



Family Responsibilities in Fulfilling the Rights of Family Members with Mental Health Disorders: *Maqāṣid al-Sharī'ah* Perspective

David Sarker*

Adelaide University, Adelaide, Australia, SA 5001

Email: davidwork77@gmail.com

Mohamed Ali Samaneh

Adelaide University, Adelaide, Australia, SA 5001

Email: ali.samaneh@adelaide.edu.au

Ibrahim Abdala

Adelaide University, Adelaide, Australia, SA 5001

Email: ibrahim.abdala@adelaide.edu.au

Salih Rasool

The Australian National University, Canberra, Australia, ACT 2601

Email: rasool@gmail.com

Article	Submitted	Revised	Accepted	Available Online
History	2026-05-30	2026-09-01	2026-09-15	2026-09-27

Abstract

Mental health issues within the family raise questions under Islamic law when the obligation to provide protection conflicts with the individual family member's autonomy, dignity, privacy, and human rights. Mental health studies have predominantly focused on medical, psychological, and policy aspects. In contrast, the construction of family responsibility through the lens of *maqāṣid al-sharī'ah* (the objectives of Islamic law) has not been adequately formulated—particularly regarding protection standards and the limits of family intervention. This research aims to construct a framework for family responsibility toward members with mental health disorders, identify the rights that must be fulfilled, and define the limits of family authority based on *maqāṣid al-sharī'ah*. Using a normative legal research method, this study draws on conceptual, *maqāṣid al-sharī'ah*, and statutory approaches through a literature review of primary and secondary legal materials, *fiqh* literature, *maqāṣid* scholarship, mental health regulations, and relevant academic studies. A normative-qualitative analysis identified norms of responsibility and rights, linked them to *ḥifẓ al-nafs* (preservation of life) and *ḥifẓ al-'aql* (preservation of intellect), and assessed the proportionality of family intervention based on public interest (*maṣlaḥah*), justice, dignity, and autonomy. The findings establish three key standards: families must ensure basic needs, access to care, social support, and protection against discrimination; preserving life and intellect requires supportive, recovery-oriented action; and the member's capacity constrains family authority, will, privacy, and best interests. Intervention is justified only when necessary to prevent serious harm while respecting individual rights. These findings affirm *maqāṣid al-sharī'ah* as the normative foundation for a model of family responsibility that is protective, proportionate, and rights-oriented.

Keywords: *Maqāṣid al-Sharī'ah*; Mental Health; Family Responsibilities; *ḥifẓ al-Nafs*; *ḥifẓ al-ʿAql*

Abstrak

Gangguan kesehatan mental dalam keluarga menimbulkan persoalan hukum Islam ketika kewajiban perlindungan berhadapan dengan otonomi, martabat, privasi, dan hak asasi manusia individu anggota keluarga. Kajian kesehatan mental selama ini lebih dominan berorientasi pada aspek medis, psikologis, dan kebijakan, sementara konstruksi tanggung jawab keluarga melalui *maqāṣid al-syarī'ah* (tujuan hukum Islam) belum dirumuskan secara memadai, khususnya terkait standar perlindungan dan batas intervensi keluarga. Penelitian ini bertujuan untuk mengonstruksi tanggung jawab keluarga terhadap anggota keluarga yang mengalami gangguan kesehatan mental, menentukan hak yang wajib dipenuhi, serta merumuskan batas kewenangan keluarga berdasarkan *maqāṣid al-syarī'ah*. Penelitian hukum normatif ini menggunakan pendekatan konseptual, *maqāṣid al-syarī'ah*, dan peraturan perundang-undangan melalui studi kepustakaan terhadap bahan hukum primer dan sekunder, literatur fikih, karya *maqāṣid*, regulasi kesehatan mental, serta kajian akademik yang relevan. Analisis normatif-kualitatif dilakukan dengan mengidentifikasi norma tanggung jawab dan hak, menghubungkannya dengan *ḥifẓ al-nafs* (perlindungan jiwa) dan *ḥifẓ al-ʿaql* (perlindungan akal), lalu menguji proporsionalitas intervensi keluarga berdasarkan kemaslahatan, keadilan, martabat, dan otonomi. Hasil penelitian menunjukkan tiga standar utama: keluarga berkewajiban menjamin kebutuhan dasar, akses perawatan, dukungan sosial, dan perlindungan dari diskriminasi; perlindungan jiwa dan akal menuntut tindakan suportif yang berorientasi pada pemulihan; kewenangan keluarga dibatasi oleh kapasitas, kehendak, privasi, dan kepentingan terbaik anggota. Intervensi hanya dapat dibenarkan secara proporsional ketika diperlukan untuk mencegah kerugian serius dan tetap menghormati hak individual. Temuan ini menegaskan *maqāṣid al-syarī'ah* sebagai dasar normatif bagi model tanggung jawab keluarga yang protektif, proporsional, dan berorientasi pada pemenuhan hak.

Kata Kunci: *Maqāṣid al-Syarī'ah*; Kesehatan Mental; Tanggung Jawab Keluarga; *ḥifẓ al-Nafs*; *ḥifẓ al-ʿAql*

Introduction

Mental health disorders are multidimensional issues affecting health, personal capacity, family relationships, legal protection, dignity, and an individual's ability to function socially (McDaid et al., 2024). Addressing these issues requires a conceptual distinction between mental health conditions, decision-making capacity, and support needs, as the severity of a disorder does not always correlate directly with a loss of personal autonomy. Families play a crucial role as the primary support system, providing care, emotional support, meeting basic needs, access to healthcare, and protection when a family member experiences psychological vulnerability (Jing An et al., 2024). However, this role also raises legal issues when the duty of care intersects with rights to autonomy, privacy, liberty, bodily integrity, access to services, and respect for dignity. Consequently, family responsibility must be distinguished from family authority.

A duty of protection does not automatically legitimize controlling mobility, dictating all medical decisions, isolating the individual, or usurping personal capacity. An Islamic legal perspective requires a framework that defines the

relationships among family obligations, the rights of family members, legal capacity, guardianship authority, the prevention of harm, and the promotion of public interest (*maṣlaḥah*). The framework of *maqāṣid al-sharī'ah* (the objectives of Islamic law) is relevant for examining these normative relationships; scholars such as al-Ghazālī (1993) and al-Shāṭibī (1997) identified the preservation of life and intellect as essential objectives of sharia, while Ibn 'Āshūr (1998) expanded the scope of *maqāṣid* to encompass human welfare, liberty, and social order.

Global health data highlight the immense burden of mental disorders and the complexity of long-term support needs. The World Health Organization (2025) estimates that nearly one in eight people worldwide lives with a mental disorder, while conditions such as depression, anxiety, bipolar disorder, schizophrenia, and substance use disorders can differentially affect personal, social, economic, and family functioning. Human Rights Watch (2020) documented practices of shackling, confinement, neglect, and the restriction of freedom imposed on people with mental disorders in various regions. Kusumawaty and Yunike (2023) highlight the role of social stigma in perpetuating shackling practices, whereas Okwaraji et al. (2026) demonstrate the contribution of family support to the rehabilitation process. These findings reveal two facets of family dynamics: the family can support recovery, yet it can also become a setting where rights are restricted when protection is established through control. Normative issues arise when families—facing safety risks, treatment needs, or an inability to make decisions—resort to restrictions as a form of protection. Such situations require parameters that distinguish proportional interventions from actions that cause greater harm.

Literature concerning mental health, the family, the rights of persons with mental disorders, and *maqāṣid al-sharī'ah* indicates that developments in this field remain fragmented across sectors. Barber and Cook (2024) identify spiritual balance as a crucial element in mental health recovery; however, their orientation leans heavily toward the psycho-spiritual dimension and does not frame the family as a subject of legal obligation. Davidson (2025) emphasizes equality and non-discrimination for persons with mental disabilities from a human rights perspective. However, the focus on the individual-state relationship fails to clarify the family's relational obligations or the limits of a relative's authority. Haber et al. (2022) identify stigma as a significant factor in shackling practices, but their analysis lacks Islamic legal parameters to distinguish legitimate protection from restrictions on freedom. Santos et al. (2021) identified the influence of family support on rehabilitation. However, its psychosocial orientation has not elucidated the normative basis, the distribution of obligations, or the legitimacy of family actions.

Fakhrou et al. (2023) highlight the importance of family capacity as a support system for individuals with mental health disorders but have not yet elucidated the relationships among caregiving functions, autonomy, decision-making capacity, and legal accountability. Al-Shaab (2026) demonstrates the relevance of *maqāṣid* as a

framework for protecting vulnerable groups; however, the discussion remains general and has not examined the application of *maqāṣid* within family relationships. A gap in the literature exists because no framework simultaneously links family obligations, the rights of family members, decision-making capacity, the limits of intervention, and *maqāṣid* parameters. This study frames this gap as an issue of Islamic family law—rather than merely an expansion of the scope of *maqāṣid* studies—by examining how the principles of *ḥifẓ al-naḥs* (preservation of life), *ḥifẓ al-ʿaql* (preservation of intellect), respect for dignity, prevention of harm, and the attainment of public interest (*maṣlaḥah*) can be translated into normative parameters for family actions.

The research problem is formulated through four progressive questions: how is the normative construct of family responsibility toward members with mental health disorders defined; what rights constitute the object of family obligations, and how can their fulfillment be articulated through *maqāṣid al-sharīʿah*; how do individual capacity, support needs, safety risks, and the principle of proportionality determine the limits of family authority; and how can *maqāṣid al-sharīʿah* be utilized to evaluate family protective actions when safety concerns conflict with the autonomy and rights of family members? This study aims to construct a framework of family responsibility, map the rights that must be fulfilled, formulate parameters for the legitimacy of family intervention, and develop a *maqāṣid*-based evaluation mechanism for protective practices. The study's initial argument stems from a normative proposition: family obligations arise from relationships of responsibility and the imperative to protect vulnerable individuals, while the legitimacy of their implementation is constrained by the prohibition of harm, respect for personal capacity, proportionality, and an orientation toward the common good. Consequently, this research is expected to serve as a reference for developing family policies, family-based mental health services, and support practices that prioritize safety and dignity as goals to be realized concurrently.

Method

This study is a normative-doctrinal legal inquiry that employs statutory, conceptual, *maqāṣid al-sharīʿah*, and rights-based approaches, integrated through a *maqāṣid*-rights analytical framework to define the boundaries and parameters of family responsibility for fulfilling the rights of family members with mental health conditions. Data sources comprise primary legal materials—specifically relevant legislation and human rights instruments—and Islamic normative sources, including the Qur'an, Hadith, *uṣūl al-fiqh* (principles of Islamic jurisprudence) works, and classical-to-contemporary *maqāṣid* literature; secondary materials include academic journal articles, scholarly books, and institutional documents concerning mental health, the rights of persons with psychosocial disabilities, autonomy, non-discrimination, and family support. Sources were selected based on substantive relevance, academic authority, currency, and document traceability. Data collection

involved a structured doctrinal study that traced, screened, verified, and classified sources into categories of rights, family obligations, *maqāṣid* principles, and rights-based approach principles. The analysis proceeded through norm identification, the mapping of rights-holders and duty-bearers, the categorization of obligations, the mapping of obligations against *maqāṣid*, and the examination of autonomy, dignity, non-discrimination, proportionality, and public interest (*maṣlaḥah*), culminating in a prescriptive synthesis to formulate criteria for family responsibility and the respective limits of obligations for the family, the individual, and the state.

Results and Discussion

Family Responsibility as the First Locus of Protection in the Perspective of *Maqāṣid al-Sharī'ah*

The Qur'an establishes the family as a normative relationship with reciprocal responsibilities, not merely a biological bond. Qur'an [66]:6 mandates the protection of oneself and one's family from ruin, while Qur'an [2]:233 outlines maintenance obligations tailored to family ties, needs, and the capacity of the responsible party. A hadith narrated by al-Bukhārī (1993)—stating *kullukum rā'in wa kullukum mas'ul 'an ra'iyatihi* (each of you is a guardian and each of you will be held accountable for those under your care)—extends the principle of accountability through a mandate of care inherent in an individual's relational position. Islamic jurisprudence subsequently elaborates on family obligations in a differentiated manner through concepts such as *nafaqah* (the obligation to provide financial support), *ḥaḍānah* (child custody/care), and the maintenance of relatives (Sameem, Rahmani, & Hilal, 2025); consequently, the term “family” cannot be treated as a monolithic legal subject. This framework positions the family as the primary locus of relational responsibility, wherein legal relationships, the needs of vulnerable parties, and the capacity of the obligated party determine the nature and intensity of obligations.

Legal obligations (*wājib*) carry normative consequences distinct from *raḥmah* (compassion) as an ethical orientation and *ta'āwun* (mutual assistance) as a principle of solidarity. Al-Kāsānī (1986) demonstrates that obligations vary across different family relationships; husbands, parents, children, and relatives bear different bases and levels of obligation depending on their legal ties and individual circumstances. The principle of *ta'āwun* in Qur'an [5]:2 reinforces the orientation of solidarity, while *raḥmah* defines the ethical character of family relationships. Neither principle should be automatically posited as a source of *fiqh* obligations without further argumentation. A more appropriate structure of responsibility emerges from the intersection of sharia-mandated obligations, moral concern, and social solidarity, guiding families to respond proportionately to the vulnerabilities of their members.

Vulnerability stemming from mental health disorders reinforces the need to fulfill family responsibilities without equating a diagnosis with total incapacity. Mental health disorders encompass conditions that vary widely in severity, duration,

functional capacity, and support needs (Reed, 2024). The World Mental Health Report (2022) identifies family support as a crucial element for recovery and social functioning; however, research on family caregiving indicates that concentrating care responsibilities solely within the family can lead to caregiving burdens, financial strain, emotional exhaustion, and role conflicts (Deng et al., 2026). Consequently, an Islamic perspective is best grounded in the principle of *ri'āyah* (care/nurturing) that remains responsive to actual needs.

The concept of *takāful* (mutual solidarity) expands responsibility from individual relationships to broader solidarity, allowing the burden of vulnerability to be shared proportionately. Adopting *takāful* as an analytical framework does not imply that all family members bear identical obligations, as Islamic jurisprudence recognizes differentiated duties based on kinship, financial means, needs, and legitimate authority (Gaffar & Al Mamari, 2024). The principle of solidarity links individual obligations to wider support networks when the family's caregiving capacity is limited. The *maqāṣid* framework reinforces this interpretation through *maṣlaḥah*, which evaluates the purpose of actions based on protecting human life and preventing harm (Azni et al., 2025). The family can be positioned as the primary locus of care because relational closeness facilitates a rapid and sustained response.

The construct of family responsibility must also be examined in light of changing social conditions that affect caregiving capacity. Factors such as labor mobility, household fragmentation, economic pressure, and diminished intergenerational closeness can reduce a family's ability to provide sustained support (Fingerman, Huo, & Birditt, 2020; Sarsenova, Sultanova, & Pervova, 2026; Schaller & Eck, 2025). Laranjeira (2025) highlights the family's dual role as both a source of support and a party susceptible to caregiver burden; thus, positioning the family as the primary locus of care should not be interpreted as shifting the entire burden of service provision onto the household. The principle of *maqāṣid* can be applied to assess the distribution of burdens based on needs and capabilities, ensuring that family solidarity does not devolve into an unrealistic obligation.

Family-related stigma illustrates the consequences that arise when relational responsibilities fail to translate into caregiving practices oriented toward wellbeing. Wall et al. (2024) show that stigma manifests through labeling, social rejection, shame, and restricted participation—conditions that can impede both help-seeking and recovery. An Islamic perspective goes beyond merely declaring stigma to be contrary to *rahmah*; it establishes normative relationships grounded in respect for human dignity, the prohibition against demeaning others, and the obligation to safeguard the wellbeing of those within a relationship of responsibility. The Qur'an [49:11] provides an ethical foundation prohibiting the disparagement and negative labeling of others. This perspective makes caregiving failures relevant to the construct of responsibility by distinguishing between limited capacity, negligence, and willful refusal.

Fulfilling the Rights of Family Members with Mental Health Disorders from the Perspective of *Maqāṣid al-Sharī'ah*

Mental health must be categorized distinctly from mental disorders, psychological distress, psychosocial disabilities, and legal incapacity. The WHO (2005) defines mental health as a state of wellbeing in which individuals realize their own abilities, cope with the normal stresses of life, work productively, and contribute to their communities. Mental disorders are conditions that can impair such functioning, whereas psychosocial disabilities relate to barriers arising from the interaction between mental conditions and the social environment (Gómez-Carrillo & Kirmayer, 2023). Furthermore, psychological distress does not necessarily meet the criteria for a clinical disorder (Kramer, 2026). A mental health diagnosis does not, in itself, negate an individual's legal capacity (Frierson & Joshi, 2024). These distinctions shape the application of *maqāṣid*: the object of protection is not a clinical label, but rather life, mental functioning, dignity, and the ability to participate according to individual needs.

The concept of the right to a dignified life stems from *ḥifẓ al-nafs* through the normative link between protecting life and preventing harm to human beings. The Qur'an [17]:70 affirms human dignity, while the Qur'an [49]:11 prohibits acts that demean or stigmatize others. Together, these foundations establish a normative premise against treatment that undermines dignity. This premise can be engaged through contemporary rights-based approaches that position dignity and non-discrimination as the basis for protection. The CRPD (2006) affirms equality, dignity, participation, and inclusion as core principles, while the WHO (2023) defines mental health as a right encompassing access to quality services and a life free from stigma and discrimination. This convergence does not imply that the two frameworks are identical: human rights formulate claims as entitlements with correlative obligations (Jonker, 2023), whereas *maqāṣid* evaluates actions based on the objectives of sharia, weighing consequences in terms of *maṣlaḥah* and *mafsadah* (Ibrahim et al., 2019).

The right to health and medical treatment gains *maqāṣid* legitimacy through a process more specific than merely linking it to *ḥifẓ al-nafs*. Sharia embodies principles governing the pursuit of medical treatment and the prevention of harm, while *maqāṣid* theory provides a framework for evaluating an action's objectives and consequences. Their normative relationship can be formulated as follows: when a condition poses a risk to life or mental functioning, an intervention proven to reduce risk and enhance functionality becomes a means of realizing *maṣlaḥah*. The obligatory nature of such actions is not uniform, as it depends on the level of need, risk, effectiveness, accessibility, and the individual's specific circumstances. The WHO (2022) indicates that mental health services in many locations remain difficult to access or unaffordable, while community-based services continue to suffer from a lack of funding and capacity. Within this framework, the family serves as a channel

for facilitating access, while *maqāṣid* legitimacy rests on the action's capacity to mitigate mafsadah and restore functioning.

The right to physical and psychological safety constitutes the next dimension, as violence, humiliation, threats, and exclusion can damage both life and mental functioning. Scriptural prohibitions against harming human beings and principles regarding the elimination of harm (*ḍarar*) provide the normative basis. At the same time, mental health research is required to demonstrate the forms of harm resulting from specific actions. Empirical and normative relationships must not be conflated: clinical evidence elucidates the consequences of an action, whereas *maqāṣid* determines the relevance of those consequences as *mafsadah* that must be prevented. The WHO (2023) notes that individuals with mental health conditions continue to face stigma, discrimination, and various human rights violations in both social life and mental health service settings. Therefore, *ḥifẓ al-naḥs* cannot be adequately measured solely by the absence of death or physical injury; psychological safety becomes relevant when stress, violence, or humiliation inflict tangible harm on human wellbeing and functioning. *Ḥifẓ al-'aql* extends the assessment to include the consequences for mental stability and the capacity to function.

Recovery needs to be positioned as a substantive dimension of *ḥifẓ al-'aql*, since protecting the intellect is inadequate if understood solely as preventing impairment. Jasser Auda (2010) shifted the orientation of *maqāṣid* from a paradigm of protection and preservation toward one of development and human rights, positioning human development as a primary expression of maṣlaḥah in the modern era. This systems-based framework allows recovery to be understood as a process of developing capabilities and achieving meaningful life goals aligned with an individual's needs, choices, and capacities. This perspective aligns with the WHO (2021) stance, which advocates for transforming mental health services into a model that is community-based, recovery-oriented, person-centered, and grounded in human rights—emphasizing respect for dignity, autonomy, participation, and social inclusion. Consequently, rehabilitation success should be measured by an individual's increased ability to perform personal and social functions, cultivate relationships, access education and employment suited to their circumstances, and participate meaningfully in community life. This approach expands the conceptual scope of *ḥifẓ al-'aql*: protecting the intellect extends beyond mere preservation and harm prevention to encompass restoration, empowerment, and the development of human capacity to lead a dignified and meaningful life.

The right to recovery also necessitates a shift in how family support is understood—moving from a model of dependency to one that expands the individual's actual capabilities. Zhang et al. (2023) identify community living, housing choice, access to support, and participation as essential elements of inclusion; meanwhile, General Comment No. 5 (2017) highlights the risks of dependency, isolation, and segregation when support is directed solely toward living

arrangements determined by others. This perspective enriches the concept of *ḥifẓ al-nafs* by framing survival as an integral part of the quality of social life, while simultaneously enriching *ḥifẓ al-'aql* through the development of functional capabilities. Families can provide emotional support, facilitate access to services, assist with rehabilitation, and create an environment that enables participation; the *maqāṣid* value of such actions depends on their impact on the individual's capabilities rather than the extent of control exercised.

Stigma must be analyzed as a form of harm encompassing psychological, social, and normative dimensions. Labeling individuals as “insane,” “dangerous,” “shameful,” or “useless” can curtail access to assistance, limit participation, and reinforce exclusion. Torales et al. (2023) identify stigma and discrimination as significant barriers to the realization of rights and access to mental health services. The *maqāṣid* perspective evaluates this issue through two avenues: first, the harm inflicted on psychological wellbeing and quality of life implicates the principle of *ḥifẓ al-nafs*; second, impediments to recovery, social interaction, and mental functioning relate to *ḥifẓ al-'aql*. While the Qur'an [49:11] establishes an ethical basis for rejecting disparagement, classifying a specific practice as a normative violation still requires an assessment of its intensity, impact, pattern of conduct, and the possibility of rectification.

Limits of Family Authority in Protecting Members with Mental Health Disorders

Family authority cannot be equated with responsibility, care, assistance, or protection. Responsibility refers to the obligation to provide support (Jamarudin et al., 2023); mentoring to maintain individuals as decision-makers (Taylor, 2019); guardianship provides representative authority in certain legal spaces (Moqadam, 2025); protection limits actions only when there are interests that must be protected (Murdiana et al., 2026). The concept of *wilāyah* (guardianship) in *fiqh* is also not singular, so *wilāyat al-nafs* (guardianship over the soul), *wilāyat al-māl* (guardianship over property), *ḥaḍānah* (child care), and the form of legal representation must have their object and basis of authority determined. Ahmed's (2025) study on *ahliyyah* (legal competence) and *ḥajr* (limitation of authority to act) shows that normative devices limit a person's actions under certain conditions, rather than automatically granting family authority. Therefore, the following analysis places authority as a limited mandate that must be proven on real grounds, with its objectives, scope, and time limits.

The *ahliyyah* framework provides a basis for rejecting the notion that a diagnosis of a mental health disorder is in itself evidence of loss of legal capacity, because jurisprudence distinguishes between *ahliyyat al-wujūb*, namely a person's ability to be a holder of rights and obligations, and *ahliyyat al-adā'*, namely the ability to carry out or produce legal consequences through action (Mian, 2012). Al-Zuhaylī (1985) also shows that *junūn* conditions can be permanent or episodic. Hurbi et al.

(2026) strengthen this approach by emphasizing that the concept of *ahliyyah* should be used more contextually so that recognizing certain limitations does not lead to the complete elimination of a person's rights. In the modern legal framework, legal capacity and decision-making capacity also need to be distinguished: legal capacity refers to a person's recognition as a legal subject and his ability to carry out actions that have legal consequences (Habbig & Robeyns, 2022), while decision-making capacity relates to a person's functional ability to make certain decisions (Moutoussis et al., 2021). A clinical diagnosis, therefore, describes the health condition or disorder a person is experiencing but does not, by itself, determine whether they have the capacity to make a particular decision. This approach aligns with developments in disability law that emphasize the need for adequate support so a person can continue to exercise their legal capacity (Szmukler, 2019).

Capacity differences have direct consequences for decision-making patterns. Accompaniment should be the initial choice when the individual can still express their wishes, including through communication that requires adjustments. Supported decision-making maintains the individual's legal capacity and position as a decision-maker (Craigie et al., 2025), while substituted decision-making refers to a mechanism in which another party makes decisions on the individual's behalf based on an assessment of their best interests (Balasubramanian, Ye, & Xu, 2022). The UN Committee on the Rights of Persons with Disabilities, through Article 12, emphasizes that persons with disabilities have legal capacity on an equal basis with other people and have the right to obtain the support necessary to exercise that capacity (Nations, 2006). From a *maqāṣid* perspective, this approach can be read as a form of protection for humans, oriented toward respecting human dignity, free will, the ability to act, and the benefits the law aims to create. In this framework, the family's position is better understood as part of a support network that helps individuals exercise their legal capacities. In contrast, representation by others should not be treated as an automatic consequence of decision-making limitations.

Decision-making capacity is specific to the decision and time; thus, an individual cannot be deemed incapable of making all decisions simply because of difficulties in a single domain (Hawkins, 2024). Medical decisions, for instance, require providing relevant information, an understanding of options and their consequences, and the ability to meaningfully grant or withhold consent (Finnikin & Collins, 2022). Asset management requires the ability to understand financial information, weigh risks, and protect against exploitation or undue influence. In contrast, decisions about residence, employment, and daily life must respect the individual's preferences and values. In certain circumstances, legal action may require mechanisms such as guardianship, powers of attorney, or determinations by competent authorities under the prevailing legal framework. Families should not view difficulties in one area as evidence of incapacity across all areas, as capacity must be assessed based on the specific decision at the time it needs to be made.

Substitutive interventions can be justified only by meeting very strict normative thresholds. Families must demonstrate a legitimate basis of authority, a specific protective purpose, the risk of serious harm or foreseeable loss, the inadequacy of less restrictive support measures, and a proportional relationship between the restriction and the intended benefit. Actions must be limited to the relevant decisions, remain in effect only for the duration of the need, and be subject to review. Jabat et al. (2026) position free and informed consent as the foundation for intervention and advocate for the elimination of coercive practices such as detention, forced treatment, isolation, and restraint. This principle can be evaluated through the lens of *maqāṣid* by assessing the level of *mafsadah*, necessity, proportionality, and available alternatives. Restrictions that fail to meet these thresholds shift from protection to control. Any exception must be legally and ethically justifiable.

Guardianship and asset management require special attention because a guardian's authority is essentially a trust to protect the interests of the individual under their care. Al-Zuhaylī (1985) asserts that the principle of *maṣlaḥah* must guide a guardian's actions regarding a ward's assets; consequently, actions that result in pure loss—such as gifting or giving away assets as charity without any benefit to the owner—are not permissible. In the context of *ḥajr* (legal restriction of the right to act), limitations on legal capacity cannot be established solely based on the wishes of the family; in many instances, the imposition or lifting of *ḥajr* falls within the purview of a judge and involves legal considerations aimed at protecting a party who lacks the capacity or ability to manage their own affairs adequately. This principle of protection also applies to medical decision-making: while a person with legal capacity provides their own consent for treatment, in cases where capacity is insufficient, a guardian's consent must still be directed toward the individual's best interests and welfare, as well as the prevention of harm; if a guardian's decision is clearly detrimental, the authority to grant consent may be transferred to a subsequent guardian and, ultimately, to the competent authority. This understanding aligns with Resolution No. 213 (9/22) of the International Islamic Fiqh Academy (2015) regarding the rights of persons with disabilities, which affirms that sharia guarantees their right to a dignified life, respect, and full integration into society, as well as the right to protection and the fulfillment of their needs by both their family and the state.

Decision-making capacity cannot be dismissed simply because family members or healthcare professionals deem an individual's choice unwise; a decision considered objectively ill-advised must still be distinguished from an actual inability to make decisions. A different situation arises when an acute episode renders an individual unable to comprehend, retain, use, or weigh relevant information and communicate a decision—particularly when there is a serious, imminent risk. In such circumstances, deciding on the individual's behalf may be considered only after

practical measures to support independent decision-making have been exhausted. This framework places the limits of family authority along a spectrum: support is prioritized, assistance is expanded as needed, representation is used sparingly, and substituted decision-making is treated as an exception that requires justification and stricter oversight.

Maqāṣid al-Sharī'ah's Assessment of the Practice of Fulfilling Rights in Muslim Families

Assessing family practices requires a *maqāṣid*-based procedure that distinguishes between identifying actions, affected interests, benefits, harms, levels of need, and alternative options. Al-Ghazālī's (1993) framework on *maṣlaḥah* positions the protection of fundamental interests as the legal orientation—specifically religion, life, intellect, lineage, and property—while categorizing levels of welfare into primary needs (*ḍarūriyyāt*), complementary needs (*ḥājiyyāt*), and refinements (*taḥsīniyyāt*). Al-Shāṭibī (1997) expanded this discourse by linking *maqāṣid* to the objectives of sharia and emphasizing the importance of considering *ma'ālāt al-af'āl*—the consequences or outcomes resulting from an action—within the legal assessment process. Jasser Auda (2008) subsequently broadened the *maqāṣid* approach through a systems framework that emphasizes inter-element connectivity, multidimensionality, openness, system dynamics, and an orientation toward human development and the protection of rights. This distinction is crucial to ensure that *maqāṣid* is not merely used as a justificatory label after a family decision has already been made. An action is deemed beneficial if the protective benefit rests on a normative basis, is relevant to actual needs, offers a sufficient probability of benefit, and maintains a reasonable proportion relative to any resulting restrictions. Assessment of harm encompasses the severity of the harm, its likelihood of occurrence, duration, reversibility, and the parties who bear the consequences.

Safety risks elevate *ḥifẓ al-naḥs* to a priority *maqāṣid* when human survival and safety face serious threats, as protecting life is a fundamental objective within the *maqāṣid al-sharī'ah* framework (Muhsin et al., 2026). In the context of health, protecting life may entail providing care and preventing life-threatening dangers; however, implementation must still account for individual dignity, capacity, interests, and rights (Padela, 2024). Supervision of medication intake may be justified when there is a genuine safety risk and support for independent decision-making is inadequate; conversely, supervision that disregards an individual's capacity and will risks undermining privacy, agency, and trust in services and support systems.

Restrictions on mobility during crises should also be framed within the least restrictive intervention possible, adhering to clear objectives, proportionality, and ongoing monitoring and evaluation of the intervention's necessity. Practices such as shackling, intimidation, exclusion, and violence lose their ethical legitimacy when

they are no longer required to prevent serious harm or when rights- and dignity-respecting alternatives are available. The WHO (2023) explicitly categorizes coercive practices—including shackling, isolation, restraint, and non-consensual treatment—as contrary to a rights-based approach to mental health. *Ḥifẓ al-nafs* is therefore best understood as an obligation to protect life and health through effective, proportionate, and needs-based measures that minimize rights restrictions whenever less intrusive alternatives exist.

Upholding *ḥifẓ al-ʿaql* requires evaluating the quality of support, information, therapy, rehabilitation, and the scope for decision-making. Family refusal of professional therapy must be assessed contextually, taking various factors into account. Spiritual practices can serve as sources of coping, hope, meaning, and psychological support, provided they are applied with sensitivity to the individual's beliefs and serve a supportive function (Britt et al., 2025). Conversely, religious or spiritual practices that delay or refuse necessary care—thereby increasing serious risk—must be evaluated as potential mafsadah based on the consequences for the individual's safety and wellbeing (Keulen et al., 2024). When families withhold information, impose therapy, or make all decisions in the absence of legitimate grounds—such as limited capacity or serious risk—the protection of the intellect risks transforming into a restriction of the individual's agency. The principle of informed consent in health ethics underscores the importance of providing adequate information and understandable options, as well as respecting the patient's capacity to accept or refuse treatment (Harrington et al., 2026). Consequently, evaluating a given course of action requires balancing therapeutic benefits, the individual's actual capacity, their wishes and preferences, the level of risk, and available support alternatives, ensuring that the protection of *ḥifẓ al-ʿaql* remains oriented toward the public good.

The dimension of *ḥifẓ al-dīn* becomes relevant when religious practices shape the experiences of family members dealing with mental health issues. Guidance in worship, prayer, spiritual support, and the attribution of meaning to difficult experiences can serve as sources of coping and wellbeing, provided they are approached adaptively and align with the individual's beliefs and needs. Dolcos et al. (2021) demonstrate that positive forms of religious coping can correlate with wellbeing, whereas negative religious coping may be linked to psychological distress. In a Muslim context, religion can act as both a source of strength and a barrier to seeking professional help—particularly when mental disorders are interpreted as signs of weak faith, divine punishment, or issues to be resolved solely through religious practice (Mahmood & McAloney-Kocaman, 2026). Such belief-based stigma can hinder the recognition of mental disorders and the pursuit of psychological services; meanwhile, in many contexts, the family serves as both a source of support and a potential environment that reinforces stigma (Al Harbi, Farrand, & Laidlaw, 2023). The imposition of rituals that exacerbate anxiety,

intensify guilt, or impede access to professional help does not automatically gain legitimacy simply by employing religious language; religious experiences must also be evaluated based on their impact on human wellbeing and dignity (Xu, 2016). Religion can foster recovery when its practices reinforce a sense of purpose, social support, resilience in the face of stress, and the individual's connection to relevant sources of aid—including professional services when necessary (Yaqub et al., 2025).

The relevance of *ḥifẓ al-nasl* must be confined to matters directly concerning the continuity of family relationships, child-rearing, and the protection of future generations. Its application cannot simply be equated with family cohesion or inclusive communication without a robust *maqāṣid*-based argument. The value of *ḥifẓ al-nasl* becomes significant when mental health issues impact parenting capacity, the continuity of the marriage, intergenerational relationships, or family decisions that could potentially lead to a permanent severance of ties. Parents with mental disorders must still be assessed based on their actual capacity to perform parenting functions and the demonstrable level of risk involved. This principle aligns with the provision that parents with disabilities should receive appropriate support in fulfilling their parenting responsibilities and that a child should not be separated from their parents solely on the grounds of the parent's disability (Heyman et al., 2023). Separating a child from their parents may be justified if there is a serious risk to the child's best interests—determined through competent procedures—whereas severing family ties without evaluating parenting capacity or considering available support options risks harming the child, the parents, and the continuity of family relationships.

Economic management creates conflicts between protecting individual assets, funding care, the family's financial capacity, and the needs of other family members. Therefore, *ḥifẓ al-māl* cannot be measured merely by the amount spent on therapy. Assessments must consider whether resources are used equitably, whether vulnerable members' assets are protected, whether health needs are met, and whether economic decisions reduce or increase dependency. Low-income families may face a choice between funding mental health services and meeting the needs of children or other family members. The *maqāṣid* framework requires an assessment of the urgency of each need, the magnitude of the risk, financial capacity, and available funding alternatives. The use of a family member's assets—specifically the member with the mental disorder—for the benefit of the family must be distinguished from legitimate use for that individual's own needs. Asset exploitation, the concealment of financial information, or the diversion of assets without regard for the individual's interests can lead to harm. Economic protection must go hand in hand with distributive justice and the prevention of exploitation.

Conflicts between *maqāṣid* highlight a crucial analytical function. Strict supervision can enhance *ḥifẓ al-nafs* when suicide risk is high, yet simultaneously curtail freedom and participation. Restricting access to funds can protect *ḥifẓ al-māl*

from exploitation, but it can also diminish autonomy. Religious practices can strengthen *ḥifẓ al-dīn*, but ritual-related pressure may compromise *ḥifẓ al-ʿaql*. Resolving such conflicts requires assessing the level of need, the severity and probability of harm, the magnitude of benefits, the duration of the intervention, reversibility, the individual's capacity, and the availability of less restrictive measures. The hierarchy of *ḍarūriyyāt*, *ḥājīyyāt*, and *taḥsīniyyāt* helps weigh needs, while the principle of proportionality limits excessive measures. *Karāmah al-insān* (human dignity) and justice serve as normative boundaries, ensuring that protecting one maqṣad does not legitimize abrogating rights associated with another. Assessment outcomes must consider the distribution of benefits and burdens, rather than focusing solely on family objectives.

Conclusion

Fulfilling the rights of family members with mental health conditions positions the family as the primary party responsible for protection—providing companionship, care, and the fulfillment of basic needs, as well as decision-making support that upholds the individual's dignity. This familial responsibility derives its legitimacy from *maqāṣid al-sharīʿah*—specifically the preservation of life (*ḥifẓ al-naḥs*) and the preservation of the intellect (*ḥifẓ al-ʿaql*)—while simultaneously being constrained by the requirement to respect the individual's capacity, will, autonomy, and rights. An orientation toward the public good (*maṣlaḥah*) necessitates proportionate protection: family intervention is ethically sound when it prevents harm and preserves life and cognitive function without devolving into paternalistic control. This framework expands the study of Islamic family law by positioning family responsibility as a protective obligation grounded in rights and dignity. Practical implications include guidelines for capacity-based support, anti-stigma education for families and religious institutions, family engagement by healthcare services that does not undermine autonomy, and policy support for families. Limitations of this normative-conceptual study include that the diversity of family practices, member experiences, variations in capacity, and differing interpretations across legal schools (*madhāhib*) and nations have not yet been empirically tested. Future research should employ qualitative interviews, case studies, and cross-national legal comparisons among Muslim countries to examine the application of *maqāṣid*, the limits of family authority, and mechanisms for rights protection. Data triangulation can integrate perspectives from affected individuals, their families, healthcare professionals, and policymakers.

Acknowledgments

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Author Contribution Statement

DS contributed to the research conceptualization, methodology formulation, data analysis, manuscript drafting, and research coordination. MAS contributed to

data collection, data analysis, literature review, and the drafting of the results section. IA contributed to data collection and verification, interpretation of results, and critical review of the manuscript. SR contributed to the literature review, validation of data and findings, substantive editing, and final review of the manuscript.

Conflict of Interest

The authors declare that there are no financial, personal, professional, institutional, or other competing interests that could have influenced the research, analysis, interpretation, or publication of this manuscript. No external relationships or affiliations have affected the authors' objectivity or the integrity of the work. All authors have reviewed and approved the final version of the manuscript and agree to its submission and publication.

AI Usage Statement

The authors used artificial intelligence (AI) technology to a limited extent to enhance language quality, correct grammar, improve editorial clarity, and format the manuscript. AI was not used to generate, develop, or validate research results, findings, concepts, analyses, interpretations, ideas, or conclusions. All scientific content, arguments, data interpretations, and conclusions are the product of the author's own work and remain their responsibility.

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