

Perspective Piece

Insight and involuntary care

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Abstract

Impaired insight is a regularly documented clinical observation in patients undergoing involuntary care, but is easily misunderstood since it refers to different phenomena depending on the context. Within the context of psychotic illness, which comprises the majority of involuntary care, it is more accurately portrayed as unawareness of illness which intersects with the element of capacity related to the ability to appreciate information and weigh it up to make a judgement. Psychotic disorders associated with persistent unawareness of illness are negatively associated with illness outcome and attitudes towards clinical services. There is some evidence that metacognitive therapy can improve insight, but compassionate care which seeks to enhance therapeutic alliance more commonly engages such patients in successful recovery. When insight is substantially impaired, the apparent will and the stated preferences of patients often diverge, in which case involuntary care should not be considered “against the will,” but more accurately “without the consent” of the patient.

Keywords: Insight; involuntary commitment; psychotic disorders

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Introduction

The term “insight” appears nowhere in legislation underpinning involuntary care in Ireland, the Mental Health Act (MHA) 2001 or (draft) Mental Health Bill (MHB) 2024. However, “lack of insight” is regularly cited as justification to support the presence of a mental disorder requiring involuntary care in medical recommendation forms, admission forms, consultant psychiatrist second opinion (section 17) forms, and mental health tribunal reports under MHA2001. It is also one of the (many) terms in psychiatric parlance which generates considerable misunderstanding, since its meaning varies depending on the disciplinary background of the user and the sociocultural context of its use.

The following are examples of different ways in which the concept of insight varies depending upon the context of its use: (i) Some critics of involuntary care processes argue that lack of insight is a subjective term used by psychiatrists within an asymmetric power dynamic in order to justify coercive treatment. In this framing the patient’s views about their illness and its management are not indicative of any pathological process at all, but rather are justifiable within the setting of their own personal narrative and sociocultural context (Diesfeld & Sjöström, 2007; Hamilton & Roper, 2006). Dismissing these views as pathological through the phrase “lack of insight” can then be seen as excluding the patient’s voice and their experienced reality, and propagating epistemic injustice within the mental health services and mental health legislation (Newton-Howes et al., 2023; Rose & Rose, 2023). (ii) Outside of a clinical setting, lack of insight may simply mean that somebody has insufficient self-awareness and does not appreciate

the underlying motivations or impacts of behaviours perceived as obvious by others. (iii) Within the context of psychodynamic psychotherapies, gaining insight into the manner in which subconscious conflicts and past experiences underpin current emotions and behaviours can be conceived as fundamental to therapeutic progress. (iv) Patients with alcohol dependence syndrome or emotionally unstable personality disorders may be described as “lacking insight” by clinicians. In this context, the phrase refers to the use by these patients of inappropriate psychological defence mechanisms like denial and projection when engaging in maladaptive behaviours such as substance misuse or self-harm. However involuntary care is actively proscribed by MHA2001 (section 8) for these conditions, acknowledging the historical social pressure to manage these disorders through detention, which is now recognised as therapeutically unhelpful and even harmful to recovery. (v) “Lack of insight” in the context of psychotic illness refers to unawareness by the patient that experiences which are not based in reality are driving their distress and dysfunctional behaviour. Indeed Amador (Amador, 2023) advocates here the use of the term “anosognosia,” rather than lack of insight, to better describe the unawareness of illness that characterises schizophrenia, given it’s evident neurobiological underpinnings and the similarity of this phenomenon to the unawareness of hemiplegia characteristic of patients with right parietal lobe stroke. Unawareness of illness in this context is not due to psychological denial, stubbornness, or a maladaptive coping mechanism, but rather can be considered a core biological phenomenon central to the pathophysiology of schizophrenia (Amador et al., 1991). It is this context of unawareness of illness in psychotic disorders that “lack of insight” is usually used to support the presence of mental disorder in accordance with MHA2001 and justify involuntary care. Here it is linked to criterion 3(1)(b)(i) of

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MHA2001 “..the judgement of the person concerned is so impaired..” that they can only receive treatment for their condition in an approved centre. Over 80% of the 2,500 patients each year who undergo involuntary care in Ireland have a diagnosis of psychotic illness (Bainbridge et al., 2018) and the vast majority of those who receive continued involuntary care long enough to be reviewed by a mental health review tribunal do so on the grounds of impaired judgement rather than risk (O’Mahony et al. 2025).

Insight and capacity

The phenomenon of unawareness of illness/lack of insight is closely linked with that of mental capacity when it comes to assessment for involuntary care. This is implied by the “impaired judgement” phrase in MHA2001, since a patient whose judgement is not impaired will usually appreciate the need for care and consent to voluntary admission and treatment when recommended. The focus on capacity is substantially inflated in (the current draft of) MHB2024, wherein substantial requirements are applied in relation to assessments of capacity to consent to treatment, with an extreme level of external legal oversight that would likely prevent timely care for such patients (Kelly, 2024). Capacity to consent is always related to a concrete situation such as inpatient admission or medical treatment. It can be defined in different ways, but is classically recognised to incorporate the abilities to 1) communicate choices, 2) understand and retain relevant information, 3) appreciate the situation and its consequences and 4) use and weigh up the information rationally to assess the risks and benefits of treatment options (Appelbaum & Grisso, 1988). Lack of insight and lack of capacity intersect in the third and fourth of these criteria, since the patient with psychotic illness undergoing involuntary care may be well able to understand and retain information, but unable to appreciate their situation or to use and weigh information given to them by a clinician about their diagnosis and symptoms, its effects of their behaviour and need for specific treatments. In acute situations patients with psychosis may also fail to fulfil the first and second capacity criteria, since the cognitive dysfunction associated with extreme distress or formal thought disorder can impair the ability to understand and retain information and even to communicate choices, but this is usually short term. Lack of insight has been demonstrated empirically to be a better clinical discriminator of incapacity than other clinical variables, including symptoms and cognitive dysfunction, for patients with psychotic disorders in an acute psychiatric setting (Owen et al., 2009). Furthermore improvement in insight after inpatient treatment is associated with regaining capacity for decision making in patients with psychotic illnesses, especially bipolar disorder (Owen et al., 2011).

Given the centrality of incapacity to justify involuntary care for mental illness, and the understandable criticism that having a whole piece of controversial legislation which can only be applied to people who suffer a psychosocial disability is discriminatory and at odds with the United Nations Convention on the Rights of Persons with Disabilities, some advocates have called for combining involuntary care legislation and incapacity legislation into one “fusion” legislation (Szmukler, 2020). Indeed such legislation is undergoing phased implementation in Northern Ireland (Lynch et al., 2017).

Although the presence of impaired insight is a pivotal factor in establishing lack of capacity, it represents only one element in determining that a mental disorder under MHA2001 is met. Also central to a recommendation of proceeding with or continuing

involuntary care is that it is likely “to benefit or alleviate the condition of that person to a material extent” (criterion 3(1)(b)(ii) of MHA2001). For many patients with episodic psychotic illness such as bipolar disorder, awareness of illness correlates with symptomatic improvement and patients realise on recovery that their psychotic beliefs and experiences were illness driven and not based in reality. Other patients with severe and enduring psychotic illnesses such as schizophrenia may recover from an episodic exacerbation and be discharged from an approved centre, without having experienced improvement in their level of insight. Empirical research demonstrates that insight levels in schizophrenia improve with treatment, but also display “trait” like features with poor insight persisting in many patients and correlating with poor premorbid functioning and less affective symptoms (Wiffen et al., 2010). It can be difficult for carers to understand why the decision is being made by a clinician to revoke involuntary care after symptomatic improvement when they perceive that their loved one is at high risk of discontinuation of treatment and relapse, due to persistent impaired insight and consequent likely non-adherence with treatment. However the patient is most likely no longer detainable because, despite ongoing impaired judgement, the criterion of further treatability in an inpatient setting is not met. Although persistent lack of insight is a risk factor for repeated relapse and “revolving door” admissions, clinicians generally seek to boost adherence to community care planning through alternative therapeutic strategies which seek to sidestep rather than confront impaired insight, such as providing wrap-around services where medication adherence is only one component of a therapeutic recovery plan. Indeed persuasion, kindness and increased therapeutic alliance, all elements of compassionate care, may help to improve adherence with treatment and thus a better outcome for many severely ill patients, without substantially changing their insight into the nature of their psychotic symptoms or capacity for autonomous decision making.

When absent insight persists after hospital discharge to such an extent that (i) capacity is continuously impaired, (ii) adherence with care planning is impossible due to nonengagement despite optimising therapeutic supports, and (iii) the patient is still able to cognitively absorb the link between non-adherence with treatment and an undesirable return to inpatient care, then there is arguably a role for community treatment orders to ensure community care is provided on a sustained basis. Such orders are available in multiple jurisdictions, but not in Ireland which is a source of debate (McDonald et al., 2017). However in their absence prolonged periods of approved leave under MHA2001 can help some patients with absent insight to achieve clinical stability (Bainbridge et al., 2014).

Insight and outcome

Insight in psychotic illness is not a binary construct, but is rather best conceptualised as incorporating different dimensions, including acknowledging the presence of a mental health condition, ability to relabel unusual experiences such as delusions and hallucinations as manifestations of illness, and acknowledging the need for treatment (David, 1990). When measured using validated quantitative scales, higher levels of insight are generally associated with better outcomes including reduced psychotic symptom severity, less use of coercion and better psychosocial functioning (David et al., 2020). Insight is only weakly associated with cognitive ability, in that intact neurocognitive function is likely a precondition for insight, but much more strongly linked to

meta-cognitive ability, ie. the ability to think of one's own and other's thinking (Gan et al., 2022). A meta-analysis of randomised controlled trials has demonstrated that metacognitive training, a form of group therapy which focuses upon correcting cognitive errors and problem solving biases, can improve insight in psychosis (Lopez-Morinigo et al., 2020).

Impaired insight also negatively impacts the patient experience of the involuntary care process. In a longitudinal observational study conducted with patients admitted involuntarily to Irish psychiatric units, which incorporated multiple clinical assessments including severity of symptoms and the experience of restrictive practices, awareness of illness was the strongest predictor of higher satisfaction with the clinical services (Bainbridge et al., 2018). Furthermore improvement in awareness of illness over time, between admission and follow-up three months post revocation of involuntary admission, was the best predictor of improved satisfaction with clinical services (Bainbridge et al., 2018). A subsequent mixed methods study stratifying patients by their levels of insight after revocation of involuntary care found that those with higher levels of awareness of illness were more likely to consider their involuntary admission, the nature of care received, and receiving a diagnosis, as beneficial (Smyth et al., 2022).

Insight and autonomy

The ethical principles of autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2009) are central to clinical practice and in most cases can be fully adhered to. Underpinning autonomy is the concept of informed consent and shared decision making, where the clinician outlines the risks and benefits of evidence based interventions and helps the patient to make a decision based on their own free will, and having weighed up the likely beneficial and adverse consequences of receiving or not receiving a treatment. Whilst this standard can reasonably be achieved in practice with sufficient time resources, it often breaks down when a patient lacks insight due to a psychotic illness. The reason involuntary care exists at all is because the application of these principles comes directly into conflict, in which case which principle should take precedence – autonomy or beneficence? In practice it depends on how beneficial the treatment and how undermined the autonomy, and clinicians balance these on a daily basis when making decisions about involuntary care. At a more fundamental level however, a reasonable question is to what extent a patient with absent insight can be considered to be engaging in autonomous decision making about psychiatric admission and medical treatment if they are unable to appreciate information about their mental illness and its treatment? Arguably the phrase of being admitted “against their will” becomes meaningless in such a situation, since their will may be unclear or must be inferred from past beliefs or from what a reasonable person might wish in terms of safety and alleviation of distress. In this regard a distinction between “will” and “preferences”, usually bundled inseparably in guidelines and legislation, can be helpful to consider, as outlined by Szmuckler (2019). Preference is taken to mean a greater liking for one alternative over another, however will is a manifestation of a person's deeply held and stable personal beliefs, values and commitments. Will and preference can diverge in relation to involuntary care. A treating clinical team may often form an opinion that a particular therapeutic action, such as continued inpatient admission or the administration of antipsychotic medication, is actually in keeping with that person's will in the sense that it will help them achieve a sustained and previously

expressed goal, but is not in keeping with a currently stated preference.

A clinical case scenario can demonstrate this point. Consider John who was involuntarily admitted to a psychiatric inpatient unit with a severe episode of psychotic mania at age 19, and recovered after treatment with olanzapine, lithium and psychosocial support. He was established on lithium prophylaxis and experienced a lengthy period of clinical stability, although expressed ambivalence about taking this medication in the longer term since he stated that it made him feel emotionally dulled. Since his teenage years he had expressed a desire to be a doctor. He gained entry to medical school and completed the first three years of the course uneventfully. At the age of 23, John stopped taking lithium and had a period of time medication free. After three months off lithium and in the run up to a stressful exam period, John began missing sleep and experiencing symptoms of manic relapse with racing thoughts, grandiosity and overspending. He decided to drop out of his course, telling relatives that his musical talent was under-appreciated and he will achieve fame and wealth as a musician rather than continue his medical studies. John's parents intervened to gain psychiatric support and he was admitted involuntarily, where he received close nursing supervision, antipsychotic medication and reinstitution of lithium, a care plan to which he vociferously objected at the time. After 4 weeks of inpatient treatment John had recovered from the manic episode, continued willingly on lithium prophylaxis and successfully passed his third year medical exams at the repeat autumn sitting. John had no insight into his illness at the time of his involuntary admission and was unable to weigh up the risks and benefits of treatment. In this scenario it is inaccurate to describe the involuntary care and medical treatment as being “against his will.” Rather the intervention can be conceptualised as against his stated preference at the time, but consistent with his manifest will as expressed in a sustained pattern of decisions and behaviours over time. When absent insight undermines autonomous decision making in this way, a more accurate description of involuntary care is “without informed consent”.

Establishing sustained will over time in relation to an intervention can be challenging for clinicians, but at a minimum should be assessed when the patient in question is at their baseline in relation to their psychotic illness rather than in the midst of an exacerbation. Assessment of sustained will should be repeated over time to confirm that it is consistent, and conducted after adequate psychoeducation to ensure that the patient and any carers are appraised of the likely risks and benefits of the intervention. There is wide heterogeneity in illness course after the onset of psychosis. Some patients experience relapses and achieve recovery even though persistently refusing antipsychotic medication for prophylaxis, and rationally justify this refusal because negative previous experiences with medication outweigh potential treatment benefits (Lincoln et al., 2016). Other patients continue to experience repeated involuntary admissions with psychotic relapses that are directly triggered by non-adherence and stabilise with the reintroduction of antipsychotic medication, and nevertheless persistently refuse prophylactic treatment after each involuntary admission has been revoked. This persistent refusal is often despite full recovery from the episode of psychosis, overwhelming evidence for the benefit of medication and exhortation by clinicians and carers, but can still be interpreted as in keeping with the patient's sustained will. In such cases (and where active psychotic symptoms or residual negative symptoms of schizophrenia cannot be invoked to explain “unawareness of

illness” after recovery from an episode, for example with bipolar disorder), the “lack of insight” can be conceptualised as more akin to the psychological denial characteristic of patients with alcohol dependence or personality disorders referred to in the introduction. Involuntary care to prevent relapse has no place in the management of such patients, since the key issue here is that the patient has capacity to make decisions about continued treatment, however unwise this may appear to carers and clinicians. This clinical situation demonstrates how lack of insight demands precision in its definition and overlaps but is not synonymous with lack of capacity (Gurbai et al., 2020; National Institute for Health & Care Excellence, 2018; Allen, 2009). Rather the illness must be allowed to take its course, the patient experience the consequences of their decisions, exacerbations treated with episodic involuntary care should they occur, and clinicians and carers continue to provide psychoeducation and support in the hope that the patient may find sustained recovery in future.

A further area where more durable will is prioritised over short term preference is in the case of advance healthcare directives. Thus a patient with a recurrent psychotic illness may make an advance healthcare directive to crystallise their will in relation to how they would like a future episode of illness to be treated when insight and decision making capacity are impaired. Such is the case with a “Ulysses clause” (so named after Homer’s Odysseus, who required his crew to put wax in their own ears and bind him to the mast of his ship while they sailed past the isle of the Sirens, so that he could listen to the bewitching song but not run his ship aground), which could explicitly provide for clinicians to respect the autonomy of patients in following a treatment plan in accordance with their previously expressed will. Advance healthcare directives are provided for in the Assisted Decision-Making (Capacity) Act (ADMCA) (2015) in Ireland and apply to adults who have capacity to make such directives. However patients are presumed to have capacity and there is no requirement for a formal assessment of capacity or insight into illness and its treatment by a clinician before an advance healthcare directive is made. Thus it is possible for a patient with persistent unawareness of illness, who is unable to weigh up the risks and benefits of a particular intervention (for example the administration of antipsychotic medication in the context of a severe psychotic relapse) to make an advance healthcare directive in order to prevent such a treatment being implemented during involuntary admission, even if their clinicians may consider such treatment critical for recovery. The currently active MHA2001 in Ireland can override advance healthcare directives made in accordance with ADMCA 2015 in such a situation when the risk criterion is present, but this does not apply in the proposed new MHB2024 (Kelly, 2025). It may be possible for mental health service providers to seek a high court ruling to invalidate an advance healthcare directive if evidence could be ascertained that the patient lacked capacity to make such a directive at the time, in order to proceed with treatment. Such a scenario where absent insight outside of the period of involuntary care directly impacts upon treatment during the period is likely to pose difficult legal and clinical challenges if MHB2024 is implemented in its current form. It is unclear how stable over time the sustained will of patients with persistent psychotic illness might be in relation to treatment interventions and whether such expressed will might vary with recurrent illness exacerbation or the social consequences of untreated illness. Research incorporating longitudinal design to identify sources of variation in patient attitudes towards

interventions, especially those that might be subject to advance healthcare directives, is warranted to clarify this.

Conclusion

Like much of clinical psychiatry, assessment of insight is inherently value laden and lacks objectivity – as such it is open to criticism and challenge by other stakeholders in the involuntary care process. This is inevitable. Yet it remains an important tool in the assessment process and in particular when its use in justifying involuntary care is restricted to the core concept of unawareness of illness and through this the assessment of capacity to consent to admission and treatment. Precision and clarity around these terms in clinical notes and in communication with stakeholders, including other clinical staff, patients and their carers, may help reduce some of the misunderstanding around such terminology. Further qualitative research with service users, staff and other participants in the involuntary admission pathway in order to elucidate the interpretation of terms such as insight and capacity could help to clarify misperceptions between stakeholders. In the meantime use of more narrow terminology such as “unaware of illness” rather than the broader “lack of insight” may convey more accurately the focus of clinical assessment and highlight the link with lack of capacity in order to justify involuntary care.

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