to the initiation of treatment, except in urgent situations where treatment is deemed immediately necessary. In such cases, the court with jurisdiction over the location of the facility is responsible for ratifying the measure within 72 h of being informed, with the facility's responsible person having 24 h to notify the court. These requirements are intended to ensure that involuntary treatment is subject to timely judicial oversight, limiting the arbitrary deprivation of liberty.

The requirement that the individual be heard by the tribunal before the authorisation or ratification of the treatment provides a procedural mechanism intended to respect the patient's voice and preferences. However, despite these legal protections, participants in this study consistently reported that the process felt perfunctory and disempowering, with little genuine consideration given to their autonomy or rights. Antonio's experience, where his interaction with the judge during his involuntary treatment review lasted only a few minutes, exemplifies this issue: "*A judge came to the hospital, to an office on the psychiatric ward. He told me to explain my case. I think it was a formality, honestly, because I didn't feel like he listened to me... It was 5 minutes.*" Maria's experience echoes these sentiments. She accounts the interview with the judge after requesting a voluntary discharge: "*They sat in front of me, but it didn't matter what I said; they were never going to reverse the decision. The one speaking most of the time was the secretary, not the judge. When I asked them to identify themselves, they did, but it was clear my explanations didn't matter. I gave my reasons for wanting to go home, but they just listened without responding. Later, I was told it was still involuntary.*" Such testimonies reveal a more profound systemic failure, where legal safeguards on paper often fail to provide meaningful protection for patient rights in practice, reflecting a broader critique of how such proceedings often fail to meaningfully engage with the patient's perspective, reducing the process to a mere formality.

These structural and discriminatory flaws in the legal text are further compounded by issues in its practical application, particularly in the judicial oversight process. The State Attorney General's office report offers concerns about procedural adequacy and judicial oversight that were echoed during interviews with participants who underwent involuntary treatment under Article 763. Participants described significant power imbalances and a lack of objectivity, often exacerbated by the presence of psychiatrists in the room during judicial interviews, which compromised the perceived fairness of the process. This raises questions about the extent to which the judge is able to independently assess the individual's situation without undue influence from medical professionals.

The literature widely criticises the view that a psychiatric diagnosis means a person cannot decide for themselves, particularly when this is used to justify laws that suspend liberal values like equality and the freedom to choose one's own way of life (Gooding, 2017). This critique is further supported by O'Mahony's (2024) exploration of decision-making rights in psychiatry, which emphasises the need for a rights-based, person-centred approach to mental health care that challenges traditional paternalism.

As Kelly (2014) notes, while legal frameworks can guarantee basic rights, they are not necessarily the only or best mechanisms for fulfilling positive rights to and needs for healthcare. The disconnect between formal legal protections and lived reality reflects broader challenges in securing informed consent and safeguarding patient autonomy within Spain's mental health system. The legal and ethical foundation of informed consent in Spain, as discussed by Otero, Oishi, Martínez, Ballester, and Basterra (2022), is rooted in the principle of patient autonomy, which asserts the patient's right to self-determination in healthcare decisions. Obtaining informed consent involves providing the patient comprehensive information about their health condition, proposed treatments, potential risks and benefits, and alternative options. The information must be presented clearly and adapted to the patient's understanding, enabling them to make an informed and voluntary decision. However, as participants have reported, the lack of comprehensive information often leaves them feeling marginalised, and without adequate participation in their care decisions, autonomy becomes an empty concept. Laura from Andalucía poignantly illustrated this by saying, "*If they had explained to me why I was there, I would have accepted it. Nobody explained to me why I was there and what the process was. They never explain the process to the patient, they explain it to the family*." The lack of comprehensive information makes the notion of informed consent hollow and undermines the patient's ability to participate in their treatment meaningfully.

The Law on Patient Autonomy (Ley 41/2002) and the Mental Health Strategy 2022–2026 underscore the importance of informed consent and patient-centred care. However, the gap between these ideals and the lived experiences of service users, such as Marina from Catalonia, who, under an involuntary admission, accounts: "*I wasn't given much information. I never even knew when I'd be discharged until right before it happened. This has been typical for all my hospitalisations. [...] They don't tell you how long you'll be there. I had no idea I was going to stay that long.*" Similarly, Graciela from Castilla y León shares her experience with medication during a voluntary treatment: "*I really had a very big lack of information. They simply limited themselves to medicating... practically all of us were given more or less the same thing.*" These testimonies of being kept in the dark about their discharge dates and medication regimens highlight the systemic failures within the system. The discrepancy reflects a more profound issue: the erosion of patient autonomy despite formal legal protections.

Matthews (2000) provides a theoretical lens through which to examine this disconnect, distinguishing between a Kantian approach to autonomy, which prioritises rational decision-making, and a Millian perspective, which prioritises individual well-being and self-determination. The system leans towards a Kantian model in Spain, where autonomy is contingent upon rationality as judged by healthcare professionals or the courts.

The limited involvement of service users in judicial decisions concerning their treatment compounds this issue. While judicial authorisation for involuntary treatment ostensibly safeguards autonomy, it often reduces it to a procedural formality in practice. Patients' subjective experiences, wishes, and understanding of the process are frequently overlooked. This marginalisation undermines the principle of autonomy and raises concerns about the quality of judicial reviews.

Interviews with prosecutors and other stakeholders further reveal the systemic nature of these challenges. Prosecutors are tasked with monitoring procedural compliance, ensuring that involuntary treatment measures meet legal standards, and safeguarding individual rights. However, their role is often constrained by resource limitations and a focus on procedural deadlines rather than substantive oversight. One prosecutor described this dynamic, explaining, "*We tend to view psychiatric internment similarly to police detention—it's a deprivation of liberty*", continuing: "… *Instead of just focusing on deadlines, Article 763 needs to be revised to address the core issues: how internment is carried out, how patients are admitted and treated. We currently lack the authority to scrutinise the treatment itself*."

This narrow focus on timelines often overshadows broader considerations of patients' rights. Another prosecutor added, "*If we had a system that allowed us to give each case the attention it requires, I believe our oversight would be more adequate*," reflecting the impact of high caseloads and limited resources on their ability to safeguard patients effectively.

The issue of superficial judicial oversight was further compounded by the COVID-19 pandemic, during which judicial reviews increasingly occurred via videoconference. While this practice offered logistical convenience, participants raised concerns about the depersonalisation of the process. Only two participants in this study experienced videoconference reviews, but their accounts highlighted potential issues with the format. The remote nature of these interactions was perceived to exacerbate the power imbalance, limiting the judge's ability to fully assess the individual's situation, thus leading to uninformed decisions. The recently enacted Royal Decree-Law 6/2023, which promotes digitalisation and efficiency within the justice system, may further impact the judicial process for involuntary treatment cases. Although the Law does not directly address the substantive Law on involuntary treatment, its focus on electronic communication and videoconferencing in judicial proceedings raises concerns about further depersonalisation of the process. While the Decree-Law aims to improve efficiency, there is a risk that the increased reliance on remote hearings and the pressure to expedite cases may compromise the thoroughness of judicial reviews.

One prosecutor interviewed expressed significant concerns about the growing use of videoconferencing for judicial reviews, emphasising that in-person interactions are particularly critical for persons with mental health conditions, who may already be in a vulnerable and disoriented state. She argued that videoconferencing can worsen the power imbalance between the patient and the legal system, making it difficult for patients to understand the proceedings and fully exercise their rights. While she acknowledged that videoconferencing may be necessary in exceptional circumstances, she argued that it should not become the default option, emphasising the importance of human connection and ensuring that individuals subjected to involuntary treatment are treated with dignity and respect. The pursuit of efficiency must be carefully balanced with the need to protect the fundamental rights of individuals with mental health conditions, especially when decisions involve the deprivation of liberty.

Moreover, an over-reliance on psychiatric assessments during judicial reviews further undermines the autonomy of service users. As seen in the experiences of Antonio and Maria, this over-reliance results in patients feeling dismissed and disregarded during brief, perfunctory interactions with judges, reflecting systemic deference to medical assessments over patient voices. Interviews with stakeholders revealed that judges often relied heavily on these assessments, potentially overlooking the individual's perspective in favour of the medical professionals' judgment. As one psychiatrist noted, judges frequently "*absolutely ratify everything we say and put in the report*." This reliance on psychiatric assessments raises concerns about the objectivity of the judicial process, as judges may defer to medical professionals without fully engaging with the individual's rights and preferences. Another prosecutor acknowledged this dynamic, stating, "*Judges and prosecutors rely heavily on our forensic medical professionals. It's important to remember that internment is a therapeutic measure, and we, as legal professionals, are not doctors*." This over-reliance on medical authority undermines the objectivity of judicial processes, further marginalising the voices of service users.

In conclusion, while Spain's legal framework theoretically enshrines protections for patient autonomy and ensures judicial oversight of involuntary treatment, the lived experiences of service users reveal significant gaps between these legal ideals and their practical implementation. Judicial reviews are often superficial, relying too heavily on psychiatric assessments and failing to provide meaningful opportunities for patients to exercise their autonomy. The push for efficiency, particularly through videoconferencing and digitalisation, may exacerbate these issues, highlighting the need for reforms that place the dignity and autonomy of individuals at the centre of judicial processes in mental health care.

4.2. Autonomy, consent, and the challenges of coercion

The pervasive use of coercion in mental health care emerged as a critical concern among the participants' narratives, starkly highlighting the gap between the intent of the legal framework and the lived reality. This discrepancy is particularly evident in emergency situations, where individuals are subject to coercive practices from the moment they arrive at a facility. Antonio, for example, recalls his involuntary admission during an emergency: "*When they admitted me, they tied my hands, feet, and torso. I couldn't move at all, and they drugged me. They gave me a sedative so that I would be asleep for two days*." Eva's experience also highlights a humiliation and instrumentalisation of the body and person. Although she entered through an emergency transfer by the police, her treatment was voluntary, but she was repeatedly restrained. She accounts: "… *They tied me to the bed with five points, they left me all night in agony. I was screaming and nobody came all night, nobody entered the room. There was only a small window at the top; I pee myself at 26 years old*." As the systematic review by Gooding, McSherry, Roper, and Grey (2018) illustrates, coercion in mental health services, whether in emergency situations or ongoing treatment, is a global concern, deeply entrenched in psychiatric systems despite international calls for reform. This issue was already identified by Bartlett (2003), who critiqued the persistence of coercive interventions and the failure of legal frameworks to protect patient autonomy. Gooding, McSherry, Roper, and Grey (2018) further confirm that, despite various legal safeguards and policies, coercion remains a default practice, revealing significant gaps between the theoretical emphasis on autonomy and the lived experiences of patients.

In this sense, coercive practices in mental health care are not unique to Spain but reflect a broader global challenge, as the WHO noted in 2019. The WHO defines these practices as including seclusion, various forms of restraint (manual, physical, and chemical), and forced treatment. Expanding on this global perspective, Aragonés-Calleja and Sánchez-Martínez (2024) distinguish between formal and informal coercion in their review. Formal coercion refers to legally sanctioned practices such as involuntary admissions, mechanical restraints and forced medication, while informal coercion encompasses subtler forms of control, such as persuasion and stigmatisation. Both forms are deeply embedded in Spain's psychiatric system, with significant consequences for patient dignity. The MNP interview further reinforces this, pointing out that professionals' subjective application of mechanical restraints, often without clear and enforceable protocols, allows for a wide variation in how coercion is used across different regions and institutions. This lack of uniformity underscores the failure of national legal frameworks to curb the widespread use of coercion, despite their intent.

While intended as emergency measures, their persistent use of restraints and coercion raises significant ethical and human rights concerns, especially given their potential to infringe on individual dignity and autonomy. In 2013, the UN Special Rapporteur on Torture declared that "any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment" (Méndez, 2013). Similarly, Pūras (2017), former UN Special Rapporteur on the right to health, condemned the use of restraints and emphasised that the right to health, as interpreted through the lens of the CRPD, requires urgent action to significantly reduce medical coercion. In his report, he called for the abolition of all forms of forced psychiatric treatment and confinement. Echoing these positions, the WHO and the OHCHR (2023) have recently called for an end to all coercive practices, emphasising an immediate international obligation to eradicate them.

Despite these global human rights imperatives and guidelines, coercion remains embedded within Spain's mental health care system. *Instrucción núm. 1/2022*, issued by the State Attorney General's Office, was introduced to regulate mechanical and chemical restraints, mandating their use only as a last resort and for the shortest possible duration. However, the *Instrucción* applies exclusively to involuntary treatment, leaving voluntary patients without the same protections. This gap exposes a critical flaw: coercive practices like mechanical restraints, forced medication, and isolation remain prevalent even in voluntary treatment settings. This lack of legal protections for voluntary admissions further perpetuates the use of coercive measures in settings that should otherwise respect patient autonomy. Juana's voluntary admission in Extremadura, which still resulted in her being tied up, raises critical questions about the autonomy of patients and the thresholds for invoking coercive measures: "*I was admitted voluntarily, and I was tied up for the first 24-48 hours. The medication made me so dizzy that I had trouble getting up, the second day after being tied up for two days, they lifted me up to go take a shower, and I literally fell down…*" This testimony underscores that the boundary between voluntary and involuntary care is often blurred, with even voluntary patients subjected to coercive measures.

The failure of Instrucción núm. 1/2022 to provide safeguards for voluntary patients reveals a systemic issue in Spain's mental health system: coercion is not simply an emergency measure but is deeply ingrained in care practices. This instruction starkly contrasts with the realities of patients who, despite seeking help voluntarily, find themselves subjected to coercive interventions. Maria's experience of being mechanically restrained every night for four weeks following a self-harm attempt exemplifies the systemic reliance on mechanical restraints as a default intervention: "*Every night I was restrained at 5 points, I fell asleep tied up*". Ostensibly applied for her protection, this prolonged use paradoxically reveals a more profound neglect of her needs and autonomy. The use of restraints in this context raises important questions about the ability of Spain's mental health care system to provide compassionate, patient-centred care. Such reliance on coercive practices reflects a broader failure to adopt the empathetic, individualised approaches recommended by international guidelines, as noted by the WHO (2019) in its 'Strategies to end seclusion and restraint'.

Beyond mechanical restraints, the issue of isolation is equally concerning. The limitations of *Instrucción núm. 1/2022* in addressing isolation further exacerbates these issues. While the instruction focuses primarily on regulating mechanical and chemical restraints, its treatment of isolation is limited. The instruction briefly references isolation only in the context of the COVID-19 pandemic, as seen in the Ministry of Health Order SND/265/2020, which suggests that individuals with neurocognitive disorders in isolation zones should be allowed to move freely within those zones without resorting to mechanical or chemical restraints. However, no clear framework exists for regulating isolation practices in general mental health settings, leaving them largely unregulated by the Spanish Civil Procedure Law, which governs involuntary treatment. The MNP interview pointed out that isolation rooms often lack any form of oversight, with the only monitoring coming from internal staff. This lack of external accountability increases the risk of isolation being overused or misapplied.

Paloma's experience—where she was isolated after receiving sedatives—illustrates the potential for misapplication of these practices when legal boundaries are unclear. She recalled: "*I put up signs because they took away my crutches, and it was like, 'We can't take you anymore,' and they injected me... they gave me three shots... I think if someone had stopped to talk to me, it would have been different... they injected me and put me in isolation. There they tied me up, I think that's when they tied my head too... and I was there for several hours*." The absence of explicit guidelines on the use of isolation raises significant concerns about proportionality, necessity, and potential human rights violations, particularly when isolation is used in conjunction with mechanical and chemical restraints. The lack of a comprehensive regulatory framework for isolation practices in Spain increases the risk of their disproportionate and arbitrary use, with severe consequences for patient well-being.

Beyond the use of restraints and isolation, the narratives of participants also pointed to the misuse of coercion as a form of punishment. Alessandro, a participant from Navarra, recalled being mechanically restrained for 12 h, not for posing any harm, but as a disciplinary measure. He recalls, "*I sat on the floor in a patch of sunlight because I was cold. A staff member yelled at me, and when I responded angrily, they tied me to the bed for 12 hours. I wasn't hurting anyone; it was purely punishment.*" Such incidents, repeatedly reflected in participants' narratives, reveal a troubling trend where coercion is employed punitively rather than 'therapeutically', further degrading patient dignity.

Informal coercion is prevalent, and persuasive tactics used to secure seemingly 'voluntary' admissions raise questions about the authenticity of patient consent. The inherent power imbalances within mental health institutions further complicate this issue, potentially obscuring the boundary between genuine consent and subtle coercion, thereby impacting patient autonomy.

Both participants and practitioners, spanning legal and medical fields, acknowledged the pressure individuals face when considering voluntary treatment. For instance, one interviewed Prosecutor questioned the authenticity of voluntary admissions, citing external pressures like family influence or medical persuasion. This view was in part echoed by an interviewed psychiatrist who admitted to using verbal persuasive tactics to avoid the bureaucratic hurdles of involuntary admissions: "*I think that I have sometimes forced, let's say, convincing someone for a voluntary admission.*" Such practices blur the distinction between voluntary and coerced consent, undermining the individual's ability to make informed, autonomous decisions. As Brosnan and Flynn (2017) have argued, 'one of the most pervasive aspects of macro structures that indirectly impacts on free and informed consent are the power imbalances present between parties.' The Prosecutor further highlighted the lack of adequate oversight in the process, stating that "*we ought to have much more intensive external oversight*," reflecting a broader concern about the systemic gaps in monitoring and regulating these coercive practices.

The pervasive use of formal and informal coercion undermines autonomy and strikes at the heart of human dignity. Persuasion, often employed not to respect patient autonomy but to expedite admission processes, perpetuates a culture of clinical expediency that erodes trust in the system. When individuals are pressured into decisions, and coercive measures such as mechanical restraint are employed, their inherent dignity is compromised. There is a crucial need for systemic reform to ensure that genuinely voluntary admissions, grounded in informed consent, are clear. Within this context, the concept of dignity becomes essential, underscoring the need to protect users of psychiatry services, including persons with psychosocial disabilities, from degrading treatment and uphold their fundamental human rights.

Participants who demonstrated familiarity with the system expressed a profound lack of trust, striving to avoid re-entry against their will. For instance, Maria, a participant who preferred to remain anonymous, recounted, "*If I had known at that time everything that having had an autolytic attempt entailed... evidently (I) would have looked for another way, either to kill myself or… ask for help it penalises you for the rest of your life.*" This statement reflects the participant's belief that the mental health system's response to her suicide attempt was not only unhelpful but actively detrimental, leading to lifelong consequences. The repeated use of the word "penalises" in her interview underscores the sense of being punished or stigmatised by the system rather than receiving the support and understanding she needed.

Maria's experience and the deep mistrust shared by others reflect how coercive practices and clinical expediency can strip individuals of their sense of control, reinforcing feelings of punishment rather than support. The erosion of trust and feelings of punishment described by Maria and others align with Stephen Ekpenyong, Nyashanu, Ossey-Nweze, and Serrant's (2021) observation that dignity is often defined by patients in terms of their feelings. This erosion of trust is intrinsically linked to the violation of dignity, as patients are treated not as autonomous individuals deserving of respect but as objects to be managed. Dignity, a cornerstone of human rights, goes beyond mere autonomy—it is about recognising the inherent worth of every person, ensuring that their treatment is not degrading or dehumanising.

Within this context, the concept of dignity becomes central to understanding how coercive practices in psychiatric settings—including the use of restraints, isolation, and punitive measures—fundamentally violate the dignity of individuals. These practices not only deprive people of their autonomy but also undermine the very core of what it means to be treated as a human being.

Dignity is a foundational principle of international human rights law, as recognised in the Universal Declaration of Human Rights (1948) and reaffirmed in numerous international Human Right Treaties, including the CRPD. The CRPD's emphasis on dignity, particularly as a general principle in Article 3, aligns with the notion of non-humiliation and non-instrumentalisation, advocating for the treatment of individuals as autonomous agents rather than passive subjects of care.

In the context of mental health care, dignity is important for all individuals with mental disorders, not just those subjected to involuntary detention and treatment (Kelly, 2014). Dignity requires that individuals be treated not merely as means to an end but as ends in themselves, as Kantian ethics asserts. This principle of non-instrumentalisation is crucial in mental health settings, where individuals must be seen as capable of making informed decisions about their treatment. Non-humiliation, on the other hand, emphasises protecting individuals from degrading treatment or conditions.

However, in psychiatric care, the power imbalance between healthcare providers and patients often leads to practices that undermine these principles. Dehumanising treatments, such as forced restraints, enforced nudity, and the imposition of diapers, highlight how patients' dignity can be compromised. Such experiences exemplify what Kelly (2014) identifies as the significant challenge of balancing and integrating rights, dignity, and welfare-based concerns relating to individuals with mental disorders.

For instance, Aidee's from Canary Island account of being restrained and diapered twice, despite her protests, starkly illustrates the dehumanising aspects of mental health care practices: "*Two times I was put in diapers. It's very degrading... 'Put a bedpan for me...' 'No, we're not going to waste time with a bedpan, come on girl...' 'Yeah, we're going to waste time to put a bedpan for you.'*" Such practices not only deprive individuals of their autonomy but also violate their inherent dignity, treating them as objects rather than as persons deserving of respect.

Experiences of being forced to undress in front of staff and wear identical hospital pyjamas were frequently cited by participants as forms of humiliating treatment. Cristina from Madrid, for instance, recounts: "*The first thing they want is for you to undress, to see yourself naked from top to bottom, from head to toe in front of 6 people... I find it absolutely embarrassing.*" Such practices not only strip patients of their dignity but also contribute to a loss of individuality, as the enforced uniformity and exposure reduce them to a depersonalised state. While such accounts invite deeper philosophical reflection on the loss of dignity, this discussion lies beyond the scope of this manuscript. However, as Wilkerson (2020) aptly observes, 'individuality is the first thing the stigmatised person loses', underscoring the dehumanising impact of these type of practices.

This and other personal accounts that came up during interviews with participants, combined with international human rights frameworks and ethical principles, reveal a concerning disconnect between the ideal of dignity and the reality of mental health care in Spain. The systemic reliance on coercion—whether as a safety measure, a form of punishment, or a response to inadequate staffing—fundamentally undermines the dignity and autonomy of individuals in psychiatric institutions. In this context, the concept of dignity becomes crucial, as the very act of coercion, whether subtle or overt, strikes at the core of what it means to respect a person's inherent value and autonomy.

Stephen Ekpenyong, Nyashanu, Ossey-Nweze, and Serrant (2021) emphasise that the management and organization of hospitals significantly influence patient dignity, highlighting the profound impact of environmental factors within healthcare settings. Building upon their insights, the present study identified that structural changes beyond legal reforms—such as enhanced better staffing, a physical environment aimed at reducing coercion, and comprehensive training programs for professionals—are essential. These themes emerged during interviews with both participants and stakeholders.

Notably, the architectural design of mental health institutions was recognised as a particularly influential factor contributing to the prevalence of coercion. As one mental health nurse from Catalonia explained, *"facilities with isolation rooms and built-in restraints foster environments where coercive practices are more likely to occur"*. He advocates for open spaces and de-escalation areas, emphasising the role of the physical environment in reducing the need for restraints. Conversely, an interviewed psychiatrist from Madrid argues that secure areas in emergency departments are necessary to prevent patients from leaving before necessary treatment can be administered, pointing to the complexity of designing environments that balance safety and autonomy. Both perspectives agree, however, on the importance of patient accompaniment as a critical factor in reducing the use of restraints.

Staffing and training also play a crucial role in the perpetuation of coercion. Both the psychiatrist and specialist nurse interviewed highlighted that insufficient staffing often leads to increased use of restraints, as overburdened staff lack the resources to manage crises through non-coercive means. The psychiatrist specifically highlighted that "*there isn't enough trained staff to provide verbal containment*," leading to a reliance on physical restraints in situations. He explained that this problem is particularly pronounced during night shifts, where the lack of support often leads to unnecessary escalation. Marta's experience exemplifies how these systemic shortcomings directly impact patient care. Her repeated requests for communication and emotional support were ignored, which led to harmful behaviours and the use of restraints. She explained: "*They take everything from you upon admission. They also take away all our coping mechanisms... I've told them many times I need to talk, but they say I'm there to learn to self-regulate... Since there was no one to talk to, I harmed myself... and they restrained me, creating a much more violent situation. For that, they had time.*" Marta's experience illustrates what many participants in this study echoed: *'If someone had stopped and talked to me'*. The lack of communication and emotional support undermined their individual needs, leading to coercive measures. This reflects Stephen Ekpenyong, Nyashanu, Ossey-Nweze, and Serrant's (2021) findings on person-centred care, where dignity is closely linked to tailoring care to patients' needs. Marta's case shows how the failure to provide such care, particularly through communication and emotional support, contributes to coercive practices and strips away patients' sense of autonomy and dignity, perpetuating cycles of violence and restraint.

The narratives of participants reveal that coercion in mental health care is not an isolated issue, but a systemic problem shaped by the power dynamics of psychiatric institutions. These dynamics are often entrenched in paternalistic models of care that prioritise control over autonomy and self-determination. As another psychiatrist who was interviewed stated, "*There is nothing therapeutic about tying a person to a bed. It represents a failure of all other measures*."

In sum, the persistence of coercion in Spain's mental health system, whether formal or informal, highlights profound structural challenges that go beyond isolated incidents or legal gaps. The blurred lines between voluntary and involuntary care, the punitive use of restraints, and the lack of comprehensive safeguards expose the vulnerability of individuals seeking mental health treatment. As participants' testimonies illustrate, coercion not only undermines the principles of autonomy and consent but also erodes trust in the mental health system. Without significant reform aimed at ending coercive practices, in line with international human rights obligations, the dignity and autonomy of service users will continue to be compromised. The systemic reliance on coercion demands a transformative shift towards patient-centred, non-coercive care that fully respects human dignity as the cornerstone of ethical treatment in the mental health system.

5. Conclusion

This study highlights the structural and systemic inadequacies within Spain's mental health care system, particularly concerning the judicial oversight of involuntary treatment and the widespread use of coercive measures. The analysis underscores that the legal mechanisms, particularly Article 763 of the Civil Procedure Law and Law 41/2002 on Patient Autonomy, offer limited protection against coercive practices. Article 763, while requiring judicial authorisation for involuntary admissions, often functions as a procedural formality. The participants' testimonies illustrate how judicial hearings are largely perfunctory and fail to consider the individual's autonomy or voice genuinely. Instead of upholding rights, the judicial process reinforces an environment where coercive interventions are normalised, reflecting a systemic preference for procedural efficiency over the substantive protection of patient autonomy and rights.

Rather than empowered, judicial decisions frequently prioritise a paternalistic "best interest" model, overriding patients' autonomy, will, and preferences as outlined in the CRPD, particularly Article 12 on equal recognition before the law and in its General Comment No. 1. Stakeholders, including prosecutors, consistently acknowledged the dominant influence of medical professionals in shaping these decisions. Judicial oversight often defers to a "doctor knows best" approach, sidelining patient voices and reducing judicial procedures to formalities, especially in cases governed by Article 763 of the Civil Procedure Law. This dynamic perpetuates a significant power imbalance in mental health settings, where a person's autonomy is systematically undermined by institutional reliance on medical authority.

This power imbalance is further entrenched by the structural aspects of the mental health care system, including the institutional design, inadequate staffing, and insufficient training. As a result, coercion becomes a routine element of psychiatric interventions, often exacerbated by institutional limitations and a lack of resources for non-coercive alternatives. Participants' accounts illustrate how coercion is used as a default response in the absence of supportive structures.

Findings highlight that coercion permeates both involuntary and voluntary treatment settings, blurring the lines between voluntary consent and imposed treatment. While legal frameworks ostensibly emphasise participation, autonomy and informed consent, participants' narratives reveal how coercion, mainly through mechanical restraints and isolation, is pervasive in both types of admissions. Voluntary patients, who should retain full autonomy over their care, are often subject to the same coercive practices as involuntary patients without equivalent legal safeguards. This issue is exacerbated by the systemic use of persuasive tactics to secure 'voluntary' admissions, calling into question the legitimacy of consent in these contexts.

Moreover, *Instrucción núm. 1/2022*, introduced as a step towards regulating the use of mechanical an chemical restraints, needs to be revised to address the broader human rights challenges. Its focus on involuntary patients leaves those in voluntary treatment vulnerable to the same coercive practices without legal recourse. The instruction fails to comprehensively address isolation practices, which remain largely unregulated and prone to misuse, as evidenced by several participants' narratives. The absence of clear regulatory frameworks for both isolation and mechanical restraints continues to foster an environment where coercive interventions are applied disproportionately, further eroding trust in the system and undermining dignity.

In conclusion, this study highlights the critical need for comprehensive reform within Spain's mental health care system. Legal frameworks, including Article 763 and Law 41/2002, must be revised to ensure alignment with international human rights standards, particularly those articulated by the CRPD. Such reforms must extend beyond procedural modifications and confront the systemic reliance on coercive practices, fostering a shift towards genuinely person-centred care that prioritises autonomy, informed consent, and dignity. Additionally, policy measures—such as improving staffing levels, rethinking care environment designs, and enhancing professional training—are essential to support this transformation. Without these combined legal and policy actions, Spain risks perpetuating human rights violations under the name of care, failing to protect the very individuals the system is meant to support.

Funding Information

This research was funded by the Maria Zambrano Scholarship, cofunded by the EU Next Generation Fund and the University of Valladolid This publication is also part of the R&D&I project PID2022-140611NA-I00, funded by MICIU/AEI/10.13039/501100011033.

CRediT authorship contribution statement

María Laura Serra: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

The author declares no conflicts of interest related to this research.

References

Aragonés-Calleja, M., & Sánchez-Martínez, V. (2024). Evidence synthesis on coercion in mental health: An umbrella review. *International Journal of Mental Health Nursing, 33*, 259–280. https://doi.org/10.1111/inm.13248

Bartlett, P. (2003). Capacity and confinement: When is detention, not detention? In K. Diesfeld, & I. Freckelton (Eds.), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (pp. 339–358). Ashgate.

Bochner, A. P., & Riggs, N. A. (2014). Practicing narrative inquiry. In P. Leavy (Ed.), *The Oxford Handbook of Qualitative Research*. Oxford University Press.

Brosnan, L., & Flynn, E. (2017). Freedom to negotiate: A proposal extricating 'capacity' from 'consent.'. *International Journal of Law in Context, 13*(1), 58–76. https://doi.org/10.1017/S1744552316000471

Cabañas García, J. C. (2012). Internamiento involuntario urgente por razones de trastorno psíquico y tutela del derecho fundamental a la libertad personal. *Anuario de Derecho Civil, 4*, 1883–1910.

Committee on the Rights of Persons with Disabilities. (2019). *Concluding observations on the combined second and third periodic reports of Spain. CRPD/C/ESP/CO/2-3*.

Committee on the Rights of Persons with Disabilities. (2022). Guidelines on deinstitutionalization, including in emergencies. In *CRPD/C/5*. United Nations.

Degener, T. (2017). A new human rights model of disability. In V. Della Fina, R. Cera, & G. Palmisano (Eds.), *The United Nations Convention on the Rights of Persons with Disabilities: A Commentary*. New York: Springer International Publishing.

Fiscalía General del Estado. (2021). Memoria de la FGE 2021 (Ejercicio 2020). https://www.fiscal.es/memorias/memoria2021/FISCALIA_SITE/index.html.

Foureur, N., & Galmiche, P. (2019). Autonomy integrity: Another way to understand autonomy in psychiatry? *Clinical Ethics, 144*, 178–186. https://doi.org/10.1177/1477750919868788

Gooding, P. (2017). *A New Era for Mental Health Law and Policy: Supported Decision-Making and the UN Convention on the Rights of Persons with Disabilities*. Cambridge: Cambridge University Press.

Gooding, P., McSherry, B., Roper, C., & Grey, F. (2018). *Alternatives to Coercion in Mental Health Settings: A Literature Review*. Melbourne: Melbourne Social Equity Institute, University of Melbourne. ISBN 978 0 9942709 9 3.

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2004). Effect of joint crisis plans on use of compulsory treatment in psychiatry: Single blind randomised controlled trial. *BMJ (Clinical Research Ed.), 329*(7458), 136. https://doi.org/10.1136/bmj.38155.585046.63

Hoffman, S. J., Sritharan, L., & Tejpar, A. (2016). Is the UN Convention on the Rights of Persons with Disabilities impacting mental health laws and policies in high-income countries? A case study of implementation in Canada. *BMC International Health and Human Rights, 16*(1), 28. https://doi.org/10.1186/s12914-016-0103-1

Kelly, B. D. (2014). Dignity, human rights and the limits of mental health legislation. *Irish Journal of Psychological Medicine, 31*(2), 75–81. https://doi.org/10.1017/ipm.2014.22

Leavy, P. (2017). *Research Design: Quantitative, Qualitative, Mixed Methods, Arts-Based, and Community-Based Participatory Research Approaches*. The Guilford Press.

Mahdanian, A., Laporta, M., Drew Bold, N., Funk, M., & Puras, D. (2023). Human rights in mental healthcare; A review of current global situation. *International Review of Psychiatry, 35*(2), 150–162. https://doi.org/10.1080/09540261.2022.2027348

Martínez Navarro, J. A. (2023). Garantías constitucionales del internamiento involuntario por trastorno mental en el Tribunal Constitucional español y en el Tribunal Europeo de Derechos Humanos. *Boletín mexicano de derecho comparado, 56*(166), 137–170. https://doi.org/10.22201/iij.24484873e.2023.166.18909

Matthews, E. (2000). Autonomy and the psychiatric patient. *Journal of Applied Philosophy, 17*(1), 59–70. https://doi.org/10.1111/1468-5930.00140

Méndez, J. E. (2013). *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. A/HRC/22/53. United Nations Human Rights Council

O'Mahony, C. (2024). The reform of Irish mental health law: Aligning with human rights obligations? *International Journal of Law and Psychiatry, 95*, Article 102004. https://doi.org/10.1016/j.ijlp.2023.102004

Otero, M., Oishi, N., Martínez, F., Ballester, M. T., & Basterra, J. (2022). Informed consent in dentistry and medicine in Spain: Practical considerations and legality. *Medicina oral, patologia oral y cirugia bucal, 27*(3), e294–e300. https://doi.org/10.4317/medoral.25265

Perlin, M. L. (2012). *International Human Rights and Mental Disability Law: When the Silenced Are Heard*. Oxford University Press.

Prados García, C. (2023). El ingreso involuntario en el contexto de los derechos fundamentales de las personas con discapacidad. *Dykinson* (pp. 209–214).

Pūras, D. (2017). *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. A/HRC/35/21*. United Nations Human Rights Council.

Sheridan Rains, L., Zenina, T., Dias, M. C., Jones, R., Jeffreys, S., Branthonne-Foster, S., … Johnson, S. (2019). Variations in patterns of involuntary hospitalisation and in legal frameworks: An international comparative study. *The Lancet. Psychiatry, 6*(5), 403–417. https://doi.org/10.1016/S2215-0366(19)30090-2

Stephen Ekpenyong, M., Nyashanu, M., Ossey-Nweze, C., & Serrant, L. (2021). Exploring the perceptions of dignity among patients and nurses in hospital and community settings: An integrative review. *Journal of Research in Nursing: JRN, 26*(6), 517–537. https://doi.org/10.1177/1744987121997890

Wilkerson, I. (2020). *Caste: The Origins of Our Discontents. Large Print Edition*. Waterville, ME: Thorndike Press, a part of Gale, a Cengage Company.

World Health Organization. (2019). *Strategies to End Seclusion and Restraint. WHO QualityRights Specialized Training. Course Guide. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO*.

World Health Organization. (2022). *World Mental Health Report: Transforming Mental Health for All*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.

World Health Organization & Office of the United Nations High Commissioner for Human Rights. (2023). *Mental Health, Human Rights and Legislation: Guidance and Practice*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.