

Mental health, human rights and legislation

Guidance and practice



World Health
Organization



UNITED NATIONS
HUMAN RIGHTS
OFFICE OF THE HIGH COMMISSIONER

Mental health, human rights and legislation

Guidance and practice



**World Health
Organization**



**UNITED NATIONS
HUMAN RIGHTS**
OFFICE OF THE HIGH COMMISSIONER

Mental health, human rights and legislation: guidance and practice

ISBN (WHO) 978-92-4-008073-7 (electronic version)

ISBN (WHO) 978-92-4-008074-4 (print version)

HR/PUB/23/3 (OHCHR)

© World Health Organization and United Nations, 2023

This publication is co-published by the World Health Organization and the United Nations (on behalf of the Office of the United Nations High Commissioner for Human Rights).

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that the World Health Organization (WHO) and/or the United Nations (OHCHR) endorses any specific organization, products or services. The use of the WHO or OHCHR logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO) or the United Nations (OHCHR). WHO and the United Nations (OHCHR) are not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition”.

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules>).

Suggested citation. Mental health, human rights and legislation: guidance and practice. Geneva: World Health Organization and the United Nations (represented by the Office of the United Nations High Commissioner for Human Rights); 2023. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase any WHO publication, see <https://www.who.int/publications/book-orders>. To submit requests for use and queries on rights and licensing, see <http://www.who.int/copyright>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO and/or the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO and the United Nations in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO and/or the United Nations to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO and/or the United Nations be liable for damages arising from its use.

Symbols of United Nations documents are composed of capital letters combined with figures. Mention of such a figure indicates a reference to a United Nations document.

This publication has been edited in accordance with WHO's editorial house style and naming conventions.

Contents

Foreword	vii
Acknowledgements	ix
Abbreviations and acronyms	xii
Glossary	xiii
Executive summary	xvi
Introduction	1
1. Background	1
2. Purpose and scope	2
3. Who is the Guidance for?	3
4. Why is the Guidance important?	4
5. How to use the Guidance	5
6. How was the Guidance developed?	6
7. A note on language	7
Chapter 1 Rethinking legislation on mental health	9
Introduction	9
1.1 Context and challenges in mental health	9
1.2 Mental health and the law	11
1.3 Mental health law and human rights	13
1.4 The international human rights framework	16
1.5 Applying the human rights framework to legislation on mental health	22
1.5.1 A cross-sectoral approach to mental health and well-being	23
1.5.2 Challenging stigma and discrimination	25
1.5.3 Access to quality, person-centred and rights-based mental health care and support	25
1.5.4 Transition to community-based mental health care and support	26
1.5.5 Respecting legal capacity and informed consent, and eliminating the use of coercion	27
1.5.6 Participation	27
1.5.7 Community inclusion	28
1.5.8 Accountability	28

Chapter 2 Legislative provisions for person-centred, recovery-oriented and rights-based mental health systems

31

Introduction	31
2.1 Ensuring equality and non-discrimination	32
2.1.1 Prohibition of all forms of discrimination	32
2.1.2 Provision of reasonable accommodation	35
2.1.3 Discrimination in health insurance	36
2.1.4 Challenging stigma and discrimination in communities	37
2.1.5 Equal recognition of rights within mental health services	39
2.2 Respecting personhood and legal capacity in mental health services	46
2.2.1 Respecting legal capacity in mental health services	46
2.2.2 Prohibiting substitute decision-making in mental health services	48
2.2.3 Making supported decision-making available for people using mental health services	48
2.2.4 Safeguarding will and preferences	51
2.2.5 Respecting children’s evolving capacities	54
2.3 Informed consent and eliminating coercive practices in mental health care	55
2.3.1 Promoting and protecting the right to free and informed consent	55
2.3.2 Advance planning	60
2.3.3 Crisis support	64
2.3.4 Prohibition of involuntary hospitalization and treatment	66
2.3.5 Eliminating seclusion and restraint	72
2.3.6 Care process redesign	74
2.3.7 Decriminalization of suicide	75
2.4 Access to quality mental health services	76
2.4.1 Parity between physical and mental health	76
2.4.2 Financing of mental health	78
2.4.3 Affordable and equitable access to mental health care	79
2.4.4 Gender-responsive mental health care	81
2.4.5 Age-appropriate mental health care	82
2.4.6 Culturally-appropriate mental health care	84
2.4.7 Anti-racist mental health care and support	86
2.4.8 Training for health care and social care providers	87
2.5 Implementing mental health services in the community	88
2.5.1 Integration of mental health in general health care settings	88
2.5.2 Developing person-centred and rights-based community mental health services	90
2.5.3 Integration of peer-led and peer-run services	92
2.5.4 Deinstitutionalization	93
2.5.5 Redistributing financial and human resources	94
2.5.6 Implementation within humanitarian contexts and emergencies	95

2.6	Ensuring full and effective participation in public decisions	97
2.6.1	Recognizing the right to actively participate in decision-making	97
2.6.2	Implementing accessible and fair consultations	98
2.7	Ensuring accountability	100
2.7.1	Information systems	100
2.7.2	Independent monitoring bodies	101
2.7.3	Implementing effective remedies and redress	103
2.7.4	Professional responsibility and liability	105
2.8	Cross-sectoral reform for holistic service provision	106
2.8.1	Promoting community inclusion	107
2.8.2	Access to justice	111
 Chapter 3 Developing, implementing and evaluating rights-based legislation on mental health		 121
<hr/>		
	Introduction	121
3.1	Stakeholder engagement and consensus-building	121
3.1.1	Actively involving all relevant stakeholders, including persons with lived experience	122
3.1.2	Building consensus and political will	123
3.2	A rights-based analysis of existing law and policy	123
3.2.1	Studying obligations under international conventions and standards	123
3.2.2	Identifying barriers to rights-based mental health care	125
3.2.3	Comprehensive review of national legislation	126
3.2.4	Reviewing legislation and good practices in other countries	126
3.3	Drafting legislation	127
3.3.1	The drafting process	127
3.3.2	The consultation process	128
3.4	The legislative process	130
3.4.1	Responsibility for adopting legislation	130
3.4.2	Debate of draft legislation and its adoption	131
3.4.3	Sanction, promulgation and publication of new legislation	131
3.4.4	Mobilizing debate and engaging public opinion	131
3.5	Implementation	132
3.5.1	Importance, role and composition of bodies responsible for implementation	132
3.5.2	Developing regulations and other guidance	133
3.5.3	Public education and awareness	133
3.5.4	Training of stakeholders in mental health and social care systems, other sectors and the community	134
3.5.5	Resource allocation	135

3.6 Evaluation	135
3.6.1 Importance of evaluation	136
3.6.2 Systemic and regular review of legislation	136
3.6.3 Evaluation criteria and strategies	137
<hr/>	
Checklist for assessing rights-based legislation on mental health	139
<hr/>	
References	165
<hr/>	

Foreword

In recent years, mental health has been increasingly recognized as a critical part of health, as reflected in the 2030 Agenda for Sustainable Development, which aims to achieve good health and well-being for all, underpinned by international human rights standards and a human rights-based model of disability. Laws and policies guaranteeing the right of access to quality mental health care and support, and the right of persons with mental health conditions and psychosocial disabilities to make their own decisions in all spheres of life, represent important advances. Many countries are working towards improving access to community mental health services, reducing stigma and discrimination around mental health issues and promoting the active participation of persons with lived experience in law reform processes and the design of policy responses. However, most countries are at the early stages of reform, and greater political will, investment and action are now needed to move mental health systems towards approaches that are rights based and person-centred.

The global impact of the COVID-19 pandemic on mental health, including loss of employment and financial insecurity, has been profound. People with existing mental health conditions and psychosocial disabilities experienced increased levels of social isolation and disruptions in support systems. The pandemic also highlighted inadequacies in mental health services and support in many countries.

At the same time, in many settings, the silence around the subject of mental health was broken, and the need to include mental health as part of universal health coverage has been raised as an important priority. In addition, there is an increasing number of examples of rights-based community mental health services, including peer support services, that can be scaled up and incorporated into mainstream health systems. More and more, the role of persons with lived experience of mental health conditions is being recognized as invaluable in providing peer support and guidance to others going through a similar experience. Within the health sector, countries are training health workers on rights-based approaches to mental health responses.

In recognizing and addressing underlying factors affecting mental health, we can contribute to building more equal, peaceful and sustainable societies. The World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR) envision a world where everyone can lead healthy lives and have access to affordable, high-quality mental health services that use a mental health paradigm based on rights, centred around each person; and where persons with mental health conditions and psychosocial disabilities can fully engage in their own recovery and participate in all areas of life. The Convention on the Rights of Persons with Disabilities is a crucial instrument in this regard, calling for a shift away from substituted decision-making and coercion, towards equality and non-discrimination, supported decision-making, free and informed consent, effective and meaningful participation, and community inclusion.

This publication, prepared jointly by WHO and OHCHR, is a call to action to realize such a vision. It offers a blueprint for laws that promote human rights in mental health, supports legal and attitudinal change, and encourages reforms that protect the rights of all persons interacting with mental health systems. It proposes steps towards establishing mental health services that are respectful of human dignity and comply with international human rights norms and standards.

We trust that this Guidance will be a useful resource particularly for States and decision-makers, as well as for persons with mental health conditions and psychosocial disabilities.



Dr Tedros Adhanom Ghebreyesus

Director-General
World Health Organization



Mr Volker Türk

United Nations High Commissioner
for Human Rights

Acknowledgements

The development and coordination of this Guidance was led by Michelle Funk and Natalie Drew Bold under the overall supervision of Dévora Kestel from the Department of Mental Health and Substance Use of the World Health Organization (WHO) jointly with the Economic, Social and Cultural Rights Section of the Office of the United Nations High Commissioner for Human Rights (OHCHR).

Writing team

This publication was written jointly by WHO and OHCHR.

On behalf of WHO

Alberto Vásquez Encalada (Consultant, Switzerland), Michelle Funk (Department of Mental Health and Substance Use, WHO) and Natalie Drew Bold (Department of Mental Health and Substance Use, WHO).

On behalf of OHCHR

Staff members of the Economic, Social and Cultural Rights Section.

WHO and OHCHR would like to thank the following individuals and organizations for their valuable contributions, feedback and inputs:

External contributors and reviewers

Natalie Abrokwa (University of Groningen, Kingdom of the Netherlands), Nazish Arman (Shuchona Foundation, Bangladesh), Peter Bartlett (Centre for Mental Health and Human Rights, Institute of Mental Health, Nottingham University/WHO Collaborating Centre on Mental Health, Disability and Human Rights, United Kingdom of Great Britain and Northern Ireland), Shreya Bhardwaj (Charles University, Czech Republic), Valerie Bichelmeier (Make Mothers Matter, France), Joann Bond (Attorney General's Chambers and the Ministry of Legal Affairs, Guyana), Mauro Giovanni Carta (University of Cagliari, Italy), Francesca Centola (Mental Health Europe, Belgium), Pyali Chatterjee (ICFAI University, India), Dixon Chibanda, (Friendship Bench and University of Zimbabwe, Zimbabwe), María Soledad Cisternas (former Special Envoy of the United Nations Secretary-General on Disability and Accessibility, Chile), Lee Allison Clark (Native Women's Association of Canada, Canada), Jarrod Clyne (International Disability Alliance, Switzerland), Ria Mohammed-Davidson (Attorney at Law, Human Rights and Mental Health, Trinidad and Tobago), Maria de Lourdes Beldi de Alcântara (Universidade de São Paulo, Brazil), Eric Diaz Mella (Centro de Reorganización Regional y Observatorio Social, Chile), Robert Dinerstein (American University Washington College of Law, the United States of America), Zuzana Durajová (Charles University, Czech Republic), Julian Eaton (CBM Global, the United Kingdom), Elisabetta Pascolo Fabrici (Azienda Sanitaria Universitaria Giuliano Isontina (ASUGI)/WHO Collaborating Centre for Research and Training in Mental Health, Italy), Alexandra Finch

(Georgetown University, the United States), Leon Garcia (Centro and Hospital das Clínicas, Brazil), Neeraj Gill (Griffith University, Australia), Guilherme Gonçalves Duarte (Permanent Mission of Portugal in Geneva, Ministry of Foreign Affairs, Portugal), Piers Gooding (La Trobe Law School, Australia), Lawrence Gostin (O'Neill Institute for National and Global Health Law at Georgetown University Law Center, Georgetown University/WHO Collaborating Center for National and Global Health Law, the United States), Kristijan Grđan (Association for Psychological Support Croatia, Croatia, and Mental Health Europe, Belgium), Vivian Hemmelder (Mental Health Europe, Belgium), Edgar Hilario (Department of Health, Philippines), Torsten Hjelmar (Citizens Commission on Human Rights Europe, Denmark), Mushegh Hovsepian (Disability Rights Agenda, Armenia), Dr Irmansyah (The National Research and Innovation Agency, Indonesia), Simon Njuguna Kahonge (Ministry of Health, Kenya), Olga Kalina (Georgian Network of (Ex)Users and Survivors of Psychiatry, Georgia, and the European Network of (Ex)Users and Survivors of Psychiatry (ENUSP), Denmark), Elizabeth Kamundia (Kenya National Commission on Human Rights, Kenya), Sylvester Katontoka (Mental Health Users Network of Zambia, Zambia), Brendan Kelly (Trinity College Dublin, Ireland), Hansuk Kim (Ministry of Health and Welfare, Republic of Korea), Seongsu Kim (Dawon Mental Health Clinic, Republic of Korea), Bernard Kuria (Ministry of Health, Kenya), Karilė Levickaitė (NGO Mental Health Perspectives, Lithuania, and Mental Health Europe, Belgium), Carlos Augusto de Mendonça Lima (World Psychiatric Association Section of Old Age Psychiatry, Switzerland), Laura Marchetti (Mental Health Europe, Belgium), Claudia Marinetti (Mental Health Europe, Belgium), Nemache Mawere (Ingutsheni Central Hospital, Zimbabwe), Felicia Mburu (Article 48 Initiative, Kenya), Roberto Mezzina (International Mental Health Collaborating Network and World Federation for Mental Health, Italy), Kendra Milne (Health Justice, Canada), Angelica Chiketa Mkorongo (Zimbabwe Obsessive Compulsive Disorder Trust, Zimbabwe), Guadalupe Morales Cano (Fundación Mundo Bipolar and European Network of (Ex)Users and Survivors of Psychiatry, Spain), Fabian Musoro (Ministry of Health, Zimbabwe), Macharia Njoroge (Championing for Community Inclusion in Kenya, Kenya), Nasri Omar (Ministry of Health, Kenya), Cheluchi Onyemelukwe-Onuobia (Babcock University, Nigeria), Hazel Othello (Ministry of Health, Trinidad and Tobago), Gemma Parojinog (Commission on Human Rights, Philippines), Soumitra Pathare (Indian Law Society, India), Eduardo Pinto da Silva (Ministry of Foreign Affairs, Portugal), Gerard Quinn (UN Special Rapporteur on the Rights of Persons with Disabilities, Ireland), Carlos Rios-Espinosa (Human Rights Watch, the United States), Gabriele Rocca (World Association for Psychosocial Rehabilitation and WAPR Human Rights Committee, Italy), Jean-Luc Roelandt (Service de recherche et de formation en santé mentale, Etablissement Public de Santé Mentale (EPSM) Lille Métropole/Centre collaborateur de l'OMS pour la Recherche et la Formation en Santé mentale, France), Marta Rondon (Instituto Nacional Materno Perinatal, Peru), Artur Sakunts (Helsinki Citizens' Assembly - HCA Vanadzor, Armenia), San San Oo (Aung Clinic Mental Health Initiative, Myanmar), Liuska Sanna (Mental Health Europe, Belgium), Josep Maria Solé Chavero (Support-Girona Catalonia, Spain), Slađana Štrkalj Ivezić (University Psychiatric Hospital Vrapče, Croatia), Charlene Sunkel (Global Mental Health Peer Network, South Africa), Kate Swaffer (Dementia Alliance International, Australia), Bliss Christian Takyi (St. Joseph Catholic Hospital, Ghana), Murali Thyloth (Ramaiah Medical College and World Association for Psychosocial Rehabilitation, India), Emanuela Tollozhina (Ministry of Health and Social Protection, Albania), Helal Uddin Ahmed (Ministry of Health and Family Welfare, Bangladesh), Yannis Vardakastanis (International Disability Alliance, Switzerland), Javier Vasquez (American University Washington College of Law, the United States), Simon Vasseur-Bacle (Ministère de la Santé et de la Prévention, France; Service de recherche et de formation en santé mentale, Etablissement Public de Santé Mentale (EPSM) Lille Métropole/Centre collaborateur de l'OMS pour la Recherche et la Formation en Santé mentale, France), Alan Woodward (Lifeline International, Australia), Stephanie Wooley (European Network of (Ex-)Users and Survivors of Psychiatry, France), Miguel Xavier (Ministry of Health, Portugal), Peter Badimak Yaro (BasicNeeds Ghana, Ghana) and Martin Zinkler (Gesundheit Nord gGmbH – Klinikverbund Bremen, Germany).

Organizations and Institutions

Alliance Defending Freedom (ADF) International, American Psychological Association (APA), Article 48 Initiative, European Network of (Ex)Users and Survivors of Psychiatry (ENUSP), Helsinki Citizens' Assembly (HCA) Vanadzor, Horatio: European Psychiatric Nurses, International Disability Alliance (IDA), International Mental Health Collaborating Network (IMHCN), International Psychogeriatric Association (IPA), Kellerkinder e.V., Maat Foundation for Peace, Development and Human Rights, Mental Health Europe (MHE), Minority Rights Group International, National Secular Society (NSS), The Authority for the Care of People with Disabilities, World Association of Psychiatric Rehabilitation (WAPR), World Federation for Mental Health (WFMH) and the World Psychiatric Association Section of Old Age Psychiatry (WPA-Soap).

WHO and OHCHR contributors and reviewers

WHO headquarters staff and consultants

Darryl Barrett, Fatima Batool, Daniel Chisholm, Alarcos Cieza, David Clarke, Tarun Dua, Antony Duttine, Fahmy Hanna, Stéfanie Fréel, Rodney Kort, Dzmitry Krupchanka, Aiysha Malik, Maria Francesca Moro, Vladimir Poznyak, Mark Van Ommeren and Inka Weissbecker.

WHO staff and consultants in regions and countries

Florence Baingana (WHO Regional Office for Africa), Andrea Bruni (WHO Regional Office for South-East Asia), Claudina Cayetano (WHO Regional Office for the Americas), Ledia Lazeri (WHO Regional Office for Europe), Carmen Martinez (WHO Regional Office for the Americas), Maristela Monteiro (WHO Regional Office for the Americas), Alejandro Morlachetti (WHO Regional Office for the Americas), Renato Oliveira E Souza (WHO Regional Office for the Americas), Khalid Saeed (WHO Regional Office for the Eastern Mediterranean), Martin Vandendyck (WHO Regional Office for the Western Pacific), Neli Demi (WHO Country Office for Albania), Ignacio Ibarra Espinosa (WHO Regional Office for the Americas), Jason Maurer (WHO Regional Office for Europe), Melita Murko (WHO Regional Office for Europe) and Jasmine Vergara (WHO Country Office for the Philippines).

OHCHR staff and reviewers

This joint publication benefitted from the substantive contributions of staff members located at OHCHR headquarters and in field presences, in addition to those made by members of the Office's Publications Committee and internally appointed peer reviewers.*

Financial support

WHO would like to acknowledge the generous financial support from the Government of Portugal towards its contribution to this joint publication.

* In accordance with OHCHR policy, contributions to its publications are not attributed to those employed by the Office.

Abbreviations and acronyms

CRPD	Convention on the Rights of Persons with Disabilities
ECT	electroconvulsive therapy
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
SOGIESC	sexual orientation, gender identity, gender expression and sex characteristics
SDG	Sustainable Development Goal
OHCHR	Office of the United Nations High Commissioner for Human Rights
UDHR	Universal Declaration of Human Rights
UHC	universal health coverage
UN	United Nations
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
WHA	World Health Assembly
WHO	World Health Organization

Glossary

Biomedical model

The biomedical model of mental health is based on the concept of mental health conditions being caused by neurobiological factors (1, 2). As a result, care often focuses on diagnosis, medication, and symptom reduction, rather than considering the full range of social and environmental factors that can impact mental health. This can lead to a narrow approach to care and support that may not address the root causes of distress and trauma.

Disability

Disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others (3).

Discrimination on the basis of disability

Any distinction, exclusion or restriction on the basis of disability, including mental health conditions, which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. Included are all forms of discrimination, including denial of reasonable accommodation (4).

Human rights-based approach

A conceptual framework of processes and actions that is based on international human rights law and aims to promote and protect human rights. A human rights-based approach to mental health entails adopting legal and policy frameworks as well as implementing practices that are compatible with State obligations under international human rights law. It is designed to equip all State and non-State actors to identify, analyse and address inequalities and discrimination to reach those who are left behind by ensuring the participation of all actors, policy-makers, civil society organizations, community- and grassroots-based groups; and when needed, ensuring avenues for redress and accountability (5).

Legal capacity

The capacity to be both a holder of rights and an actor under the law. Legal capacity to be a holder of rights entitles persons to full protection of their rights by the legal system. Legal capacity to act under the law recognizes the person as an agent with the power to engage in transactions, and create, modify or end legal relationships (6).

Marginalized groups

Different groups of people within a given culture, context and history, at risk of discrimination and exclusion due to unequal power relationships and the interplay of different personal characteristics or grounds, such as race, sex, gender identity or expression, sexual orientation, sex characteristics, age, disability, national, ethnic, indigenous or social origin, caste, migrant or refugee status, language, religion, political or other opinion, education or income, or living in various geographical localities (7).

Recovery

The recovery approach in mental health focuses on helping people to regain or stay in control of their lives. The meaning of recovery can be different for each person and may include (re)gaining meaning and purpose in life; being empowered and able to live a self-directed life; strengthening the sense of self and self-worth; having hope for the future; healing from trauma; and living a life with purpose. Every person should have the opportunity to define what recovery means for them, and which areas of their life they wish to focus on as part of their own recovery journey. Recovery considers the person and their context as a whole, and no longer adheres to the idea or goal of the person “being cured” or “no longer having symptoms” (8).

Procedural accommodation

All necessary and appropriate modifications and adjustments in the context of access to justice, where needed in a particular case, to ensure the participation of persons with disabilities and other groups on an equal basis with others. Unlike “reasonable” accommodations, “procedural” accommodations are not limited by the concept of “disproportionate or undue burden” (9).

Reasonable accommodation

All necessary and appropriate modifications and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities and other groups the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms (4).

Psychosocial disability

This guidance adopts the CRPD definition of disability and understands psychosocial disability as arising from the interaction between persons with actual or perceived mental health difficulties and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. Examples of such barriers are discrimination, stigma and exclusion (10). This term aims to reflect a social rather than a medical approach to mental and emotional experiences, placing the focus on the attitudinal and environmental barriers that restrict a person’s equal participation in society (11, 12). While the Convention uses the term “impairment”, this Guidance avoids this term to respect the diverse perspectives of persons with lived experience of psychosocial disability, and the dynamic nature of mental and emotional states.

Substitute decision-making

Regimes where legal capacity is removed from a person, even if this is in respect of a single decision; a substitute decision-maker is appointed to make decisions on behalf of the person concerned; or decisions are made by another person based on what is believed to be in the “best interests” of the person concerned, as opposed to being based on the person’s own will and preferences (13).

Supported decision-making

Regimes comprising various support options which allow a person to exercise legal capacity and make decisions with support (14). While supported decision-making regimes can take many forms, under such regimes, legal capacity is never removed or restricted; a supporter cannot be appointed by a third party against the will of the person concerned; and support must be provided based on the will and preferences of the individual (15).

Executive summary

Introduction

Mental health is a growing public health priority and human rights imperative. As a result, increasing numbers of countries are adopting or reforming mental health-related legislation. Existing legislation often fails to address the social and economic factors that affect mental health, and can thereby perpetuate discrimination and human rights violations, such as denial of legal capacity, coercive practices, institutionalization, and poor-quality care, including in mental health care settings.

In response, the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR), among other international stakeholders, are actively advocating for a human rights approach to mental health. The international human rights framework, particularly the Convention on the Rights of Persons with Disabilities (CRPD), calls for a significant shift from biomedical approaches towards a support paradigm that promotes personhood, autonomy, and community inclusion.

This joint WHO–OHCHR publication, *Mental health, human rights and legislation: guidance and practice* (hereinafter, “the Guidance”), aims to assist countries in adopting, amending, or implementing legislation related to mental health. Its objective is to ensure that mental health policies, systems, services, and programmes provide high-quality care and support for all, in line with international human rights standards, including the CRPD. The Guidance encourages the integration of mental health into general legislation rather than the adoption of mental health-specific laws.

The Guidance is intended for legislators, policy-makers, and professionals involved in mental health legislation and care. It may also be helpful to those working in related fields, such as United Nations entities, government officials, persons with mental health conditions and psychosocial disabilities, professional organizations, family members, civil society organizations, organizations of persons with disabilities, humanitarian workers, community-based organizations, faith-based organizations, researchers, academics and media representatives.

The Guidance has three chapters and a checklist covering the process and content of ensuring rights-based legislation:

- **Chapter 1** discusses the challenges associated with current mental health legislation and highlights the need for reforms that align with the international human rights framework.
- **Chapter 2** describes the main principles and issues that legislation on mental health should incorporate, with examples of rights-based provisions.
- **Chapter 3** explains how to develop, implement, and evaluate mental health-related legislation following a rights-based process.
- **Checklist** for countries to evaluate whether their legislation adopts a rights-based approach.

Chapter 1. Rethinking legislation on mental health

Mental health and well-being are strongly associated with social, economic, and physical environments, as well as poverty, violence, and discrimination. However, most mental health systems focus on diagnosis, medication, and symptom reduction, neglecting the social determinants that affect people's mental health. Too many people experience discrimination and human rights violations when seeking mental health care and support: some are denied care because of their race, gender, sexual orientation, age, disability, or social status. Others are exposed to poor-quality services and inhuman living conditions, without safe water and basic sanitation or are subjected to treatment that is dehumanizing and degrading. Involuntary hospitalization and treatment, seclusion or solitary confinement, and the use of restraints are also prevalent in most mental health systems. Women, girls, and people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) can further face harmful practices, such as forced sterilization, coerced abortion, and conversion therapies. The widespread human rights violations and harm caused by mental health systems has led to a legacy of trauma that impacts many individuals and communities and spans generations.

During the past 150 years, legislation on mental health has legitimized and, in some cases, facilitated these human rights violations: early laws consolidated paternalism and the concept that people with mental health conditions and psychosocial disabilities are “dangerous”. Existing mental health laws have significant implications for human rights, being often outdated, narrow in their understanding of human rights, and reliant on a reductionist biomedical model. The stand-alone legislation of most countries includes provisions to limit rights, such as through involuntary commitment and forced treatment, restraint, and seclusion. Furthermore, mental health laws often reinforce power structures and contribute to the oppression of marginalized populations. While the adoption of the Convention on the Rights of Persons with Disabilities (CRPD) has renewed interest in revisiting legislation on mental health from a human rights perspective, most countries have not challenged longstanding biomedical approaches and compulsory treatment powers.

The international human rights framework requires that countries adopt a rights-based approach to legislation on mental health. Mental health is a fundamental human rights concern and essential to realize the right to health. The CRPD reinforces the protection of international standards of human rights in mental health care and recognizes that the rights of persons with mental health conditions and psychosocial disabilities are equal to those of any person. The CRPD creates an enabling legal environment from which to develop rights-based mental health systems that prioritize a person's empowerment and active participation in their own recovery.

Legislation on mental health must therefore take a new direction away from the narrow traditional “biomedical paradigm” that has contributed to coercive and confined environments in mental health services (16). To achieve this and fully embrace human rights, the Guidance proposes new approaches, such as setting a clear mandate for mental health systems to adopt rights-based approaches; enabling person-centred and community-based services; raising awareness and challenging stigma; eradicating discrimination and coercion; promoting community inclusion and participation; and developing accountability measures. Any new direction requires the engagement and participation of those with lived experience, including experience of intergenerational trauma, in shaping the law to reflect and respond to their perspectives in the pursuit of recovery, reparation and healing. This collaborative approach is essential to create a mental health system that respects human rights, prioritizes care and support over control, and supports individuals in achieving their full potential.

Chapter 2. Legislative provisions for person-centred, recovery-oriented and rights-based mental health systems

Chapter 2 proposes a set of legislative provisions that countries can adopt to support a human rights-based approach to mental health. It covers areas in which legislation can protect, promote, and support international human rights treaties as they pertain to mental health. It also offers examples of texts and provisions that different countries have adopted, with detailed guidance for drafting rights-based provisions. The areas covered are:

Equality and non-discrimination: key national legislative provisions for upholding the principles of equality and non-discrimination in the mental health system and ensuring the equal enjoyment of rights for all people in the provision of mental health services. Examples include the prohibition of all forms of discrimination, including in health insurance and in the provision of reasonable accommodation; challenging stigma and discrimination in communities; and the equal recognition of rights within mental health services, including in relation to access to information, confidentiality, privacy, and facilities.

Personhood and legal capacity: important legislative provisions for the recognition of and respect for the legal capacity of people using mental health services and providing them with appropriate support if required. Examples include the prohibition of substitute decision-making; making available supported decision-making; safeguarding a person's will and preferences; and respecting children's evolving capacities.

Informed consent and eliminating coercive practices: essential legislative provisions for eliminating coercion in mental health services and upholding the right to free and informed consent. Examples include promoting and protecting the right to free and informed consent; supporting advance planning; the provision of crisis support; the prohibition of involuntary hospitalization and treatment; and eliminating seclusion and restraint.

Access to quality mental health services: important provisions for addressing these issues with a view to eliminating barriers to accessing good-quality mental health services and support. Examples include ensuring parity between physical and mental health; the availability, accessibility, acceptability and quality of mental health services; financing; and gender, cultural and age considerations in mental health care.

Implementing mental health services in the community: key provisions for transforming and implementing person-centred and rights-based community mental health and support services. Examples include integrating mental health in general health care settings; developing person-centred and rights-based community mental health services; integrating peer-led and peer-run services; and supporting deinstitutionalization.

Full and effective participation in public decisions: important legislative provisions for recognizing and supporting the rights of people with lived experience to participate and be actively involved in all public decision-making processes concerning mental health systems.

Accountability: legislative provisions to ensure and enforce accountability within mental health services. Examples include strengthening information systems; establishing independent monitoring bodies; and initiating effective mechanisms for remedies and redress.

Cross-sectoral reforms: principal legislative provisions dealing with the interface between mental health and other sectors, including the judiciary. Examples include promoting community inclusion and multisectoral coordination and action; supporting organizations of persons with lived experience and families; and their access to justice.

Chapter 3. Developing, implementing and evaluating rights-based legislation on mental health

This chapter emphasizes the importance of adopting a human rights-based approach when reviewing or adopting legislation related to mental health. It outlines the basic steps to be taken in the process, including:

- involving and consulting persons with lived experience and their representative organizations;
- understanding the international human rights law framework;
- conducting a comprehensive review of legislation on mental health;
- assessing the barriers to rights-based mental health care; and
- drafting and debating a proposal for mental health related legislation.

The Guidance also identifies entry points for advocacy and mobilization and discusses the process of implementing the law. This includes the role of bodies responsible for implementation; the development of regulations and other guidance; the importance of public education and awareness; and the training of key stakeholders.

In conclusion, the Guidance highlights the importance of evaluating the law and suggests a number of policy options for carrying it out.

Checklist for assessing rights-based legislation on mental health

The checklist forms an important part of the Guidance by providing a practical way for countries to determine whether mental health-related legislation or a draft bill are compliant with international human rights obligations. It aims to identify the principal issues that need to be addressed to ensure that the legislation is rights-based.

The main content of the Guidance should be referred to when using the checklist, as the questions are not exhaustive.

Introduction

1. Background

Mental health is recognized as a public health priority and a fundamental human right. In recent years a complete transformation in the field of mental health has been called for, particularly in how mental health is understood, addressed and supported, in and outside of health care settings, (2, 10, 17, 18). The growing awareness of the role of social determinants and the importance of providing person-centred, human rights-based and recovery-oriented care and services, has prompted governments worldwide to design and implement policies that improve mental health for all.

The number of countries that have adopted or are considering adopting new legislation on mental health or reforming existing legislation has increased rapidly (see [section 1.2](#)). Most of these reforms have been passed through stand-alone mental health laws, which are widely viewed as progressive in advancing universal health coverage (UHC) and service provision (19). However, these laws often fail to address the legacy of outdated legal, policy and institutional frameworks governing mental health, and the overreliance on biomedical approaches and treatment options (20, 21). The social and economic factors impacting people's mental health and well-being are much overlooked. Globally, people experiencing distress and trauma continue to face wide-ranging human rights violations and discrimination, including in mental health care services (22, 23); moreover, a significant function of many mental health laws is to authorize and regulate coercive mental health interventions. As highlighted by the Special Rapporteur on the rights of persons with disabilities, for too long mental health laws have focused heavily on establishing procedural safeguards rather than prioritizing liberties and “breathing life into rights” (24).

Mental health, human rights and legislation are inextricably linked. Every individual has the right to the highest attainable standard of health (hereinafter referred to as the “right to health”), which includes both physical and mental health. Countries have corresponding obligations to respect, protect and fulfil this right and address inequities in social determinants for all, without discrimination of any kind, and to respect and protect all human rights and freedoms in the provision of care and support. The 2006 Convention on the Rights of Persons with Disabilities (CRPD) (4), which entered into force in 2008, brings a greater understanding of these obligations and calls for a significant paradigm shift within the mental health field. Building on the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), the CRPD challenges long-standing harmful practices in mental health systems, such as the denial of legal capacity and the use of coercive practices, and provides instead for a “support paradigm” that underlines the duty and importance of rethinking the objective and role of legislation on mental health to promote personhood, autonomy, full participation, and community inclusion.

The World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR) promote a human rights approach to mental health. WHO's Comprehensive Mental Health Action Plan 2013–2030 (25), updated in 2021 at the Seventy-fourth World Health Assembly, calls on countries to align their mental health-related legislation with the CRPD and other international and regional human

rights instruments, and to amend or repeal legislation that perpetuates stigma, discrimination and human rights violations. Similarly, OHCHR has recommended that countries carry out legal reform in line with the CRPD in all sectors relevant to mental health (21).

The *WHO resource book on mental health, human rights and legislation* (26), published in 2005, aimed to assist countries in drafting, adopting and implementing mental health legislation. At the time, the resource represented a significant advance in recognizing the rights of people using mental health services. However, many of the recommendations outlined fall short of those proposed in the CRPD and the evolving interpretation of the right to health and other related human rights (see [section 1.4](#)) and the publication has since been withdrawn, leaving gaps in information and guidance.

In response to increased requests from countries for technical cooperation to support national efforts, this joint WHO–OHCHR publication seeks to address this gap, providing clear guidance on how to develop, amend or implement legislation on mental health in line with international and regional human rights law.

2. Purpose and scope

This non-binding Guidance acts as a resource for countries that are considering adopting, amending or implementing legislation related to mental health systems, care and support. The objective is to ensure that mental health policies, systems, services and programmes embrace a rights-based approach and provide high-quality care and support for all, in line with international human rights standards, including the CRPD. It replaces the *WHO resource book on mental health, human rights and legislation* (26).

The Guidance seeks to encourage reforms that promote, protect, and uphold the rights of all people who interact with, or benefit from, mental health systems and services, no matter what the cause of their condition, their diagnosis or psychosocial disability, or how they may identify themselves. This includes persons who experience short-term distress or crisis, those with mental health conditions, psychosocial disabilities, intellectual disabilities, or neurological conditions, and persons who use drugs.

Recognizing that mental health and well-being are not exclusive to the health sector, this Guidance highlights the cross-sectoral reforms needed in the social and justice sectors to address the social determinants of mental health.

However, addressing all the social determinants of mental health requires the transformation of different bodies of law and involves a larger, coordinated effort from all government sectors, civil society, and the private sector. This falls beyond the scope of this Guidance which focuses specifically on law reform related to mental health care and support.

The Guidance does not promote the adoption of stand-alone mental health laws. Countries without consolidated legislation for mental health should consider integrating it into general legislation (see [section 1.5](#)). At the same time, it is acknowledged that countries with existing stand-alone legislation may need assistance in the progressive transition towards a human rights-based approach; this Guidance can be used as a resource for this.

In line with WHO's Comprehensive Mental Health Action Plan 2013–2030 (25), the Guidance is based on the international human rights framework. It references the CRPD – the highest human rights standard of protection of the rights of persons with disabilities – given its centrality in transforming mental health practice and addressing stigma, discrimination and rights violations experienced by persons with mental health conditions and psychosocial disabilities. Countries may refer to the Guidance to advance their international obligations concerning mental health care and support, while keeping in mind that legal harmonization to implement the CRPD and other human rights instruments requires legal and policy reform that extends beyond the scope of this Guidance.

Given that countries are at various stages of developing their mental health systems, the successful implementation of the reforms proposed in this Guidance requires continued efforts, political commitment, public investment, and compliance with the obligation of progressive realization. This will ensure mental health services that are rights-based, community-based and person-centred, and that systematically address the social determinants of mental health (27).

The Guidance encourages translating into law the myriad evidence-based approaches and practices anchored in human rights that are emerging and proliferating around the world. Transformation to a rights-based, person-centred, recovery-oriented and community-based mental health paradigm is not only enabled by, but necessitates, the accompaniment of the law and requires reform, regeneration and renewal.

3. Who is the Guidance for?

The Guidance is aimed primarily at legislators and policy-makers directly involved in drafting, amending and implementing legislation on mental health, as well as those responsible for monitoring and evaluation. This includes health and mental health service providers, professionals and bodies; representatives of national human rights institutions; and those working on related social services.

The Guidance may also be of interest to individuals or representatives of an organization, civil society or any other entity involved in mental health policy, work and advocacy.

4. Why is the Guidance important?

The Guidance is important for several reasons:

- **A fundamental shift is required within the field of mental health.** Stigma, discrimination, and other human rights violations continue in mental health care settings. There is an overreliance on biomedical approaches to treatment options, inpatient services and care, and little attention given to social determinants and community-based, person-centred interventions. Legislation can help ensure that human rights underpin all actions in the field of mental health.
- **Most legislation on mental health fails to embrace a rights-based approach.** Many people using mental health services, particularly those belonging to marginalized groups, are not treated equally before and under the law, and are often discriminated against. Furthermore, legislation may be paternalistic and detrimental to a person's autonomy and community inclusion. People with mental health conditions and psychosocial disabilities are routinely deemed incapable of making decisions, including those relating to whether or not they wish to receive mental health services. There are also no adequate mechanisms to prevent, detect, or remedy these and other human rights violations.
- **International human rights law requires non-discrimination and respect for all human rights in the implementation of the right to health.** Legislation must ensure a framework for the protection of all human rights in the context of mental health policies, programmes, plans and service provision, and to help all persons attain their full potential. The Human Rights Council has reiterated in several resolutions (28–31) the importance of United Nations (UN) Member States adopting, implementing, updating, strengthening and monitoring, as appropriate, laws, policies and practices to eradicate any form of discrimination, stigma, violence and abuse in the context of mental health care.
- **The international human rights framework requires a transformation in the way mental health services are provided.** All persons should be able to exercise their right to give free and informed consent to accept or reject treatment in mental health systems. Denial of legal capacity, coercive practices and institutionalization must end. To date, 187 countries and the European Union have ratified the CRPD¹ and are thus legally bound to replace harmful practices with community-based services and support structures that enable the full exercise of human rights.
- **Legislation can bring about cultural change and social transformation in relation to mental health.** Legislation is fundamental to framing attitudes and behaviour towards people with mental health conditions and psychosocial disabilities. By aligning with international human rights norms and standards, legislation can foster a cultural shift that promotes social transformation in the realm of mental health. This involves a transition away from a narrow emphasis on biomedical approaches towards a more holistic and inclusive understanding of mental health.
- **The World Health Assembly has called for a review on mental health legislation in line with human rights.** WHO's Comprehensive Mental Health Action Plan 2013–2020 (extended to 2030) (29) urges countries to strengthen their leadership and governance on mental health, including by developing, implementing, strengthening and updating related laws and regulations within all relevant sectors. Codes of practice and mechanisms to monitor the protection of human rights and implementation of legislation must also align with evidence, best practice, the CRPD, and other international and regional human rights instruments. Many countries are currently seeking advice on how to ensure compliance of their mental health legislation with the CRPD and other international and regional human rights instruments.

¹ 187 parties as of 25 July 2023. See: https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?Treaty=CRPD.

5. How to use the Guidance

The Guidance can be used by countries as a resource tool while carrying out legislative reform concerning mental health care and support. It brings together information related to human rights, mental health and legislation in a single comprehensive publication. It further clarifies aspects of previous human rights standards and references technical guidance publications that are not fully consistent with – or may even contradict – the human rights-based approach.

The Guidance has three chapters covering the content and processes of rights-based legislation on mental health:

- **Chapter 1** discusses the challenges related to legislation on mental health and the need for reform, in line with the international human rights framework;
- **Chapter 2** describes the main principles and issues that legislation should reflect, and presents examples of different rights-based provisions; and
- **Chapter 3** explains ways to follow a rights-based process while developing, implementing and evaluating mental health-related legislation.


The Guidance includes a checklist to be used by countries to assess and evaluate legislation on mental health so that it adopts a rights-based approach. It identifies the principal components to be reflected in the legal framework, and can be used for informing the development of any new legislation related to mental health care.


While the Guidance proposes a set of principles and addresses issues and provisions that could be mirrored in national legislation, countries can adapt and tailor these to their specific circumstances (national context, languages, cultural sensitivities, legal systems, etc.), without compromising human rights standards.


Further information on mental health reform and human rights is available through WHO's QualityRights initiative, which provides guidance and tools with a rights-based approach, and which complements and supports the translation of law into practice ([Box 1](#)). The WHO QualityRights materials can be consulted for training, guidance and transformation (32), along with the 2021 WHO publication *Guidance on community mental health services: promoting person-centred and rights-based approaches* (33). WHO's 2022 *World mental health report: transforming mental health for all* underscores the need for legislation to comply with international human rights instruments: It echoes and reinforces the need for countries to put in place person-centred, human rights-based, recovery-oriented care (10). This WHO–OHCHR publication, *Mental health, human rights and legislation: guidance and practice*, can be read in light of these other resources, as well as the new guidance on policies and strategic action plans which is currently being developed and which will present new resources and pathways for organizing rights-based mental health systems.


Box 1

QualityRights materials and tools

 **WHO QualityRights e-training on mental health, recovery and community inclusion:** <https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training>.

 **WHO QualityRights materials for training, guidance and transformation:** <https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools>.

 **WHO guidance and technical packages on community mental health services:** <https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services>.

 **WHO information and resources on promoting rights-based policy and law for mental health:** <https://www.who.int/activities/promoting-rights-based-policy-and-law-for-mental-health>.

6. How was the Guidance developed?

The Guidance was developed between August 2020 and January 2023 through an iterative and collaborative process which involved literature reviews and analysis of the international human rights framework, mental health related technical material, national legislation, as well as several rounds of consultation with UN experts, government officials, persons with lived experience, mental health practitioners, academics, and representatives from national human rights institutions and civil society organizations, including organizations of persons with disabilities. As part of the development process, during July and August 2022, the WHO and OHCHR issued a call for feedback on the draft Guidance. All inputs received are available on the OHCHR website (34).

7. A note on language

Language is not neutral and is constantly evolving. Terms commonly used to refer to mental and emotional experiences include “mental illness”, “mental disorders”, “mental health problems” and “mental health conditions”. Although some people may identify with their diagnosis and the medical terminology used, others may consider certain terms stigmatizing or reject the medicalization of distress, trauma or diversity and use other expressions such as “persons with lived experience”, “consumers”, “service users”, or “psychiatric survivors”. Individuals must be able to decide on the vocabulary, expressions and descriptions of their own experience, situation, or distress. When undertaking legal reforms, the meaningful participation and engagement of law-makers, parliamentarians, and other public officials with the target populations is crucial for clarifying the appropriate use of language in each given context.²

Throughout this Guidance, the inclusive terms “persons with psychosocial disabilities”, “persons with mental health conditions”, “persons using mental health services”, and “persons with lived experience” are used.

While individuals can self-identify with certain expressions or concepts, human rights apply to everyone, everywhere. Above all, a mental health diagnosis or attribution of a disability status should never define a person: every individual has a unique social context, personality, autonomy, dreams, goals, aspirations and relationships.

² For more information on mental health related definitions, see WHO’s World mental health report: transforming mental health for all; 2022 (<https://www.who.int/publications/i/item/9789240049338>).

Chapter 1

Rethinking legislation on mental health

Introduction

Chapter 1 provides an overview on the state of mental health and related legislation worldwide. It examines important human rights issues in the current context of mental health and highlights how most existing legislation on mental health does not align with international human rights law, thereby calling for a paradigm shift in the provision of mental health care towards holistic, person-centred, and human rights-based approaches.

The chapter further introduces the international human rights framework, including the contributions of the CRPD, and provides guidance for revisiting legislation on mental health from a human rights perspective.

1.1 Context and challenges in mental health

Mental health is a state of physical, mental, emotional and social well-being, determined by the interaction of the individual with society (10). It is shaped by the conditions in which people are born, grow, live, work, and age and cannot be considered in isolation from the realization of human rights and fundamental freedoms. As such, mental health and well-being must be addressed holistically, applying multisectoral approaches that involve non-health sectors such as those of education, employment, justice, or the interior – including in the context of migration, child protection, law enforcement or humanitarian and disaster responses.

The multiple and intersecting layers of people’s identities, along with social structures of oppression (racism, ageism, ableism, etc.), must not be viewed as isolated from their experiences of mental distress and trauma. A wide range of factors influence a person’s mental health as well as their access to quality care and support; these include the person’s age, sex, sexual orientation, sex characteristics, gender identity or expression, disability, caste, racial, indigenous or ethnic origin, socioeconomic status, migration or refugee status, and other markers of identity. Mental health policies, services and programmes should be responsive to the diversity of needs and seek to overcome the negative impact of all forms of discrimination experienced.

The different ways of being, thinking, sensing, expressing, and making sense of the world are part of human diversity: there is no “normal” or “right” way to be. A failure to understand and respect these differences can lead to isolation and discrimination. Many people experience voices, visions or unusual states of consciousness positively, with no need to “recover” (35). Distress resulting from negative events or trauma

can prove meaningful and provide an opportunity for growth and change (36, 37). Rights-based and person-centred support should always be available to help people make sense of their experiences and achieve their own recovery goals.

Mental health and well-being are essential for sustainable development. Without good mental health, people may experience challenges in carrying out daily living activities, being actively part of their communities, or living a life that has meaning for them. Mental health is relevant to all of the Sustainable Development Goals, explicitly Goal 3 (SDG3)³ on good health and well-being. Persons with mental health conditions and psychosocial disabilities are more likely to fall into poverty, experience poor physical health, and have less access to livelihood opportunities and resources (38, 39).

Within SDG3, target 3.4 on noncommunicable diseases and mental health, suicide rates are highlighted as a key indicator (indicator 3.4.2). Suicide affects all ages, genders, and regions of the world, with rates disproportionately higher among young people; suicide prevention has thus been recognized as a global public health priority (40, 41). Furthermore, as recent global events have shown, the harmful consequences of humanitarian crises such as environmental disasters, pandemics, armed conflict and other forms of adversity on mental health, are significant but often insufficiently addressed (42).

While the economic case for investing in mental health and well-being is well documented (10, 43, 44), investment in quality and rights-based mental health care and support is typically seen as a cost rather than as an investment, and is often scarce. The WHO *Mental Health Atlas 2020* reports that public expenditure on mental health is low, involving a global median of 2.1% of government health funding (45). Underinvestment in mental health systems results in a struggle to provide adequate support to meet people's needs. However, mental health concerns cannot be addressed solely by the mental health sector, nor by simply increasing resources: there is an imperative to transform the way mental health care and support are conceived and provided.

Recognition is growing that mental health and well-being are intimately linked to a person's social, economic, and physical environment, including exposure to poverty, violence and discrimination. However, most mental health systems fail to embrace a holistic approach to care. The biomedical model, which focuses predominantly on diagnosis, medication and symptom reduction, prevails across existing mental health systems. As a result, social determinants that impact people's mental health are often disregarded, resulting in repeated cycles of trauma, exclusion and violence. For example, people with mental health conditions and psychosocial disabilities face higher rates of unemployment, poverty, homelessness, and incarceration (46–48). Additionally, the rapid destabilization of ecosystems due to climate change increasingly and negatively affects people's mental health (10).

When seeking mental health care and support, too many people experience discrimination and human rights violations. Many will face specific challenges in accessing care, or are often excluded from public health systems or denied care because of their race, gender, sexual orientation, age or disability; their national, ethnic, indigenous or social origin; their caste, migration or refugee status; or simply its unaffordability. Others receiving care through psychiatric hospitals are often denied general health treatment, including access to life-saving treatment (49).

³ See: <https://sdgs.un.org/goals/goal3>.

People are often exposed to poor-quality services and suboptimal living conditions, without safe water and sanitation, or subjected to treatment that is dehumanizing or degrading. Rates of involuntary hospitalization and treatment continue to rise globally, particularly in high-income countries (50). Seclusion or solitary confinement and the use of restraints, including chemical restraints, are frequently employed as a way to enforce compliance to treatment and medication (51). Many people are institutionalized, and live in mental health facilities or social care institutions for months, years and even for life (52, 53); some remain in the community but are locked at home or shackled (54).

Women, girls and lesbian, gay, bisexual, transgender, intersex and queer persons experience violence and discrimination based on sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC). Gender-related stereotypes may influence the diagnosis of mental health conditions and lead to higher prescription rates of psychotropic drugs for women (55). Conversely, gender stereotyping in men can lead to the invisibility of mental distress (55). Women and girls with psychosocial disabilities are often deemed incapable of making decisions about their sexual and reproductive health and rights, leading to violence, sexual abuse, forced sterilization, coerced abortion, and forced contraception (56). Lesbian, gay, bisexual, transgender, intersex and queer individuals continue to be targeted through so-called “conversion therapies” that aim to change sexual orientation and gender identity (57).

Despite increasing awareness of the importance of mental health, a human rights-based approach remains a neglected part of global efforts to improve mental health. Political commitment and funding continue to be limited for human rights-based, community and person-centred approaches. Public expenditure on mental health is directed mostly towards inpatient care, especially psychiatric and social care institutions, while community-based and non-coercive psychosocial services are barely funded and portrayed as “alternative” care rather than being embedded in general health and mental health policies and systems. Hence, most people in the world do not receive quality mental health care or support (2, 22, 58).

Legislative reform can lead to the adoption of new policies and practices that challenge stigma, discrimination, and segregation, ensure a human rights-based approach, and increase access to quality health care.

1.2 Mental health and the law

Legislation on mental health has changed considerably during the past 150 years. While the origins of Western mental health law can be traced back to the Middle Ages, its expansion was consolidated during the nineteenth and twentieth centuries (59). This development occurred in parallel with the evolution in understanding of “mental illness”, treatment perspectives, and human rights standards.

The French mental health law of 1838 and the English and Welsh Lunacy Act of 1890 represent two of the earliest and most influential efforts to regulate mental health admission and treatment in the modern era. These laws consolidated paternalism and notions of “dangerousness” in the field of mental health by introducing new procedures that authorized compulsory confinement in a mental health institution based on “need for treatment” or alleged “dangerous behaviour”, which continue to justify involuntary admission and treatment to this day (60). Although these laws are no longer in force, their structures have become the blueprint of “modern” mental health legislation, exported to countries that were under colonial rule, and whose legacy remained following their independence (61). In some countries, the notion of “dangerousness” has been used to confine political dissidents in psychiatric facilities (62).

Since the 1970s, legislation on mental health became increasingly influenced by rights-based discourses with a focus on regulating the use of mental health powers. The main purpose of the law was to regulate adequate procedural safeguards for the “needed” limitation of rights, such as involuntary commitment, forced treatment, restraint and seclusion. Criteria for the compulsory treatment of individuals varied from “need for care and treatment” to “danger to self and others” depending on the country’s practice and legal tradition. This remains the model for mental health legislation in most countries. The jurisprudence of the European Court of Human Rights (63–69) and the adoption of the Principles for the Protection of Persons with Mental Illness (MI Principles) adopted by the General Assembly in 1991 (res. 46/119) strengthened this approach and prompted a new wave of mental health law reform around the world (70).

A different approach was taken by a few countries, including Italy, which adopted legislation aimed at expanding community mental health services. In 1978, Italy adopted Law No. 180, also known as the Basaglia Law, which was later incorporated into Law No. 833 that instituted the National Health Service (71). The law placed significant focus on reorganizing mental health services; it prompted the development of a network of decentralized community-based services and established a ban on building new mental health hospitals and on admitting new patients to existing ones, which were gradually closed. While coercive measures are still authorized under specific circumstances, the law rejects the notion of “dangerousness” because of its stigmatizing effects. The Basaglia Law has been highly influential in Latin America where, together with the “Caracas Declaration” of 1990 (72), it inspired laws in Brazil (73), Argentina (74), Uruguay (75), Peru (76), and Chile (77), which focus on psychiatric reform and combine the procedural safeguards approach with a reformist drive.

Currently, the overarching trend across countries is the development of stand-alone mental health legislation. A survey for the WHO *Mental Health Atlas 2020* was completed by 171 of the 194 WHO Member States. Of the 171, a total of 111 (65%) reported having a stand-alone law for mental health, representing 57% of all Member States (19). As regards WHO regions, in the Western Pacific, Eastern Mediterranean, and European regions, more than 70% of responding countries reported the existence of stand-alone mental health laws. The percentage of countries with such legislation has increased in almost all WHO regions since the first WHO Mental Health Atlas was published in 2014 (78).

Stand-alone mental health legislation often includes provisions on issues such as the rights of users of mental health services; diagnostic criteria; voluntary and involuntary admission and treatment; community treatment orders; informed consent for “special treatments” (e.g. electroconvulsive therapy, psychosurgery, sterilization); monitoring and review mechanisms; criminal offenders; and governance and administration of mental health services. In countries where there is no specific legislation on mental health, or even where it exists, other legislation on health, social services, local governments or criminal law, often contain similar provisions that are detrimental to the rights of people with mental health conditions and psychosocial disabilities.

The adoption of the CRPD has prompted new commitment in reforming legislation on mental health. While it is too early to understand the true impact of the CRPD on national mental health legislative frameworks, as discussed in Chapter 2, several countries have begun to integrate CRPD-inspired measures into their laws, such as reasonable accommodation, advance directives, and supported decision-making. Nevertheless, most countries have fallen short of challenging biomedical approaches and the legitimacy of the denial of legal capacity and compulsory treatment powers, thus failing to embrace rights in the field (79–83).

1.3 Mental health law and human rights

While mental health laws have become the natural response of countries to regulate mental health services and ensure the protection of rights within them, they also raise significant human rights concerns that reflect deep and lasting tensions around mental health practice and law (84).

Albeit decreasingly prevalent, legislation inherited from colonial rule can be described as “archaic and obsolete” (61). Language is often stigmatizing and derogatory with individuals described as, for example, “lunatic”, “insane”, “mentally ill”, “mentally abnormal”, “mentally disordered”, or “of unsound mind”, and significant discretion is given to families and mental health professionals to decide on behalf of the individual concerned. “Welfare protection” and “public safety” are frequently invoked as criteria for involuntary commitment, with an emphasis on custodial administration.

More recent legislation on mental health continues to embrace a narrow understanding of human rights and psychosocial differences even if embellished by rights-based language. Focus is placed on the restriction of rights with lower standards of protection provided to people on the basis of a mental health diagnosis. This discriminates against a person’s rights to informed consent, privacy, liberty and security, personal integrity, and access to justice, among others. Moreover, laws fail to challenge harmful stereotypes that these individuals are “dangerous” and “incompetent”, thereby contributing to the perpetuation of their use (85).

An additional concern is the explicit use of a reductionist Western biomedical model in mental health law, which works to the detriment of other holistic, person-centred and human rights-based approaches and strategies for understanding and addressing distress, trauma, and unusual perceptions or beliefs (2, 86). Furthermore, applying a Western reductionist approach to different cultures including Indigenous populations who may have their own conceptions and methods of approaching mental health, well-being and healing, may be detrimental both to the individual and the collective. Mental health law often reduces persons experiencing distress to being a “problem”. Scant attention is given to the underlying economic, social and cultural factors causing the distress or discrimination, which affects the capacities of individuals, families and communities to overcome them (87). This framing often leads to stigma; an overemphasis on biomedical treatment options; undue attention to changing the individual rather than the circumstances in which they live; and a general acceptance of coercive practices (33).

Coercion remains a core component of existing mental health laws across jurisdictions (50) and is a major concern (Box 2). Coercion encompasses a broad range of practices in the context of mental health care, characterized by the use of force and threats (88, 89). Such practices may include involuntary hospitalization, involuntary medication, involuntary electroconvulsive therapy (ECT), seclusion, and physical, chemical and mechanical restraint. In general, mental health laws continue to assume the underlying correctness of coercive practices, which are deemed to be a legitimate form of “patient management” through clearly-specified parameters and safeguards (e.g. as a “last resort” and for the “shortest period of time”) (90).

Criteria for the use of coercion vary across jurisdictions. In most countries, having a mental health condition is the principal requirement for civil commitment, in addition to other variables, such as risk to self or to others, or need of treatment (91). A few countries also use lack of capacity or lack of “insight” as a criterion (92); others have further widened their criteria to authorize coercion within the community through community treatment orders. Although several countries have tightened their criteria for involuntary commitment, rates have not declined; rather they are increasing, even within well-resourced mental health care systems (50, 93).

In a study conducted between 2008 and 2017, it was found that 11 of 18 countries reporting data experienced an increase in involuntary hospitalization rates of up to 8.45% (92).

Another pressing concern is the practice of institutionalization, to which mental health legislation has directly contributed (94). The legitimization of civil commitment has contributed to high rates of people being admitted to and living in institutions; condoned discrimination and human rights abuses; entrenched barriers; and neglected reform towards systemic transformation. Having a clear legal mandate to close psychiatric and social care institutions and other similar facilities, and to provide people with the support they need in the community, could boost change in many parts of the world (95).

Mental health legislation also continues to serve as an instrument to reinforce asymmetrical power structures in society and, thus, sustain the exclusion and oppression of specific populations. It has traditionally regulated women and girls and their bodies through explicit provisions that override free and informed consent to their sexual and reproductive health and rights (96). For example, legislation may mandate sterilization, contraception or abortion – on the basis of alleged “best interests”, including to prevent harm to a woman or girl’s mental health.

Similarly, mental health laws often deny the rights of children and adolescents to express their views and be heard, taking into account their evolving capacities or identities (97). Mental health law has enabled the segregation and institutionalization of children in mental health or social care facilities. In these settings, services wield significant power and operate as gatekeepers; any decision to institutionalize a child violates the child’s rights, including to family life.

In many parts of the world, because of the lack of law enforcement and accountability mechanisms, people who are most marginalized – for example those from a low socioeconomic or educational background, or those who belong to a minority – are often denied the few protections mental health legislation may provide for. This leads to the proliferation of harm, both within and outside the mental health system. For example, “therapeutic communities” and “prayer camps” often target people from marginalized backgrounds and subject individuals to ill treatment such as shackling, confinement and punishment (54, 98). Although in some countries these practices are prohibited by law, the intersectional discrimination these groups face, together with the lack of state oversight, limits their access to any form of justice. In other cases, such as for undocumented migrants, the fear of law enforcement mechanisms or the presence of law enforcement officials in health care settings reinforces marginalization and exclusion.

Widespread human rights violations and harm caused by mental health systems, and enabled by mental health laws, has led to a legacy of trauma that impacts many individuals and communities, and spans generations. Indeed, the structural violence and harm exercised through and facilitated by mental health laws are, in themselves, forms of historical trauma (99, 100). The process of legislative reform calls for further social examination, research, and meaningful dialogue among all concerned. Legislation that supports a new paradigm for the enjoyment of the right to mental health could impact this legacy and enable its redress. This would require, above all, the engagement and participation of those who have lived experience to shape the law to reflect and respond to their perspectives, in the pursuit of recovery, reparation and healing.

There is therefore a need to rethink legislation on mental health, including stand-alone mental health laws, to ensure it does not continue to be a vehicle for the violation of rights, but rather serves as a tool to promote the exercise of rights and social inclusion.

Box 2

The case against coercion

Coercion is contested legally, ethically and from a clinical point of view.

From a human rights perspective, coercive practices in mental health care contradict international human rights law, including the CRPD. They conflict with the right to equal recognition before the law, and protection under the law, through the denial of the individual's legal capacity. Coercive practices violate a person's right to liberty and security, which is a fundamental human right. They also contradict the right to free and informed consent and, more generally, the right to health.

Coercion can inflict severe pain and suffering on a person, and have long-lasting physical and mental health consequences which can impede recovery and lead to substantial trauma and even death. Moreover, the right to independent living and inclusion in the community is violated when coercive practices result in institutionalization or any other form of marginalization (101).

Coercive practices in mental health care violate the right to be protected from torture or cruel, inhumane and degrading treatment, which is a non-derogable right (102). In 2013, the UN Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment (103) called on countries to impose a total ban on all forced and non-consensual medical interventions, including the involuntary administration of psychosurgery, electroconvulsive therapy, "mind-altering drugs", and the use of restraints and solitary confinement (104). More recently, the UN Special Rapporteur stressed that purportedly "benevolent" purposes, such as "medical necessity", "re-education", "spiritual healing", or "conversion therapy", do not vindicate coercive or discriminatory practices and may amount to torture (105). There is an immediate international obligation to end these practices.

Many experts have noted that compulsory treatment powers are ineffective in their own terms (84). There is limited evidence to support the success of coercion in reducing the risk of self-harm, facilitating access to treatment, or protecting the public (106–108). Predicting self-harm or the risk of harming others is both extremely difficult and ethically questionable (109, 110). Although mental health conditions are associated with both suicidal ideation and attempt, there is little evidence that risk assessment tools and coercive mental health treatment prevent suicide (111, 112).

In addition, there is considerable evidence that persons with mental health conditions and psychosocial disabilities are more likely to be the victims of violence than the perpetrators (113). Findings on the association between violence and certain mental health diagnoses need to be interpreted in the broader context of systemic

Box 2

The case against coercion [cont.]

discrimination (114, 115). Even in such cases, there are good and validated policy options for supporting these individuals without coercion. Furthermore, there is no evidence that coercion facilitates access to mental health care and, conversely, it may discourage people from seeking support (116–118). Against this background, the reasonableness of the restrictions placed by mental health law on fundamental rights does not hold, especially when there is a growing pool of non-coercive practices that can be implemented in their place (33). There is also a growing body of evidence that indicates that non-coercive practices lead to better mental-health outcomes (119–121).

1.4 The international human rights framework

The Universal Declaration of Human Rights (UDHR), commemorating its seventy-fifth anniversary in 2023 (122), set out, for the first time, the fundamental human rights to be universally protected. Building on the UDHR, the body of international human rights treaties has developed these rights and described them in more detail and what they entail. The treaties comprise two covenants – the International Covenant on Civil and Political Rights (123), and the International Covenant on Economic, Social and Cultural Rights (124) – and seven group-specific conventions, including the CRPD. All UN Member States have ratified at least one core international human rights treaty, and 80% have ratified four or more. All countries have obligations to respect, protect and fulfil the rights under the specific treaties that they have ratified (125). Other instruments have been adopted at the regional level, reflecting specific human rights concerns and providing for protection mechanisms.

Human rights are universal, inalienable, indivisible and interdependent. A human rights-based approach to mental health addresses political, economic, social and cultural barriers while empowering individuals and groups, especially those that are most disadvantaged. Adopting this approach contributes considerably to mental health policies, making them more holistic and responsive to individual needs. State actors have an obligation to respect, protect and fulfil all human rights in the provision of mental health care and support. Non-State actors have specific human rights responsibilities. The private sector has a responsibility to respect human rights – including, for instance, when it is part of the health care system.

The right to health is a fundamental human right which covers physical, mental and social well-being and is indispensable for the exercise of other human rights. Mental health is an integral and essential component of the right to health (126). The arbitrary division between physical and mental health has contributed to a situation of unmet needs and human rights violations in the context of mental health (127). The promotion, protection and realization of mental health should be regarded as a vital human rights concern.

The right to health is inclusive: it contains freedoms and entitlements, and is conditioned by the underlying determinants of health. It also contains the essential and interrelated elements of availability, accessibility, acceptability, and quality (known as the AAAQ framework) (128) which must be addressed holistically in the provision of mental health care. In addition, the right to health requires ensuring participation and accountability. A rights-based approach to mental health involves adopting a legal and policy framework explicitly grounded in the principles and obligations of human rights. This contributes to advancing reform in mental health policies, programmes and practices, and in identifying and challenging human rights violations within the health system.

The CRPD reinforces the protection offered by the existing international human rights framework in the field of mental health. Persons with psychosocial disabilities played a decisive role in the processes of negotiation, development and drafting of the CRPD. The CRPD enshrines the most advanced international human rights standards relating to the rights of persons with disabilities, including persons with mental health conditions and psychosocial disabilities. It challenges traditional understandings of disability, equality, and personhood, and supersedes previous “soft law” instruments, such as the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) (129).

The CRPD recognizes that disability is an evolving concept resulting from the interaction between persons with actual or perceived impairments and attitudinal and environmental barriers. For too long, under the medical model, mental health conditions and psychosocial disabilities were understood to be problems residing in the individual; the ultimate aim was to “cure” or “fix” the person so that they could become “normal” (130, 131). Rather than promoting social change, diversity and inclusion, the medical model implied that persons with mental health conditions and psychosocial disabilities needed, themselves, to change, which has led historically to disempowerment, discrimination and institutionalization.

The CRPD shifts the focus to the interaction between the individual and the environment (132). Under this model, persons with mental health conditions and psychosocial disabilities are part of human diversity. The CRPD also reaffirms that all persons with disabilities have the same rights as any other person in society. Policy responses should centre on removing barriers, supporting participation and embracing diversity, as opposed to reforming people to meet societal demands. This departure from the medical model does not dismiss the importance of access to health care interventions: rather it questions many current practices within the medical sector which undermine human rights and inclusion (133).

The CRPD embraces a substantive model of “inclusive equality” relevant to mental health care and support, which extends over four dimensions (134):

1. A recognition dimension: combating stigma, stereotyping, prejudice and violence and recognizing intersectionality.
2. A redistributive dimension: addressing socioeconomic disadvantages.

3. A participative dimension: reaffirming the social nature of people as members of social groups and the full recognition of humanity through inclusion.
4. An accommodating dimension: making space for difference as a matter of human dignity.

The Convention further expands the understanding of legal personhood in the international human rights system – that is, the ability to hold rights and act freely upon those rights. Focus is shifted away from restrictions towards support that enables individuals to make decisions for themselves and expand their capacities to do so, thereby challenging the coercive practices embedded in traditional understandings of human rights. The support paradigm of the CRPD is built around the recognition of the interdependence of the human experience. Support is fundamental to interdependence, expanding individual autonomy rather than undermining it (135).

Upholding the interdependence and indivisibility of rights, the CRPD, as with other group-specific conventions, erases the artificial division between civil and political rights on the one hand, and economic, social and cultural rights on the other, while appreciating the holistic nature and exercise of such rights. The Convention also imposes obligations of immediate effect, such as the duty of non-discrimination, and others which may be realized progressively, such as the right to access individualized support services. Progressive realization, nonetheless, entails an immediate obligation to take deliberate steps towards the full realization of such rights and ensure that any such steps are undertaken in a non-discriminatory manner (136). The CRPD also recognizes the importance of international cooperation and an enabling environment for development to support national efforts for the realization of rights (Article 32 of the CRPD).

The values, principles and standards of the CRPD, applied to the broader human rights discourse, provide a new perspective for creating an enabling legal and policy environment for the development of rights-based mental health systems, which prioritize the person's empowerment and active participation in their recovery (Box 3).

Box 3

CRPD provisions for a rights-based approach to mental health

The CRPD has contributed significantly to the field of mental health. The Convention has innovated the understanding of the human rights of persons with disabilities and of human rights standards in general. Its principles and provisions are relevant to mental health systems and services in their demand for the principles of equality and non-discrimination to be applied across the board. Persons experiencing distress or seeking care who may not self-identify as persons with psychosocial disabilities or who do not face disabling barriers are nevertheless protected under the CRPD because, under this treaty, discrimination based on a person's actual or perceived impairment or mental health condition is prohibited.

Legal capacity

Legal capacity is a precondition for the exercise of rights and for making autonomous health care decisions. In most legal systems, the legal capacity of a person can be restricted in many areas of life based on a mental health diagnosis or the lack of “mental capacity” (137). Often, a legal representative is appointed to make decisions on the person's behalf, or decision-making is delegated to medical personnel or to a court (138).

Article 12 of the CRPD recognizes that all persons with disabilities, including those with psychosocial disabilities, enjoy the right to exercise their legal capacity on an equal basis with others in all areas of life. Accordingly, a person's “mental capacity” cannot be the basis for denial of legal capacity. People should have the right to make legally-binding decisions and, if wanted, be provided with access to the support they may require in exercising their legal capacity, including formal and informal support (139). According to the CRPD, States Parties have an obligation to replace all forms of substitute decision-making, such as guardianship, curatorship, and conservatorship, with supported decision-making schemes (see [section 2.2.3](#)).

Liberty and security of person

The mental health legislation of most countries authorizes the deprivation of a person's liberty based either on a mental health diagnosis or impairment, or in combination with other factors, most commonly when the individual presents an alleged risk to self or others, or is deemed in need of care.

Article 14 of the CRPD reaffirms that persons with disabilities enjoy the right to liberty and security on an equal basis with others, and clarifies that “the existence of a disability shall in no case justify a deprivation of liberty”. The Committee on the Rights

Box 3

CRPD provisions for a rights-based approach to mental health [cont.]

of Persons with Disabilities has stressed that Article 14 establishes an absolute ban on deprivation of liberty based on impairment, thereby precluding all forms of involuntary commitment to mental health facilities, including on the basis of “dangerousness” or “need of care” (see [section 2.3](#)) (140). Despite growing consensus among human rights experts and mechanisms on these standards (23, 33, 86, 141–146), it continues to be maintained that involuntary commitment may be necessary in exceptional circumstances to protect people from serious harm or to protect others (147, 148). This difference in criteria reflects the ongoing transformation in perspectives and attitudes as well as tensions between CRPD standards and previous approaches to mental health law (149).

Free and informed consent

Currently, most mental health laws continue to restrict the right to free and informed consent for the treatment of persons with mental health conditions and psychosocial disabilities, and favour substitute decision-making.

Article 25(d) of the CRPD provides that States Parties ensure that health care for persons with disabilities is provided on the basis of free and informed consent; Article 15 stipulates that no one shall be subjected to medical or scientific experimentation without their free consent. Involuntary treatment has been interpreted as being a violation not only of the right to health, but also of legal capacity (Article 12), freedom from torture and ill-treatment (Article 15), freedom from violence, exploitation and abuse (Article 16), and personal integrity (Article 17) (150–152). A fundamental shift is needed to create an enabling legal framework for the development of mental health services that respect the rights of all service users and base all treatment decisions on the free and informed consent of the individual (see [section 2.3](#)).

Living independently and being included in the community

Historically, persons with mental health conditions and psychosocial disabilities have been subjected to practices of segregation, institutionalization and isolation in mental health and social care.

Article 19 of the CRPD recognizes the equal right of all persons with disabilities to live independently and be included in the community. This involves a person exercising freedom of choice and control over the decisions affecting their life, with the maximum level of self-determination and independence within society (153). Accordingly, persons

Box 3

CRPD provisions for a rights-based approach to mental health [cont.]

with mental health conditions and psychosocial disabilities must have the opportunity to choose how, where, and with whom to live, on an equal basis with others, without being obliged to live in a particular living arrangement, such as an institutional setting. Furthermore, they must also have access to a range of community support services, including individualized disability-specific support and mainstream services and facilities for the general population in the community.

Access to justice

Access to justice for persons with mental health conditions and psychosocial disabilities has commonly been restricted, affecting their right to a fair trial and denying them the possibility to contest arbitrary detention, forced treatment and abuses in mental health services. Examples include laws that restrict a person's right to file a complaint or stand trial; diversion from criminal, civil and administrative processes resulting in deprivation of liberty, forced treatment and institutionalization; lack of credibility; ineffective remedies; and lack of legal aid. These compounded barriers leave persons with mental health conditions and psychosocial disabilities without effective access to justice, increasing their risk of abuse and neglect within mental health services and beyond, and rendering them significantly overrepresented in the criminal justice system.

Article 13 of the CRPD sets out the obligation to ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations to facilitate their roles as direct and indirect participants in all legal proceedings (see [section 2.8.2](#)). In addition, States Parties are obliged to promote appropriate training for those working in the field of administration of justice, including police and prison staff.

1.5 Applying the human rights framework to legislation on mental health

Throughout history, mental health law has swung between periods in which procedural safeguards were expanded to allow greater autonomy, and times when they were severely reduced to favour rapid access to mental health services (154). In practice, however, the situation of persons experiencing distress has consistently involved constant neglect within both the community and institutions (155). At the core of this failure is the inability of mental health policies and systems to fully embrace human rights.

The international human rights framework requires countries to revisit legislation on mental health from a rights-based perspective. Any new direction must entail a break from the past in the biomedical model of mental health and the use of compulsory powers. This process of transition is likely to be complex; however moving towards new ways to understand, promote and support mental health and well-being is essential and requires a fundamental shift in mental health policy and service transformation.

The objectives for legislation proposed in this Guidance serve not as an endpoint for countries, but rather as a point of departure for their own journey of transformation. A central aspect is to build an enabling legal framework for the development of mental health systems that strive for the highest attainable standard of mental health and well-being for all people. Given the context and challenges described earlier, legislation should also aim at guaranteeing equal rights for people engaging with mental health systems, to counter the inertia of current harmful practices.

Objectives that legislation can pursue to advance a human rights approach to mental health and well-being include:

- setting a clear mandate and providing a solid foundation for the transformation of mental health systems that benefit the whole of society;
- enabling rights-based, person-centred, recovery-oriented services and initiatives in the community, including those that are peer-led and peer-run, both within and outside of the health system, which prioritize the person's empowerment and active participation in their own recovery;
- raising awareness, including among public sector officials, and supporting mental health promotion and community development strategies to address stereotypes, stigma, discrimination and social determinants, and improve the circumstances in which people live;
- developing and investing in a range of community-based programmes and services that are holistic and free from coercion and violence, both within and outside of the health system;
- explicitly upholding the rights to legal capacity and free and informed consent and supporting the eradication of discrimination, stigma, violence, coercion and abuse in services;
- setting out sustainable deinstitutionalization processes, ensuring the provision of adequate and appropriate economic and social support for the person to live independently in the community;
- ensuring that the expertise of persons with lived experience is recognized, and that they are closely consulted and actively participate in decision-making processes and the design, development, monitoring and evaluation of laws, policies, plans and services;
- allocating clear roles and responsibilities across government sectors and levels, and regulating the involvement of non-State actors;

- promoting the adoption of protocols and training on a human rights-based approach for health and social workers, first responders, police officers, immigration officials and other community actors; and
- securing the financing and resources necessary to carry out all the above objectives.

The following sections outline the main overarching directions to meet these objectives and explain how they align with and support a human rights-based approach to mental health.

1.5.1 A cross-sectoral approach to mental health and well-being

Achieving the highest attainable standard of mental health should be a strategic objective of every country. This requires a nationwide response that involves the health system and cross-sector coordination.

Strategic planning towards achieving this objective implies leveraging the strengths of certain sectors and countering the weaknesses of others. Health systems have strong transformative potential through their building blocks: organizing quality service delivery; mobilizing the workforce; strengthening information systems; providing access to medicines; mobilizing financial resources; and developing governance structures that provide for accountability. Economic, social and justice sectors are better prepared to address the social determinants of mental health, for example through anti-discrimination and equal opportunity strategies, community-based support systems, comprehensive social protection systems, housing, employment, climate change action, and the promotion of community structures that increase social recognition and the support of diversity. Legislation can help integrate mental health and well-being into all policies; mainstreaming facilitates their promotion across the life course as well as addressing social determinants.

Legislation often treats mental health as a separate regime, either through stand-alone laws or separate “mental health” sections in general health laws. This has been shown to emphasize the segregation of mental health, potentially reinforcing stigma and a siloed approach. Furthermore, these separate regimes reinforce the view that mental health is a specialized practice that requires exceptions to the equal exercise of rights, thus enabling arbitrary restrictions to generally accepted principles of the right to health, such as the right to free and informed consent.

Instead of adopting stand-alone legislation, countries should consider addressing mental health comprehensively in relevant pieces of legislation such as those related to health, patients’ rights, anti-discrimination, employment, or social protection. This approach would contribute to reducing stigma and underscore community inclusion. Moreover, by being part of mainstream legislation benefiting a much wider constituency, the possibility of differentiated standards may be reduced and opportunities for mental health-related provisions to be put into practice, increased. Where a stand-alone law already exists, it should be reviewed by countries to prevent separate or distinct regulation. Countries should also avoid the separate regulation of the rights of persons with psychosocial disabilities through stand-alone mental health laws, which are amenable to being mainstreamed into disability or anti-discrimination legislation. In this regard, it is important that disability-related legislation explicitly encompasses persons with psychosocial disabilities for them to benefit.

Mainstreaming mental health and well-being as a strategic objective in legislation should be developed in close consultation with, and the active involvement of, people with lived experience and with the commitment to integrate a rights-based and person-centred approach ([Box 4](#)).

Box 4

Examples of mainstreaming mental health as a strategic objective in general legislation

Typical provisions of stand-alone mental health law	Laws where provisions could be integrated
Access to mental health services	General health law
Mental health prevention and promotion	General health law; education law
Development of community-based mental health services and programmes	General health law; social care law
Prohibition of discrimination in mental health care	Anti-discrimination law; law on equal opportunities; patients' rights law
Rights of service users	Patients' rights law; social services law
Informed consent to treatment	General health law; patients' rights law
Advance directives	General health law
Supported decision-making	Civil Code; capacity laws; patients' rights law
Remedies	Patients' rights law; general health law; access to justice legislation; criminal law
Mental health in the workplace	Employment law
Rights of persons with psychosocial disabilities	Disability laws; anti-discrimination laws

1.5.2 Challenging stigma and discrimination

There is widespread and long-standing stigma associated with mental distress and unusual perceptions within society and mental health services themselves. Persons with psychosocial disabilities are commonly believed to be violent and dangerous, a stereotype that is consistently reinforced by the media. As a result, persons with mental health conditions and psychosocial disabilities are often treated with fear and contempt, and may be subject to human rights abuses. Within many mental health services, these prejudices are often reinforced through narrow biomedical understandings of distress and diversity that are uniformly applied, as well as the widespread practices of discrimination that occur in such settings and shape the attitudes of health professionals. Stigma that prevails in families, communities and even among health professionals can impact the self-perception of individuals experiencing distress and trauma, who sometimes internalize these negative attitudes, thus furthering their disempowerment and exclusion.

Tackling stigma and discrimination, and promoting inclusion contribute to creating a rights-based mental health framework. Not only does this clear the way for equal access to quality mental health services, it also serves to eliminate barriers to participating in the community, promotes acceptance to embrace diversity, and contributes to developing inclusive communities that foster attention to the mental health and well-being of their members (33). Awareness-raising is essential to changing attitudes that underlie stigma and discrimination. The CRPD is the first human rights treaty to include awareness-raising as a stand-alone provision (Article 8). The article sets out measures to foster respect for rights, and to combat stereotypes through the use of public awareness campaigns, as well as education and training that target health professionals, the wider public, the media, individuals themselves and their families.

Experiences of discrimination in accessing quality mental health services are manifold, particularly for persons belonging to marginalized groups who are at greater risk of intersectional discrimination. Legislation on mental health must recognize the universal nature of human rights and adopt and integrate the principle of equality and non-discrimination across policies and interventions. Allowing for limitations or lower levels of human rights standards for certain groups is contrary to the fundamental principles of human rights. Moreover, in addition to prohibiting all forms of discrimination, the principle of equality calls for positive action for all people to enjoy equality of rights, including provisions on accessibility, reasonable accommodation, individual support, and legal benefits. Specific measures such as quotas and other forms of affirmative actions may also be needed to accelerate or achieve equality for persons with mental health conditions and psychosocial disabilities, in the pursuit of the commitment to “leave no one behind”, as part of the 2030 Agenda for Sustainable Development and its goals.⁴

1.5.3 Access to quality, person-centred and rights-based mental health care and support

Many people around the world are denied access to quality mental health services and suffer from inadequate care. A rights-based approach to mental health calls for equal access to quality care, and support that is holistic and person-centred. Health facilities, goods and services for mental health must be available in sufficient quantity and be accessible and affordable on the basis of non-discrimination (128). They must also be gender-, age- and culturally-appropriate, of good quality and align to medical ethics, such as respect for autonomy and individual choice (128).

⁴See: <https://sdgs.un.org/2030agenda>.

Respecting human rights in mental health requires a person-centred approach based on people's unique identities and lived experiences. The CRPD calls for the respect of differences and an acceptance of human diversity, as well as the right of children with disabilities to preserve their identities (Article 3(d) and (h)). While the biomedical model frames mental health conditions as “brain diseases” that need to be treated with drugs, a human rights-based perspective embraces human differences and recognizes individuals experiencing distress or unusual perceptions as having a full set of diverse experiences and contexts and not as having a problem that needs to be “cured” or “fixed”. Through adopting a human rights-based perspective, feelings, behaviours and lived experiences are not addressed in isolation through medicalized interventions, but approached and understood in the wider context of human diversity and environmental factors (86).

Legislation that provides for this approach will not only challenge biomedical models that reduce mental distress and diversity to illnesses, but also reassess the role of mental health services in people's lives. Recovery is a personal process, different for every individual, and tied to self-determination, healing relationships, and social inclusion. Moreover, mental health services provided by the health sector, form one of many options that can benefit people in their recovery and help them pursue the lives they want to live. Nonetheless, some people may decide not to use such services for specific reasons that may include previous traumatic experiences with those services; these decisions must be respected and supported. Options that fully respect the self-knowledge, will and preferences of the individual, should be made available outside of the health care system as primary services without the need for mental health diagnosis or treatment. These services would be provided in the individual's own community, and include crisis support, decision-making support, support to heal from trauma, and other support needed to live in the community and to enjoy solidarity and companionship (12).

The rights of individuals, such as the right to social protection, cannot be contingent on the use of mental health care and support; mental health services must not become gatekeepers to the exercise of rights.

1.5.4 Transition to community-based mental health care and support

Although the importance of primary care has been reaffirmed since the Alma-Ata Declaration of 1978,⁵ mental health systems have yet to bring care and support into the community. An important aspect of a rights-based approach to mental health is ensuring that care and support are accessible and within safe physical reach for all sections of the population, especially marginalized groups (128). This makes it easier to maintain family relationships, friendships and employment while receiving care and support.

Article 19 of the CRPD calls for transforming care and support systems, including mental health services, to enable independent living and community inclusion. Practices of institutionalization and segregation of services have resulted in centuries of social exclusion and marginalization of persons with mental health conditions and psychosocial disabilities from their communities (33). To unlock and dismantle these systems, a strategy and plan of action to close psychiatric institutions and transform mental health services is needed to ensure respect for people's right to live in the community (156).

⁵ See: <https://www.who.int/publications/i/item/WHO-EURO-1978-3938-43697-61471>.

The transition to community-based mental health care and support can be facilitated by legislation. Reinforcement by law will also support the required transformation of service provision to ensure a range of community-based and person-centred services. This network of services should include multidisciplinary and de-medicalized options and draw on the expertise of people with lived experience.

1.5.5 Respecting legal capacity and informed consent, and eliminating the use of coercion

The CRPD sets obligations on States Parties to revisit their mental health systems to end all forms of coercion and to develop non-coercive responses that respect the rights of service users. This implies rethinking the role of legislation – from a focus on restrictions of rights to the provision of support to guarantee them.

An important aspect of this endeavour, in line with the support paradigm of the CRPD, is to respect and promote people’s autonomy. Respect for legal capacity and free and informed consent, without discrimination, must be at the centre of all reform efforts. Being able to make decisions is instrumental to a person in taking control over their life and choices, and thus for recovery and inclusion. In line with Article 12 of the CRPD, States Parties have an obligation to repeal legal provisions that authorize substitute decision-making and make supported decision-making available for persons with mental health conditions and psychosocial disabilities or, in general, for any adult who may want access to support for exercising their legal capacity.

The legal reforms necessary to recognize the full legal capacity of all persons with mental health conditions and psychosocial disabilities are many and fall beyond the scope of this Guidance (e.g. reforms of Civil Codes, family laws, laws on wills, and others). [Section 2.2](#) provides guidance on how the law can ensure respect for legal capacity in mental health systems and facilitate access to support measures for its exercise.

1.5.6 Participation

“Full and effective participation and inclusion in society” is a general principle set out in Article 3.c of the CRPD (157). The meaningful participation of all stakeholders, particularly those who are most impacted, in public decisions and policies on mental health and well-being, should be ensured through transparent processes. Historically, persons with lived experience have been seen only passively as “patients”, and not recognized as key contributors and partners in the development of mental health responses, while mental health professionals, service providers and family members have substituted their voices in decision-making processes.

Echoing the motto of the disability movement, “nothing about us without us”, Article 4(3) of the CRPD obliges States Parties to ensure the participation of persons with psychosocial disabilities, including children and adolescents, in all public decisions affecting them.

The meaningful participation of persons with lived experience at all stages of policy-making – from design and implementation to monitoring and evaluation – is key to upholding a rights-based approach to mental health and ensuring that their valuable expertise and experiences inform the development of relevant and effective policy responses (158, 159).⁶

Partnership and collaboration can further improve person-centred and rights-based responses and accountability, contributing to sustainable system transformation. With this objective, countries should support organizations of persons with diverse lived experiences to build their capacities to participate in decision-making and to claim their rights (160).

1.5.7 Community inclusion

Being included in the community means having equal opportunities and access to services and support to enable participation in all areas of life (161). The implementation of a human rights-based approach to mental health requires respecting the personal autonomy and independence of individuals, ending all forms of institutionalization, and responding both to people's immediate and longer-term needs which are shaped by social determinants and intersecting forms of oppression.

A critical role for mental health systems is thus to support people to access relevant services and support that can enable them to live and be included in the community, based on their own choices. For the most part, it is not the responsibility of the health sector to provide the range of support services that people may need. This is a primary obligation of other sectors and programmes such as social protection, housing, food security, children's affairs, education, and employment. Nonetheless, mental health systems can serve as an interface with these sectors, and vice-versa, to overcome barriers and obstacles in a holistic manner (33). Additionally, there is an overarching need for governments to transform and empower communities, so that they can better respond to distress and provide support to their members.

1.5.8 Accountability

Accountability is an important component of the human rights framework. Without accountability, human rights lack enforcement and are rendered meaningless. Governments and other actors are accountable to rights-holders, and mechanisms need to be established to define clear responsibilities, to measure and monitor progress, and to engage with rights-holders to improve policy-making. Countries can integrate accountability mechanisms in all aspects of mental health policy through legislation. Such mechanisms are central to monitoring and improving mental health systems and services. For example, complaint mechanisms can help to identify gaps and trends in the exercise of rights and serve to facilitate service improvement (162).

⁶ For additional guidance on participation see: Committee on the Rights of Persons with Disabilities: General comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention, CRPD/C/GC/7, 27 August–21 September 2018 (<https://digitallibrary.un.org/record/3899396?ln=en>).

Similarly, the work of monitoring and accountability bodies, such as courts, national human rights institutions and monitoring bodies, with the participation of persons with lived experience, contribute to raising the visibility of human rights challenges and fostering the respect and protection of human rights. Data collection and public access to information are also necessary to ensure transparency and to enable monitoring by both civil society and the general public (163).

Access to justice is also essential to accountability. It allows persons interacting with mental health services to challenge human rights violations and enforce rights, including the right to an effective remedy. Those who have suffered torture, ill-treatment and general violations of their human rights by the mental health system should be given effective reparations and redress. Effective remedies also entail the duty to investigate and bring to justice those who are responsible, to hold them to account, combat impunity and prevent repetition of violations. Training staff, including law enforcement officials, judges and lawyers, on the rights of service users and persons with mental health conditions and psychosocial disabilities is fundamental to understanding and recognizing the rights violations they encounter and ensuring people's access to effective remedies and redress. Finally, providing the necessary support and accommodations to people in accessing justice is another fundamental component required to achieve equality in this area.



Chapter 2

Legislative provisions for person-centred, recovery-oriented and rights-based mental health systems

Introduction

Chapter 2 aims to provide practical guidance on the legislative provisions that countries could adopt to support a human rights-based approach to mental health. It covers the main areas where legislation can protect, promote and support the implementation of provisions in international human rights treaties as they pertain to mental health. There is no hierarchical order among the areas covered. In some cases, further guidance will be needed to ensure full legal harmonization with international human rights standards.

Some of the areas covered in this chapter are beyond the strict realm of mental health systems but have a critical bearing on ensuring a holistic approach to service provision and enjoyment of the full scope of human rights. Regrouped as elements of cross-sectoral reforms, implementing these provisions is the responsibility of different sectors, not solely health.

A practical format is provided for the content of mental health-related provisions in legislation. Using real examples of different texts and provisions that various countries have adopted, some of which have been edited to better reflect current human rights language, the chapter offers detailed guidance for drafting rights-based provisions. These examples are not intended to be prescriptive: each country could consider and adopt legislation as part of a thorough process of assessment, legal review and stakeholder engagement (see [Chapter 3](#)). Furthermore, references to specific provisions from national legislation do not imply an endorsement of all aspects of such laws.

It is important that countries take into account the process of implementing laws when drafting their legislative provisions. Reviewing and amending existing mental health laws to ensure that they are consistent with the CRPD standards, but not embracing its paradigm shift, will not achieve the transformation required by international human rights law.

2.1 Ensuring equality and non-discrimination

Non-discrimination is a fundamental principle of human rights and is central to the enjoyment of all human rights, including the right to health. Mental health care and support must be provided to all persons without discrimination, and no one should be discriminated against in any way when accessing or using mental health and support services.

This section proposes legislative provisions to uphold the principle of non-discrimination in the mental health system and ensure the equal enjoyment of rights for all people in the provision of mental health services. Most of these provisions could be integrated into human rights laws, equality laws, anti-discrimination legislation or disability legislation, as well as in their health acts or any existing mental health laws. The different sections of this chapter are relevant to ensuring the principle of non-discrimination in mental health care, including the sections on respecting legal capacity ([section 2.2](#)), respecting free and informed consent and eliminating coercion ([section 2.3](#)), and accountability ([section 2.7](#)).

2.1.1 Prohibition of all forms of discrimination

Legislation is an important means to prohibit all forms of discrimination in health care, including mental health care. Discrimination can be direct, indirect, structural, multiple or intersectional, by association, and can include practices such as harassment and denial of reasonable accommodation (see [section 2.1.2](#)).

The prohibition of all forms of discrimination should cover all interactions with the mental health system, including access to treatment, quality of treatment offered, confidentiality, consent to treatment and access to information. Prohibited grounds of discrimination could include race, sex, gender identity or expression, sexual orientation, sex characteristics, age, disability, national, ethnic, indigenous or social origin, caste, migration or refugee status, language, religion, political or other opinion, among others.

In Mexico, the General Health Law as amended in 2022 (164), establishes a comprehensive list of prohibited grounds in Article 72 which states: “Every person has the right to enjoy the highest possible standard of mental health, without discrimination based on ethnic or national origin, skin colour, culture, sex, gender, age, disabilities, social, economic, health or legal status, religion, physical appearance, genetic characteristics, migratory situation, pregnancy, language, opinions, sexual preferences, identity, gender expression, political affiliation, marital status, language, criminal record or any other ground, that undermines human dignity and aims to annul or impair the rights and freedoms of individuals.”

Legal reforms may also be needed to remove structural barriers to accessing mental health care and support – that is, legal, administrative and other barriers that discriminate indirectly against certain groups. For example, legal obligations to report the irregular status of migrants using public services to law enforcement or immigration authorities which may prevent persons in such situations from seeking support.

In addition, countries can consider initiating a comprehensive review process to repeal all discriminatory legislation affecting persons with mental health conditions and psychosocial disabilities in different areas of life. As discussed in [Chapter 1](#), legislative reforms that go beyond the scope of this Guidance are required to ensure that persons with mental health conditions and psychosocial disabilities are recognized as having the same rights as everyone else ([Box 5](#)). For example, in some legal systems persons with mental health conditions and psychosocial disabilities are not allowed to access justice.



Examples of what the law can say

- Mental health services shall not discriminate on the basis of race, sex, gender identity or expression, sexual orientation, sex characteristics, age, disability, national, ethnic, indigenous or social origin, caste, migration or refugee status, language, religion, political or other opinion, or other grounds.
- All persons with mental health conditions and psychosocial disabilities are entitled to the equal protection and equal benefit of the law without discrimination.
- Discrimination on the basis of mental health status or psychosocial disability shall be prohibited. The prohibition shall apply to any distinction, exclusion or restriction, on the basis of an actual or perceived mental health condition or impairment, which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of rights, privileges, legal interests or benefits, in the political, economic, social, cultural, or any other field, and includes all forms of discrimination including denial of reasonable accommodation and discrimination by association.
- Denial of legal capacity and free and informed consent to treatment based on mental health status or psychosocial disability is discriminatory.

Box 5

Legal reforms beyond legislation on mental health

Addressing discrimination and achieving equal rights for persons with mental health conditions and psychosocial disabilities requires the introduction of legal reforms that go beyond the scope of this Guidance and the mental health sector. These reforms are essential for people with mental health conditions and psychosocial disabilities to exercise their rights on an equal basis with others. Important areas for legal reform include:

- Recognition of the right to equality before the law, including legal capacity in all aspects of life.
- Recognition of the right to access to justice, on an equal basis with others.
- Recognition of the right to obtain, possess and utilize documentation of identification.
- Recognition of the right to personal privacy, and protection of the privacy of personal, health and rehabilitation information, on an equal basis with others.
- Recognition of the right to own, inherit or administer property, on an equal basis with others.
- Recognition of the right to education, at all levels, and to lifelong learning.
- Recognition of the right to work, on an equal basis with others, and prohibition of discrimination in access, permanence, and conditions of work.
- Recognition of the right to an adequate standard of living for themselves and their families, including adequate food, clothing and housing.
- Recognition of the right to social protection; and elimination of discrimination in social protection programmes and entitlements.
- Ensuring that exploitation, violence and abuse against persons with mental health conditions and psychosocial disabilities, including gender-based violence, is prevented, identified, investigated and prosecuted.

2.1.2 Provision of reasonable accommodation

Apart from accessible infrastructure, services, information and communication (see [section 2.1.5](#)), some people may have individualized requirements to access information, make decisions, work, or interact with mental health care and support services. Reasons for these may include disability, gender identity, religion, and age. Mental health systems must, therefore, ensure the provision of reasonable accommodation to enable all service users to exercise their rights on an equal basis with others.

Reasonable accommodation is intrinsic to the duty of non-discrimination (165). As set out in the CRPD, “reasonable accommodation” involves any necessary and appropriate modification and adjustments, not imposing a disproportionate or undue burden, where needed in a particular case, to ensure the equal enjoyment or exercise of rights (166). Examples of denial of reasonable accommodation include not accepting an accompanying person during a consultation, or refusing to accommodate religious beliefs in mental health services.

The term “reasonable” refers to the relevance, appropriateness and effectiveness of the accommodation. An accommodation must achieve the purpose (or purposes) for which it is being made, and be tailored to meet the requirements of the individual (165). Furthermore, the concept of “disproportionate or undue burden” sets a limit to what a third party must do to provide an accommodation; an accommodation should not pose a possible excessive or unjustifiable burden on the accommodating party (165).

Anti-discrimination and other related legislation can ensure that people using mental health services are provided with reasonable accommodation as an intrinsic part of their right to equality and non-discrimination. Legislation must recognize and incorporate the denial of reasonable accommodation as a form of discrimination. For example, in the Philippines, the Mental Health Act of 2017 includes the denial of reasonable accommodation in its definition of discrimination (167). Given the importance of legal capacity, countries can recognize explicitly a duty to provide reasonable accommodation in the exercise of legal capacity (168).



Examples of what the law can say

- ◉ Denial of reasonable accommodation constitutes a form of discrimination. The prohibition of all forms of discrimination is an immediate obligation and not subject to progressive realization.
- ◉ A person using mental health services shall be provided with reasonable accommodation for the exercise of rights, if required.
- ◉ A request for reasonable accommodation for the exercise of legal capacity shall not be used to question a person’s legal capacity and is complementary to the right to support in the exercise of legal capacity.
- ◉ Guidance on how to assess whether a reasonable accommodation imposes a disproportionate or undue burden on the duty bearer shall be prepared by the competent authority.
- ◉ Earmarked funds for the implementation of reasonable accommodation shall be allocated by relevant public institutions.

2.1.3 Discrimination in health insurance

In many countries, individuals need health insurance to access health care and health-related services. Legislation in such countries could contain provisions to prevent discrimination against people when obtaining public, private or mixed health insurance for care and treatment related to physical and mental health (169). In the Marshall Islands, for example, legislation establishes that the fees for, and access to, health care, health services, health insurance, and life insurance must not differ on the basis of disability (170).

Legislation can also ensure that health insurance companies do not discriminate on the basis of either pre-existing mental health conditions or the predicted likelihood of mental health conditions, such as family history or alleged genetic predisposition. In many countries, private insurance will refuse covering such cases or will significantly increase premiums, raising equity concerns (171, 172).

Legislation can also ensure that mental health is recognized as being equal to physical health, and that funds are specifically earmarked for mental health (see [sections 2.4.1](#) and [2.4.2](#)).

Additionally, legislation can also support countries in the operationalization of their commitment to the 2030 Agenda, which is grounded on the UDHR and other international human rights instruments. UN Member States have committed to ensuring healthy lives and promoting well-being for all, at all ages (SDG3), as well as to achieving UHC (target 3.8). Efforts by States to realize the 2030 Agenda and their obligation to provide the necessary health insurance and health care facilities, goods and services to those who do not have sufficient means, are thus mutually reinforcing (173) (see [section 2.4.3](#)).



Examples of what the law can say

- ◉ Discrimination is prohibited on the basis of race, sex, gender identity or expression, sexual orientation, sex characteristics, age, disability, national, ethnic, indigenous or social origin, caste, migration or refugee status, language, religion, political or other opinion; or other prohibited grounds in the provision of health insurance.
- ◉ A person with mental health conditions and psychosocial disabilities shall have equal access to health insurance offered by public, private or mixed insurance providers.
- ◉ A person with mental health conditions and psychosocial disabilities shall have access to interventions, services and support offered by public, private or mixed health insurance, on an equal basis with others.
- ◉ Discrimination is prohibited for health insurance based on pre-existing psychosocial disability or a mental health condition.
- ◉ Mental health services should be covered by all health plans offered by insurers.
- ◉ Insurance premiums should be established in a fair and reasonable manner on the basis of actuarial and statistical estimations, and non-discriminatory assessments.

2.1.4 Challenging stigma and discrimination in communities

Legislation is fundamental in framing attitudes and behaviour towards people experiencing distress, or diagnosed with a mental health condition, and persons with psychosocial disabilities (174). The law itself can reinforce stereotypes and prejudice; for example, some legislation in force today contains derogatory terms, such as “idiot”, “lunatic”, “of unsound mind” or “mentally ill”, and carry significant symbolic value, negatively impacting public and self-stigma. The biomedical model of mental health in law and policy, which emphasizes biological understandings of distress, and disregards the role of environmental and social factors, can also reinforce stigma and self-stigma by framing distress as an individual problem and creating a fatalistic view of recovery (175, 176).

Furthermore, discriminatory laws reinforce a culture of stigma, shame and secrecy around distress, trauma and disability. This environment discourages people from seeking support and often results in marginalization and human rights violations. The criminalization of suicide and the legal authorization of coercive and other discriminatory practices are important drivers of stigma and actual manifestations of discrimination in health systems and communities (see [section 2.3](#)). Confronting discriminatory practices resulting from stigma is critical for challenging stereotypes and prejudice around mental health.

Other ways in which law reform can be used to help address mental health stigma include mandating action related to raising mental health awareness, and mental health training for health care providers and other actors, including the general public. These could be developed in collaboration with persons with lived experience (see [section 2.4.8](#)). In the United States of America, some states have mandated mental health education in public schools as a way to improve students’ mental health awareness (177). These measures can help to destigmatize mental health and distress, promote acceptance and inclusiveness of diversity, enable understanding of the role of social determinants, and debunk myths that link mental health conditions and violence.

It is important that awareness and training initiatives on mental health are guided by a human rights-based approach and do not reinforce a biomedical paradigm. As stigma is a social process which is dependent on power structures, changing attitudes and behaviour towards people who are experiencing distress, are diagnosed with a mental health condition, or have psychosocial disabilities, require multifaceted and multilevel interventions that address contextual factors and power imbalances (178). Hence, the importance of people with lived experience participating in public life. Through shaping the narratives of diversity and inclusion, mental health services, and community support systems, people with lived experience play a vital role in reducing stigma and discrimination (see [section 2.6](#)).

Prejudices and discriminatory attitudes within mental health services can also lead to incorrect diagnoses and interventions. Biases in psychiatric diagnosis are well documented: racial and gender biases have been shown to lead to both overdiagnosis and underdiagnosis of mental health conditions (179, 180). In addition, existing diagnostic tools and criteria have been criticized for being too broad and all-encompassing to be clinically helpful, thus potentially leading to ineffective, stigmatizing and harmful interventions (181). As noted by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, mental health diagnoses have been misused to pathologize identities and other diversities (182). Although combating the medicalization of everyday life is beyond the scope of the law, legislation can establish certain frameworks to prevent its misuse.

People should have the right to a second opinion or to reject a diagnosis if they believe it does not characterize their experience in a helpful way (183). Every person should be allowed to define their own lived experience. A diagnosis should never be used to deny or limit rights.



Examples of what the law can say

- Stigmatizing and discriminatory terminology related to mental health and marginalized groups, including persons with psychosocial disabilities and lesbian, gay, bisexual, transgender, intersex and queer persons, shall be removed and replaced with appropriate language.
- The mental health authority shall conduct awareness-raising programmes, in collaboration with persons with lived experience, to combat stigma and discrimination in mental health services.
- The health authority shall ensure mandatory mental health training for health care providers and other actors, developed in collaboration with persons with lived experience.
- Public campaigns to improve awareness of mental health, and respect for diversity and the rights of persons with mental health conditions and psychosocial disabilities, shall be conducted in a multisectoral manner and with the active participation of persons with lived experience.
- The Ministry of Education shall ensure that mental health education is included in the school curriculum, to increase awareness about mental health, and the human rights-based approach to mental health.
- Mental health diagnosis shall not be determined on the basis of political, economic or social status; membership of a cultural, racial or religious group; age; or for any other reason not directly relevant to the mental health status of the person.
- Gender or sexual diversity, or non-conformity with moral, social, cultural, work or political values or religious beliefs, prevailing in a person's community must not be used as a reason for making a psychiatric diagnosis.

2.1.5 Equal recognition of rights within mental health services

No one accessing mental health care and support should be limited in their rights. Every person using mental health services should be recognized as having equal rights to all people within mental health settings. In efforts to ensure this, some countries have established charters, or a list of rights of users of mental health services, that must be respected. However, in most cases these lists are incomplete, set exceptions, or are misinterpreted as being exhaustive. Legislation can indicate the rights of all people using mental health services as being equal to those using other general health services, with no limitations based on diagnosis or capacity. Exceptions to the enjoyment of any rights based on mental health status or psychosocial disability constitute discrimination and should be abolished.



Examples of what the law can say

- A person using mental health services shall enjoy, on an equal basis with others and without discrimination, all rights guaranteed by national and international law.
- A person using mental health services shall enjoy the same conditions and standards of treatment as people in all other health settings.
- The rights of all persons using mental health services shall be respected, protected and fulfilled.

The law can also ensure that every person using health services is recognized as having equal rights in access to information, communication, confidentiality, and privacy. These rights are not specific to persons with mental health conditions and psychosocial disabilities. The protection of these rights is particularly important in inpatient services but must also be upheld across all types of services, including those that are community-based. These rights should not be denied or restricted by mental health services or professionals.

Access to information

People using mental health services have the right to access information about their diagnosis, treatment, prognosis and health-related data on an equal basis with others (184). This includes copies of medical files, records and other relevant reports and documents. Information should be available in all relevant languages and provided in a way that is not oversimplified or paternalistic but is clearly understood by service users, and which respects their dignity. If desired, users should be allowed support from someone they trust or from an independent advocate. Information should be provided in accessible formats, such as Easy Read, and augmentative and alternative communication.

Protocols on access to information can be developed to ensure respect for the dignity and privacy of those concerned, including for example, the offer of support to review and explain the information in people's file or record. A service user should have the right and means to complain to an independent authority about a lack of access to their medical files, as well as any other potential issues.



Examples of what the law can say

- A person using mental health services is entitled to receive full information, in an individualized form and accessible manner, about their diagnosis, treatment and prognosis.
- Prior to any intervention, a person using mental health services is entitled to receive, in a clear and understandable manner, detailed information concerning:
 - their state of health, including their medical assessment;
 - the proposed examinations and interventions;
 - the anticipated effects of any examination or intervention offered, including the potential benefits, risks, side effects and harms;
 - their right to decide on the proposed examinations and interventions; and
 - information about possible alternative procedures.
- A person using mental health services is entitled to ask further questions during and after receiving the information.
- A person using mental health services is entitled to know the results of the individual examinations and interventions carried out during their care.
- Medical records shall be completed at the time of service and in a way that respects the dignity and privacy of the individual.
- A person using mental health services is entitled, upon request, to access and receive copies of information and documentation contained in their medical and other health records; these should be provided in accessible formats where required.
- The right of access to medical records can also be exercised by duly accredited legal representatives.
- A person using mental health services has the right to request that their comments be inserted in the medical records without altering the existing records.
- A person using mental health services has the right to complain or take legal action if the right to information is not respected.
- Staff working in mental health services shall receive training in the use of accessible formats.

Confidentiality and personal data protection

People using mental health services have the right to the protection of their health-related information, on an equal basis with others (184). Such information should not be disclosed to third parties without the consent of the person concerned. In areas such as employment, education, health insurance, and migration, disclosure commonly leads to discrimination.

Professionals working in the field of mental health are bound by rules and codes of conduct that generally include confidentiality and the protection of personal data. It is important that the exchange and disclosure of data between health workers be limited to information necessary for the coordination or continuity of care (185). It is important that all members of the mental health care team are aware of the rules that bind them to maintaining confidentiality. Authorities in charge of mental health settings can ensure that adequate procedural safeguards and systems are in place so that only relevant, authorized individuals can access people's medical records, clinical notes, cloud-storage or other electronic data-recording mechanisms. This may include explicit and binding firewalls between immigration enforcement and health services. Legislation may also protect confidentiality by providing sanctions and penalties for breaches.

Disclosure of information related to mental health for purposes other than providing health care – for example, for planning, improving or monitoring health care services, or facilitating the work of independent human rights-monitoring mechanisms – may be permitted if authorized by law under necessary and proportionate criteria, and on an equal basis with other health-related information (186). Insurance companies, employers and external contractors cannot have access to this information without the consent of the person concerned (187).

Individuals cannot be compelled to disclose their mental health-related information or disability status. Where proof of disability is needed to access a benefit or service, certification by an authority is generally sufficient (188).



Examples of what the law can say

- Persons using mental health services must enjoy equal rights to personal data protection and statistical confidentiality as every other person.
- Health services shall keep confidential all information, communications, records and personal data related to an individual's physical or mental health, including the provision of health care services.
- Information, communications, and records shall not be disclosed to, or shared with, third parties, including families, without the written consent of the person concerned. Records shall be kept that relate to the provision of information and communications to the service user.
- The exchange and disclosure between health workers and services of data related to a person's mental health must be limited to information necessary for the coordination or continuity of care, and subject to rules of confidentiality.
- All health services shall have a confidentiality policy.
- The request by employers or educational centres for mental health certificates when applying for a job, or as a requirement for admission to an educational centre, is prohibited.
- A person using mental health services has the right to complain or take legal action if confidentiality is not respected.

Privacy

Every person has the right to privacy. The right related to privacy limits the extent to which society can intrude into a person's affairs, and protects the privacy of personal information, communications, bodily privacy, and privacy of personal environment. This right is frequently violated for persons using mental health services, particularly by staff in inpatient settings.

Legislation can establish a clear mandate to guarantee the right to privacy within mental health services; interferences may only be permissible if they are neither arbitrary nor unlawful. The use of new technologies in the context of mental health care, such as online counselling, mental health apps, biometric monitoring technologies (e.g. video sensor, or "smart pills") and other algorithmic and data-driven technologies, pose significant ethical challenges which warrant robust legal and regulatory protective frameworks (183). These may include assessments of human rights risks and impacts, to be carried out with the participation of persons using mental health services, as well as transparency guarantees, independent oversight, and access to remedies relating to the use of new technologies in the context of mental health services, and the adoption or review of data protection legislation in line with human rights obligations.



Examples of what the law can say

- ◉ A person using mental health services has the right to privacy on an equal basis with others, both in physical spaces and online.
- ◉ All health interventions shall be conducted in a manner that respects a person's right to privacy.
- ◉ A person who receives inpatient services shall have the opportunity and right to communicate and correspond with others privately, including counsels and personal representatives.
- ◉ A person who receives inpatient services shall have the right to appropriate space and privacy in order to practice their cultural, religious or spiritual beliefs.
- ◉ The health authority shall adopt regulations to ensure data safety, transparency, and independent oversight of digital mental health services.

Communication

Persons using mental health services have the right to freely communicate with anyone they choose, on an equal basis with everyone else. Communication is important for ensuring accountability, and can operate as an informal monitoring system, preventing violence and abuse. Regrettably, in many inpatient mental health services, communication is curtailed and monitored; correspondence is opened and sometimes censored on the basis of the “best interests” standard. Intimate meetings with family, including a person’s spouse and friends, are also often restricted. Even in some outpatient services, communication is occasionally limited. Legislation can explicitly ban such practices by moving away from “best interests” towards the equal recognition of rights.

People using inpatient mental health services should enjoy and exercise their right to access information. This includes regular and meaningful access to newspapers, television, radio and the Internet, on an equal basis with others.



Examples of what the law can say

- A person using mental health services has the right to communicate with anyone they choose on an equal basis with others.
- A person who receives inpatient mental health care has the right to freedom of communication, which includes the freedom to communicate with other people within and outside the service; to send and receive private communications without censorship; to receive, privately, visits from a personal advocate or representative and, at any appropriate time, from other visitors; and have access to postal and telephone services, newspapers, radio, television and the Internet.

Receiving information about rights

People using mental health services are frequently unaware of their legal rights and thus unable to exercise them. Legislation could provide for service users to be informed of these when interacting with both primary care and inpatient mental health services. Their rights, and how they may be exercised, could be explained in ways that can be clearly understood.

Relevant information about rights should be communicated in a format and language that is understood by the person, in an age-appropriate manner. Accessible formats such as Easy Read, sign language interpretation and augmentative and alternative communication, should be used where appropriate.



Examples of what the law can say

- A person using mental health services shall receive, in a clear and understandable way, and at the time of any contact, both verbal and written information about their rights, how to exercise them, and how to access available complaint mechanisms.
- The rights of persons using mental health services must be displayed visibly for service users in all public and private health care settings that provide mental health care.
- All information about rights in mental health services shall be available in accessible formats.

Physical and social conditions within services

The provision of safe, hygienic and comfortable mental health services is critical to a person's recovery and overall well-being. When receiving care and support, no individual should be subject to unsafe or unsanitary conditions, such as lack of water and sanitation, dirty or dilapidated walls and floors, or bad heating. Substandard conditions, particularly in inpatient services, may constitute torture and ill-treatment (189).

Conditions in mental health services should be as good as in any other health care facility where inpatient treatment, care and support is provided (190). The design of services should follow universal design principles. Legislation and subsequent regulations can set minimum requirements for a safe, hygienic, therapeutic and welcoming living environment, including where social interaction and activities are facilitated (191). Monitoring and accountability mechanisms are important to ensure these obligations are upheld (see [section 2.7](#)).

In some mental health services, under the guise of occupational therapy, service users are forced to work. Such practice constitutes inhuman or degrading treatment and is in breach of Articles 7 and 8.2 and 8.3 of the ICCPR. Although the use of forced labour and exploitation may be banned in legislation, certain areas are unclear; for example, situations where service users, as part of a programme, must participate in household activities, such as making their beds or preparing meals. Legislation should provide as much clarity as possible and ensure the voluntary nature of occupational activities.

The WHO QualityRights module, *Transforming services and promoting rights* (192), together with the *WHO QualityRights assessment toolkit* (190), provide countries with practical information and tools for assessing and improving quality and human rights standards in mental health and social care facilities.



Examples of what the law can say

- ◉ Mental health services shall be physically accessible for persons with disabilities.
- ◉ Mental health services shall comply with the standards of hygiene and safety applied to all health facilities and services.
- ◉ Inpatient mental health services shall provide an environment that is welcoming, comfortable, stimulating, and conducive to recovery.
- ◉ A person who receives inpatient services shall have appropriate space to practice physical activities, sports and other leisure activities.
- ◉ The health authority shall adopt regulations to ensure proper standards in relation to mental health inpatient services, including adequate and suitable accommodation, food and care. Such regulations may prescribe requirements relating to design, maintenance, repair, cleaning and cleanliness, ventilation, heating and lighting.
- ◉ Persons using mental health services shall be protected from forced labour and exploitation in health care and social services.

2.2 Respecting personhood and legal capacity in mental health services

Legal capacity is the attribute of a person to have rights and to exercise those rights. In most countries, persons with a mental health diagnosis and those with psychosocial, intellectual, or developmental disabilities, are often considered to lack capacity for decision-making and, therefore, are denied the ability to uphold their rights by themselves. This situation is particularly prevalent in mental health services, where people are often treated as objects of care rather than as subjects of rights.

Article 12 of the CRPD reflects a deeper and fuller understanding of legal capacity by emphasizing its universality and relevance in all aspects of life, including health. It also provides for access to the support people may require in exercising their legal capacity.

Recognizing legal capacity and supported decision-making is a precondition to exercise the right to health and related rights. All people using mental health services, including persons with psychosocial, intellectual and developmental disabilities, must have the right to make decisions for themselves about their health and medical treatment, and to have those decisions recognized as valid under the law.

This section proposes legislative provisions that respect the legal capacity of people using mental health services and to provide them with appropriate support if required. To ensure that the legal capacity of persons with psychosocial, intellectual and developmental disabilities is not restricted in other areas of life, it is important for countries to comprehensively examine all areas of law, including civil codes, guardianship or family laws, and mental capacity acts (193). Although these wider reforms are outside the scope of this Guidance, they are essential for a person's full participation and inclusion in the community.

2.2.1 Respecting legal capacity in mental health services

Since the adoption of the CRPD, several countries have included provisions recognizing the legal capacity of persons with disabilities, including those with psychosocial, intellectual and developmental disabilities (194). In some countries, the recognition of legal capacity has been provided in laws relating to mental health to reaffirm that persons with mental health conditions and psychosocial disabilities enjoy legal capacity in the context of mental health service provision and also to facilitate their access to supported decision-making (see [section 2.2.3](#)).

By establishing a clear mandate, legislation can help mental health services respect the legal capacity of all service users. Exercising legal capacity in the context of mental health services is not reduced to respecting free and informed consent (see [section 2.3](#)) since legal capacity can be denied in many ways; for example, by limiting the ability to appoint supporters, file complaints or reports, or participate in clinical trials. Legislation can further recognize the “dignity of risk” of service users, that is, the right of persons to make their own decisions and to take risks.

Respecting legal capacity does not involve ignoring people's diverse decision-making skills or abilities; rather, supported decision-making regimes should be made available in recognition of this diversity. Having different decision-making skills or a mental health diagnosis should not lead to the restriction of people's legal capacity to make their own decisions and for others to respect these.

Supported decision-making may include establishing mechanisms that enable people to appoint one or more trusted persons of their choice to assist them in accessing relevant information, and in weighing up the pros and cons of a particular decision, and asserting their decisions and choices (see [section 2.2.3](#)). It may also involve the implementation of advance planning mechanisms that allow people to express their will and preferences regarding future situations at a time when they are in a position to communicate them (see [section 2.3.2](#)). Laws that stipulate compliance with such mechanisms by mental health services uphold respect for legal capacity of all persons with mental health conditions or disabilities on an equal basis with others, including in cases where a person may be unable to articulate their will and preferences (195).

Provisions for the respect of legal capacity within mental health services are sometimes contradicted by other provisions within the national legal framework. However, mandating respect for the legal capacity of all persons using mental health services, helps to reinforce a paradigm shift and can be a first step to opening the space for further law reforms and court interventions in accordance with new provisions (196).



Examples of what the law can say

- ◉ Every person using mental health services is entitled to: (a) be recognized as a person before the law and as having legal capacity on an equal basis with others; and (b) be provided access to the freely chosen support they may require to exercise their legal capacity.
- ◉ Mental health services shall respect the legal capacity of all persons with mental health conditions or disabilities on an equal basis with others at all times, including in crisis situations.
- ◉ No person shall be subjected to any limitation of their legal capacity based on an actual or perceived mental health condition or impairment; or an actual or perceived difficulty in decision-making.
- ◉ A person using mental health services has the same rights as other members of the community to make decisions that affect their lives – including decisions involving risk – and to be supported in making those decisions if requested.

2.2.2 Prohibiting substitute decision-making in mental health services

An important aspect of upholding the legal capacity of people using mental health services, including those with psychosocial, intellectual and developmental disabilities, is ending “substitute decision-making”. The latter occurs when:

- legal capacity is removed or restricted from an individual, even if this is with respect to a single decision;
- substitute decision-makers such as guardians, judges or experts are appointed by someone other than the individual concerned against their will; or
- decisions are made by substitute decision-makers based on the “best interests” of the individual concerned, rather than on the will and preferences of the individual themselves (197).

Countries such as Colombia, Costa Rica, Georgia, Spain, and Peru have abolished guardianship and other substitute decision-making regimes from their legal systems. Although these reforms have limitations, particularly in the context of health decisions, they open possibilities for other countries to follow suit.

The law can prohibit substitute decision-making in the provision of mental health care and support. This includes repealing the provisions that allow guardians and family members to make decisions for people receiving mental health care or support, as well as eliminating all instances in which the law allows the treating doctor to decide for the person in their “best interests”. The law can also expressly prohibit health professionals from making decisions without the person’s informed consent (see [section 2.3.4](#)) and facilitate access to supported decision-making (see [section 2.2.3](#)). Implementing supported decision-making options while maintaining substitute decision-making regimes, is insufficient to comply with Article 12 of the CRPD (198).

2.2.3 Making supported decision-making available for people using mental health services

Legislation on mental health can make supported decision-making available for service users who may want support to exercise their legal capacity in the context of mental health care.

While the scope and formality of supported decision-making may vary among different countries, generally it allows individuals to appoint one or more persons to assist them to: i) obtain and understand information; ii) evaluate the possible alternatives and consequences of a decision; iii) express and communicate a decision; and/or iv) implement a decision (199). People should be free to choose from regimes and arrangements of varying types, intensities and formalities; for example, circles of support, support networks, support agreements, peer support, independent advocates, personal ombudspersons, personal assistance, advance directives, support from family and friends, and online communities.

Regulation of the provision and access to these different forms of support does not fall under the domain of legislation. Nonetheless, it is important that the law concerning mental health provision recognizes and reinforces supported decision-making in the exercise of legal capacity for people using such services, including those with psychosocial, intellectual and developmental disabilities.

For example, legislation can establish specific forms of supported decision-making taken in the context of health and related social services. This support can include the right to be accompanied and supported by a trusted person when making health care decisions; the adoption of advance directives; and the appointment of nominated persons to be informed and/or consulted during a crisis (see [section 2.3.2](#)). Legislation can also ensure that advocates who are truly independent from mental health services are available to provide support and advocate on behalf of people's rights at no financial cost. The lack of financial resources should not be a barrier to accessing support in the exercise of legal capacity (200).

Some countries have legislated co-decision-making regimes where a co-decision-maker can be appointed to help an individual to make decisions jointly. This involves the co-decision-maker and the individual jointly consenting to interventions. Such arrangements cannot be considered as a form of supported decision-making unless they are voluntary. The individual has the right to select the co-decision-maker and to end or change the relationship at any time (201). Supported decision-making should never be imposed on people. If a person chooses not to have support, their wishes should be respected.





Examples of what the law can say

- ◉ A person using mental health services shall be provided with access, without undue influence or coercion, to the support that they consider appropriate to exercise their legal capacity. The person concerned determines the form, identity, scope, duration and number of supporters.
- ◉ Supported decision-making is a form of assistance that facilitates the exercise of a person's legal capacity. Support may entail: i) understanding the options, responsibilities, and consequences of a person's decisions; ii) accessing, collecting, and obtaining information that is relevant to a given decision; iii) understanding such information; and/or iv) implementing the person's decision, including assisting in communicating the person's decision as regards third parties.
- ◉ A support person, based on the consent of the person concerned, shall have the authority to: i) access the person's medical information and records; ii) assist the person in relation to any proposed treatment or therapy; and/or iii) be present during the person's appointments and consultations with mental health professionals, workers and other service providers, during the course of a treatment or intervention.
- ◉ Mental health services shall recognize and respect the agreements and arrangements of supported decision-making.
- ◉ The existence of an agreement or arrangement for supported decision-making does not preclude a person from exercising their legal capacity to make decisions without support.
- ◉ Independent advocates shall be available in mental health services, upon request at any time, to provide support to service users to access information, understand their rights and options, and have these and their will and preferences respected. Advocates must be independent of the mental health services; perform services free of charge; have appropriate experience and training as well as secure and sustainable funding; be guided by human rights principles; and include persons with lived experience. Mental health services shall facilitate the exercise of the functions of independent advocates and ensure their access to every person and service.
- ◉ Advocacy services should also be available for family members and informal carers of persons using mental health services.

2.2.4 Safeguarding will and preferences

Legal safeguards are needed so that the rights, will and preferences of the individual being supported are respected, and to prevent abuse. Safeguards are not intended to prevent people from making decisions, nor from them taking risks: the goal is to ensure that the person's will and preferences are respected (202). Hence, safeguards must: i) be based on the person's rights, will and preferences; ii) offer protection against conflict of interest, exploitation, abuse and undue influence; iii) be proportional and tailored to the individual; and iv) include complaint and redress mechanisms.

While safeguards for the exercise of legal capacity should be addressed in the general legislation on legal capacity, legislation on mental health can ensure that these safeguards are respected in the field of mental health care and support, particularly in countries where reform on legal capacity is not yet in line with the CRPD.

Respecting will and preferences in supported decision-making

Support should not amount to substitute decision-making. Legislation can mandate that supported decision-making in mental health services must respect the will and preferences of the person concerned, including the right to refuse support and terminate or change the support relationship at any time (203).

Ensuring that persons using mental health services have access to different forms of support, including independent advice, also contributes to reducing the risk of undue influence.



Examples of what the law can say

- Support for the exercise of legal capacity shall be provided in accordance with the will and preferences of the person concerned.
- Safeguards shall be established to guarantee respect for the rights, will and preferences of the person concerned; and to prevent conflict of interest, exploitation, abuse and undue influence of the supporter.
- A supporter is prohibited from: i) exerting undue influence upon the person being supported; and ii) acting outside the scope of authority provided in the supported decision-making agreement or arrangement.

Protection against abuse and undue influence

Legislation can help to offer protection against abuse and undue influence in supported decision-making in the mental health context. Undue influence occurs when the support person takes advantage of a position of power over the person being supported, reflected in “signs of fear, aggression, threat, deception or manipulation” (204).

Legislation can include accountability mechanisms to ensure that the person’s will and preferences are respected, as well as mechanisms to challenge the action of a supporter should they not be acting in accordance with them. Mechanisms could include mandatory reporting, periodic review, accessible complaint mechanisms, information requests, and third party monitoring, among others. These should be implemented with respect for the person’s autonomy and privacy. Persons who use support need to be informed of their rights and the complaints mechanisms available.

Legislation can also regulate clear rules of conduct for those who provide support, such as acting diligently and in good faith, or keeping personal information confidential, in addition to respecting the will and preferences of the person supported. In some legal systems, there are limitations on who can be supporters; these include not having a pending litigation with the individual concerned, or not having a conflict of interest in relation to the decision to support.



Examples of what the law can say

- ◉ Safeguards are measures designed to ensure that supported decision-making arrangements respect the rights, will and preferences of the person concerned and are free of conflict of interest and undue influence.
- ◉ Safeguards shall be established in a proportional manner and according to the circumstances of the person concerned.
- ◉ The inclusion of safeguards in supported decision-making arrangements is mandatory.

Best interpretation of will and preferences

In some exceptional cases, it is difficult – sometimes impossible – to know a person’s will and preferences. For example, when a person is unconscious, or is experiencing mental health issues for the first time, and there is no one with intimate knowledge on communicating with a person with significant communication difficulties. For these situations, the Committee on the Rights of Persons with Disabilities introduced the standard of best interpretation of will and preferences (205). This standard implies ascertaining what the individual would have wanted instead of deciding on the basis of their “best interests”.

While the notion of best interests varies across jurisdictions, determinations of “best interests” often rely on an external evaluation of the person’s care and welfare needs, which may conflict with what the person wishes. The best interpretation of will and preferences involves consideration of the person’s life trajectory: their beliefs, values, attitudes, feelings and everyday actions, including non-verbal cues. This interpretation process is complex and can be resource- and time-intensive. Moreover, there is a risk that the person’s will and preference are “manufactured” to meet the wishes of the supporter. Nevertheless, this approach is better than attempting to determine “what is good for them” because it keeps the will and preferences of the person at the centre of all efforts. To prevent abuses, countries must strictly regulate the use of the “best interpretation” standard and ensure that it is used only as a last resort and after all significant efforts have been made. It should also be subject to close judicial review to prevent abuse.

The application of the best interpretation standard in the mental health field should be carefully considered and discussed with the active engagement of persons with lived experience. A significant concern, particularly from people with psychosocial disabilities, is that mental health services, based on widespread existing prejudices and paternalism, may consider people in crisis, experiencing intense distress, or having unusual perceptions to be unable to express their will and preferences – a situation which can also occur with people with intellectual or cognitive disabilities, about whom there is a strong presumption of “incapacity”. As a result, they may be hospitalized and medicated without their consent, and even if they actively refuse it (206).



2.2.5 Respecting children's evolving capacities

Children should be involved in decisions related to their health care in a manner consistent with their evolving capacities (207). As set out in Article 12 of the Convention on the Rights of the Child, States Parties have the obligation to respect the right of children to express themselves and to participate in all matters affecting them, in accordance with their age and maturity.

Legislation can ensure the child's views are actively sought and given due weight in health care-related decisions in accordance with their evolving capacities. Children should be provided with adequate and appropriate information in order to understand all the relevant aspects in relation to health care decisions, and be allowed, where possible, to give their consent in an informed manner (208).

Adolescents⁷ should be provided with access to information that is essential for their health and development in order to make appropriate health behaviour choices (208). It is important that legislation also recognize their right to confidential mental health counselling and advice without the consent of a parent or guardian, if they so wish (208). This obligation is distinct from the right to give medical consent and should not be subject to any age limit (208). While involving parents or guardians in young people's health care decisions is sensible, many adolescents will not seek support if they are forced to involve their parents.

Legislation can also ensure that mental health services respect the will and preferences of children and adolescents who have received a mental health diagnosis or have a psychosocial, intellectual and developmental disability, on an equal basis with other children (209). In addition, legislation can recognize the right of children and adolescents to be provided with age- and disability-appropriate support to express their views and make decisions.

⁷The term "adolescents" refers to children from age 10 to <18 years. This age range is similar to the definition of adolescence employed by WHO which is from age 10 to 19 years, and therefore facilitates consistency in data collection; see: https://www.who.int/health-topics/adolescent-health#tab=tab_1 and General Comment No. 20 of the CRC Committee on the implementation of the rights of the child during adolescence CRC/C/GC/20 (<https://digitallibrary.un.org/record/855544?ln=en>).



Examples of what the law can say

- Children and adolescents shall be given the opportunity to provide their free and informed consent to mental health care, in a manner consistent with their age and maturity (210).
- All adolescents have the right to have access to confidential mental health counselling and advice without the consent of a parent or guardian, if they so wish (211).
- Children and adolescents shall be provided with age- and disability-appropriate decision-making support if they so wish, in a manner consistent with their evolving capacities.

2.3 Informed consent and eliminating coercive practices in mental health care

Free and informed consent should be the basis of all mental health-related interventions. Being able to make decisions about one's own health care and treatment choices is an essential element of the right to health.

Ending coercive practices in mental health – such as involuntary commitment, forced treatment, seclusion and restraints – is essential in order to respect the rights of people using mental health services. Coercion is harmful in terms of both physical and mental health, alienating people from mental health and support systems. Moreover, many persons with mental health conditions and psychosocial disabilities have experienced trauma in their lives. When violence, coercion and abuses occur in mental health services, not only are people failed by the service, they may be retraumatized and their original difficulties compounded (212). Once considered a “necessary evil”, there is growing evidence to support the implementation of non-coercive practices (33, 213).

This section proposes legislative provisions which could help to end coercion in mental health services and to uphold the right of all service users to receive mental health-related and other health interventions only with their free and informed consent. Given that in most countries the right to informed consent and its exceptions are regulated in health and mental health laws, many of the reforms necessary to end coercive practices should be specified in such normative documents.

2.3.1 Promoting and protecting the right to free and informed consent

The right to free and informed consent is a fundamental element of the right to health. It encompasses the right to consent to, to refuse, or to choose an alternative medical treatment (214). Generally, all adults have the right to refuse any treatment, even if the treatment would be lifesaving. Persons with mental health conditions and psychosocial disabilities should enjoy this right on an equal basis with others (215).

Legislation can ensure that the right to consent to treatment is respected, protected and fulfilled within mental health services, including in challenging situations; for example when a person is experiencing a crisis or intense distress, all support and treatment should be provided voluntarily (see [section 2.3.3](#)). Legislation can state that all people using mental health services have the right to free and informed consent, and that no mental health treatment shall be given without such consent.

In addition, legislation can ensure that persons using mental health services have access to the information and support required to understand and consider the treatment and non-medical options, including potential benefits and side effects, to make a fully informed decision (see [sections 2.1.5](#) and [2.2.3](#)). For example, some people may require certain accommodations such as information in accessible formats, or the support of a person they trust, before giving their consent.

Legislation can require people to be informed of the existence of non-medical options available to them (e.g. peer support, meditation-based therapies, nutrition strategies) as well as to address the possible underlying circumstances of suffering and distress (e.g. through legal aid, social services, housing programmes). Similarly, persons using mental health services should be informed of the chance to nominate a support person to make decisions about their health and medical treatment. Every individual should

be given the opportunity and support to write advance directives to anticipate future support needs and express in advance their preferences (see [section 2.3.2](#)).

Children and adolescents also have the right to consent to or to refuse treatment, including admission to mental health inpatient services, as expressed by themselves and not a third party, in accordance with their age and maturity. Legislation can ensure children and adolescents with disabilities have the right to consent or refuse treatment on an equal basis with other children and have access to appropriate support to realize that right (see [section 2.2.5](#)). The consent of adolescents to mental health care and support should be always obtained, whether or not there is parent or guardian consent (212).



Examples of what the law can say

- Free and informed consent is required before any mental health intervention or treatment. Free and informed consent cannot be replaced by a third party.
- The provision of mental health services, including outpatient and inpatient mental health services, must be based on the free and informed consent of the person concerned.
- The informed consent discussion shall include the nature of the intervention and its foreseeable risks and benefits; and available treatments including non-medical options and alternatives, and their risks and benefits.
- Information shall be specific to the person's case and be provided in a manner that is accessible and culturally-appropriate and that the person can understand.
- Informed consent shall be given without threat, coercion, undue influence, deception, fraud, manipulation, or false reassurance.
- A person has the right to withdraw their consent at any time.
- Mental health services shall inform a service user about their right to refuse or withdraw their consent at any time.
- Mental health services shall provide a service user with information about advance directives and access to support to develop or change them.
- Access to supported decision-making shall be facilitated to make decisions about the person's health and medical treatment.

Medical emergencies

As a general rule in health care, no medical treatment or procedure can be performed without the person's informed consent. Only in exceptional circumstances can health care professionals provide treatment without consent, for example, during an emergency when immediate medical attention is needed to save a person's life or prevent serious damage to their integrity and they are unconscious or unable to communicate their will. This is based on the assumption that people would not want to be denied necessary medical care under such circumstances. It should be noted, however, that most persons in emergency settings, including those with traumatic injury, do not require immediate intervention to prevent death or serious harm and have the capacity to provide consent (216).

This emergency exception is regularly applied in a discriminatory manner in the mental health context with persons experiencing intense distress or unusual perceptions, either because the individuals are not recognized as having the capacity to provide informed consent, or because their feelings, thoughts and behaviours are immediately treated as life-threatening medical emergencies. Legislation on medical emergencies should not discriminate against persons with mental health conditions and psychosocial disabilities by setting different standards.

Prescription of psychotropic drugs

Countries should adopt a higher standard for the free and informed consent to psychotropic drugs given their potential risks of harm in the short and long term (217, 218). Countries, for example, can require written or documented informed consent (e.g. expressed by a recording in video or audio formats) after providing detailed information on potential negative and positive effects, and the availability of alternative treatment and non-medical options.

Legislation can require medical staff to inform service users about their right to discontinue treatment and to receive support in this. Support should be provided to help people safely withdraw from treatment with drugs.

The prescription of psychotropic drugs and follow-up requires careful physical health assessment and monitoring.



Examples of what the law can say

- The prescription of psychotropic drugs is regulated by the technical and ethical standards that govern medical activity and requires written or documented free and informed consent.
- The prescription of psychotropic drugs shall be carried out within the framework of interdisciplinary approaches.



- Medical professionals have the obligation to inform persons using mental health services of the possible risks, harms and side effects in the short, medium and long term associated with use of the proposed psychotropic drugs, and of the right to initiate a process of discontinuation and to be supported to do this safely.
- Psychotropic drugs should be prescribed only as a response to the fundamental needs of the person; they must be administered exclusively for therapeutic purposes and never as punishment or for the convenience of third parties, or to meet the need for therapeutic support or specialized care.
- The indication and renewal of the prescription of psychotropic drugs can only be carried out based on the pertinent professional evaluations and never automatically.
- A medical practitioner shall not administer psychotropic drugs in a dosage that, having regard to professional standards, is excessive or inappropriate.
- A medical practitioner shall ensure monitoring for negative effects and establish measures to ensure safety including discontinuation of the drugs.
- Mental health services must make provisions for an adverse drug reactions register with a clearly defined procedure for reporting, and a well-documented process for addressing adverse outcomes.
- The health authority shall report, on regular basis, the availability of discontinuation programmes for psychotropic drugs.

Other specific safeguards

Countries may decide to enact legislation to protect people against abuses in the use of specific mental health interventions, such as electroconvulsive therapy (ECT), psychosurgeries and other irreversible interventions.

Significant controversy surrounds the use of ECT and its associated risks (219), and there have been calls for it to be banned altogether (219, 220). Its use has dramatically declined in many countries (221), and in Luxembourg and Slovenia, for example, it is not made available (222).

If permitted, ECT must only be administered with the written or documented, free and informed consent of the person concerned. International human rights standards clarify that ECT without consent violates the right to physical and mental integrity and may constitute torture and ill-treatment (104). People being offered ECT should also be made aware of all its risks and potential short- and long-term harmful effects, such as memory loss and brain damage (223, 224). Moreover, it should only be administered in modified form; that is, with the use of anaesthesia and muscle relaxants. ECT is not recommended for children, and this should be prohibited through legislation.

Psychosurgery is another contested procedure in mental health care history. While “lobotomy” or “leucotomy”, a form of psychosurgery, is no longer performed, this procedure was carried out on more than one hundred thousand people around the world in the mid-twentieth century, causing severe, irreparable

brain damage and, for many, death (225). Nowadays, psychosurgery continues to be practiced – albeit very rarely and not without controversy – for the treatment of cases which do not respond to medications or therapy. Many jurisdictions prohibit certain forms of psychosurgery altogether, or their use in certain populations (e.g. children and prisoners) (226).

Performing such surgery, and other irreversible mental health treatments, without free and informed consent should be prohibited. Legislation could provide an additional level of protection to consenting service users by making it mandatory that an independent review body, or similar safeguard, sanction the treatment. The review body could interview the candidate, review their medical history and records, and ensure that their written or documented consent to surgery was given freely and after being provided comprehensive and detailed information on the risks, possible complications, harmful impacts and side effects.

However, given the irreversible nature of psychosurgery and lack of clear evidence of its safety and efficacy, countries need to consider banning it completely regardless of technique or target population.



Examples of what the law can say

- Any major medical or surgical procedure requires the person's prior written or documented free and informed consent. Access to supported decision-making shall be facilitated.
- Medical professionals shall inform a person using mental health services of the potential benefits, risks of harm and side effects associated with any major medical or surgical procedure.
- Where electroconvulsive therapy continues to be practised, its administration without a person's prior written or documented free and informed consent is prohibited. It shall only be administered in modified form, i.e. with the use of anaesthesia and muscle relaxants, and not be applied to children or adolescents.
- A person must not administer to, or perform on, another person any of the following: (a) deep sleep therapy; (b) insulin coma therapy; (c) psychosurgery; and (d) any other operation or treatment proscribed by regulations.
- Where psychosurgery continues to be practised, in addition to prior written free and informed consent of the person, it requires prior approval from the National Ethics Committee or any other equivalent authority.

Medical research and experimentation

Article 7 of the ICCPR prohibits clinical and experimental research without free and informed consent (227). Article 4.2 explicitly prescribes that the provision is non-derogable and can never be limited, even under conditions of national emergency. The content of this article is also reaffirmed by Article 15 of the CRPD. The Committee on Economic, Social and Cultural Rights has also stressed that freedom from non-consensual medical treatment and experimentation is part of the content of the right to health (228).

Legislation should prohibit medical and scientific research, including all research studies and scientific experiments in the field of mental health (e.g. drug trials and clinical trials), without informed consent.

The exclusion of persons with mental health conditions and psychosocial disabilities from research, before they can provide their free and informed consent, based on lack of “mental capacity”, should also be prohibited. Informed consent obtained through supported decision-making (see [section 2.2.4](#)) shall be subjected to appropriate safeguards to ensure the respect of the person’s rights, will and preferences.



Examples of what the law can say

- No one shall be subjected to medical or scientific experimentation without their written or documented free and informed consent.
- Free and informed consent for medical or scientific experimentation provided through supported decision-making shall be subjected to appropriate safeguards to ensure the respect of the person’s rights, will and preferences.
- Discrimination based on a mental health status or psychosocial disability in medical and scientific research is prohibited.

2.3.2 Advance planning

Advance plans are sometimes referred to as “advance directives” or “living wills”; they are used for decisions made in different domains, from health care to end-of-life and social care. Advance planning is a form of supported decision-making which allows individuals to express their will and preferences prior to when they are needed, and at a time when they are in a position to communicate them ([Box 6](#)).

In the context of mental health care, advance planning can help individuals declare their treatment preferences or to nominate a supporter or power of attorney to express or make decisions on their behalf should they become unable to do so. The advance instruction can include a description of desired support, recovery options, treatments, and place of care or respite, including the option to receive support in the person’s own home. People may also specify instructions related to practical life matters (caring for children, paying bills, etc.), as well as a refusal of certain support, care or treatment options.

Legislation can make advance planning options widely available and ensure services have immediate access to them so that advance directives can be implemented and followed. Countries can choose different forms and requirements for creating advance directives, from a single form to a notarized procedure. People should be able to cancel, add to, or modify an advance directive at any time, including a previously nominated person. Legislation can ensure advance directives are updated on a regular basis, so they better represent the person's current circumstances.

Box 6

Self-binding advance directives

In addressing the question of how to resolve potential contradictions between the will at the time of making an advance directive, and the will at the time of crisis, some jurisdictions allow individuals to insert self-binding clauses authorizing mental health services to act above their objections to a pre-determined directive during a crisis. In the legal context, these are often called “Ulysses” clauses or contracts (230). An individual can revoke a “Ulysses” clause, but only through a procedure that may be difficult to perform during a crisis.

Some argue that these self-binding directives would allow individuals who have experience of episodic crises to better anticipate some of the potential problems in implementing their advance directives, and avoid any unwanted consequences (230, 231). Others consider that their legalization poses a risk for all service users, since people using mental health services may be pressured to establish this type of clause, leading to a legitimization of coercion.

Self-binding directives remain an area of law which requires more research, practice and engagement with people with lived experience to understand the full human rights implications.

In most jurisdictions, advance plans only enter into force when the person is found to “lack decision-making capacity”. However, in line with the CRPD, the use of advance planning should not be understood as a limitation to a person’s legal capacity. To achieve this, legislation can establish that the person concerned should decide the moment in which an advance planning document enters into force and ceases to have effect. The advance directive’s purpose is not substitution of the person’s will and preferences. If the person refuses to follow the advance directive, or chooses a different option while the advance directive is in effect, priority must be given to the person’s will and preferences as expressed at the moment.

In many countries, a health care professional is not required to follow an advance decision in certain circumstances, including crisis situations; this undermines its purpose and impact (see [section 2.3.3](#)). Legislation can ensure advance planning documents are binding. For example, in Germany, living wills are binding and allow people to refuse or limit specific treatments in advance, including hospitalization. Where there is ambiguity, the will of the person must be established based on their previous statements, beliefs and personal values (229). Legislation should only allow for advance decisions not to be followed where there are clear signs of undue influence or coercion (e.g. the advance directive was concluded under duress or undue influence), or total lack of practicability of the advance decision (e.g. the proposed intervention is not feasible).

When implementing advance directives, it is important to ensure a paradigm shift in accordance with the CRPD, so that the main objective is to honour the will and preferences of the person, and move away from substitute decision-making.





Examples of what the law can say

- ◉ Every person of legal age shall have a right to make advance directives with regard to health care interventions specifying any or all of the following: i) the way the person wishes to be supported and treated; ii) the way the person wishes not to be supported or treated; iii) the individual or individuals, in order of precedence, they want to appoint as their nominated representative or supporter to make or communicate decisions on their behalf. The document shall state the moment or circumstances in which the advance directives enter into force.
- ◉ An advance directive may be made by a person irrespective of their past mental health diagnosis or treatment.
- ◉ An advance directive can be expressed in written documents, a recorded video or audio format.
- ◉ A person retains the right to make health care decisions directly after the advance directive has been drafted.
- ◉ An advance directive may be modified or revoked at any time by the person concerned. Any new decision related to mental health care and treatment shall override any previously written or documented advance directive.
- ◉ An advance directive shall be binding on all providers of medical services who apply medical procedures.
- ◉ Mental health services have the duty to inform service users of their right to make an advance directive, provide information related to it, and ensure access to support for its development.
- ◉ The health authority shall implement a central registry to store advance directives for swift access by health care providers, the person concerned, and their nominated representatives or supporters.
- ◉ Mental health practitioners who adhere to advance directives and respect the will and preference of service users shall not be held legally responsible for any unsatisfactory outcomes that may occur, and will be indemnified from any unforeseen consequences arising from adhering to advance directives.

2.3.3 Crisis support

Legislation can establish an obligation to provide support to people who are experiencing crisis. A crisis, often referred to as a “mental health crisis”,⁸ is a situation involving acute mental distress. This may include situations in which a person is feeling extremely anxious, worried or agitated, experiencing suicidal thoughts, or having intense emotions or thoughts which disrupt everyday life. These feelings and thoughts can stem from many circumstances, such as loss, conflict, trauma, stress, violence, substance abuse, and others. The experience of crisis will depend on the individual; for example, for some people, hearing voices or having visions can be common experiences that are part of their diversity or have personal or cultural significance and, thus, not distressing; for others, the experiences may be difficult to cope with.

Most crisis interventions take place in emergency departments or psychiatric hospitals which often serve to exacerbate the situation (232, 233). Traditionally, crisis interventions are dealt with under mental health laws or general health laws, and contain provisions on involuntary hospitalization or psychiatric emergencies. These procedures are either inherently coercive, or assume that there are no alternatives to the use of coercion. Few opportunities are offered that help build trust and connections, and ultimately embrace crisis as an opportunity to learn and grow.

Legislation can establish a framework for crisis support to transform these practices and eliminate the use of coercion. The law can provide for the implementation of community-based crisis support services, hotlines and respite services, which can offer support and counselling to people in crisis situations, 24 hours a day, seven days a week, helping to de-escalate conflicts and minimize the need for hospitalization. These services should aim to avoid the need for law enforcement involvement in crisis situations. The *WHO Guidance on community mental health services: promoting person-centred and rights-based approaches* showcases a selection of crisis services that provide effective care and support for people experiencing acute mental distress, while respecting their legal capacity and other human rights, and without resorting to the use of force or coercion (33).

The law may regulate the composition and functions of crisis support services. Legislation can set up basic principles and guidelines for crisis intervention applicable to any service provider, such as respect for legal capacity, conflict de-escalation, non-judgmental and open communication, flexibility, continuity of support, peer involvement, harm reduction, temporary respite accommodation, and practical responses to basic needs (234, 235). Respecting a person’s legal capacity should not involve neglecting a person in crisis; rather, mental health services should actively reach out and offer support in such situations.

Based on past and ongoing physical, psychological and emotional harms to service users by mental health systems, it is important to ensure non-medical options for crisis support. Outside the health care system offering support related to distress or unusual perceptions, including crisis support, should be made available as primary services in the individual’s own community (see [section 2.5.3](#)) (12).

⁸ Some advocates with psychosocial disabilities avoid the term “mental health crisis” to avoid addressing crises through a medical lens. The Committee on the Rights of Persons with Disabilities uses the terms “individual crisis” and “crisis situation”. See: Committee on the Rights of Persons with Disabilities: General comment No. 1 (2014) Article 12: Equal recognition before the law, paras. 18 and 42 (<https://digitallibrary.un.org/record/779679>); and Guidelines on deinstitutionalization, including in emergencies, CRPD/C/5, 10 October 2022, para. 10 (<https://digitallibrary.un.org/record/3990185?ln=en>).

Furthermore, the literature on crisis intervention indicates that providing individual non-medicalized support carries significant value to service users (233, 236). Therefore, the law can mandate the availability of non-medical crisis support services, for example, by supporting the financing of peer-run crisis services, managed and staffed by persons with lived experience. Mental health services should inform and link people with these other options for support.

Legislation can establish mandatory training for all first responders, such as firefighters, emergency health care workers, community workers or crisis workers, who are usually the first point of contact providing assistance at the scene of an emergency or crisis (Box 7). Monitoring, evaluation reports and statistics are important for crisis services.

Box 7

What mandatory training can cover

- Respect for legal capacity
- The human rights-based approach to crisis intervention
- Zero-coercion strategies
- De-escalation and communication techniques
- Trauma-informed approaches
- Unconscious bias
- Rights of persons with mental health conditions and psychosocial disabilities
- Intersectional and life-course approaches.



Examples of what the law can say

- Community-based crisis support services to support persons experiencing crisis shall be made available and adequately funded.
- The creation of peer-run crisis support services, as well as the participation of peer workers in state-run services, shall be promoted and adequately funded.
- Crisis support services and teams shall be available 24 hours per day, 7 days per week, 365 days per year.
- A person experiencing a crisis shall have immediate access to crisis support services by means of telephone, or electronic or face-to-face communication, regardless of their ability to pay for this.
- Crisis support services shall include crisis hotlines, mobile crisis teams, de-escalation assistance, respite facilities and short-term beds.
- Crisis support services shall not use force and shall operate independently from law enforcement responses.
- Crisis support workers, first responders, health care providers and other relevant actors must respect the will and preferences of a person at all times, including in crisis situations.
- The health and justice authorities shall be responsible for ensuring that first responders, health care providers and other relevant actors, respect human rights and do not neglect individuals based on risk assessments.

2.3.4 Prohibition of involuntary hospitalization and treatment

To ensure a complete paradigm shift away from coercion in mental health care, legislation can prohibit all involuntary measures and mandate that all services, outpatient or inpatient, implement non-coercive responses.

There is evidence that legislative changes can help prevent involuntary commitment (92, 93, 237) and direct it towards abolition. For example, in Mexico, the General Health Law, as amended in 2022 (164), establishes that all mental health treatment and hospitalization must be carried out on a voluntary basis; seclusion, restraints or any practices that constitute cruel, inhuman or degrading treatment are prohibited. The law does not establish exceptions to free and informed consent related to mental health. There is one general rule only for medical emergencies: where a person is unable to consent to treatment at a specified time by any means; or where there is no advance directive, and the person's health is such that if treatment is not given immediately their life will be at imminent risk, or irreversible damage to their physical integrity, the

health service provider will proceed immediately to preserve the life and health of that person. Furthermore, the law states that a person cannot be considered as being unable to provide their informed consent to a choice of treatment if, for example, the mental health service, a medical professional or other person (such as a family member), deems the person incapable of giving consent, or disagrees with their choice. This means that involuntary hospitalization and treatment are no longer permitted in Mexico. However, it is important to note that alongside law reform, political commitment, appropriate policies, human, financial and technical resources need to be secured and services and support put in place to achieve real changes on the ground. These measures play a critical role in translating legislative provisions from legal concepts into tangible realities.

To be effective, the prohibition of involuntary hospitalization and treatment should be accompanied by the development of mental health services that are community-based and person-centred, with the ability to offer individualized support to those who are in crisis or experiencing intense distress, as well as systematically addressing the social determinants of mental health to address the root causes.

Community-based services, advance directives, supported decision-making, peer support, and appropriate crisis support can usually provide a comprehensive framework to support individuals experiencing a crisis. However, there may be exceptional cases in which a crisis escalates and responses fail to create a safe and supportive environment for all persons involved. With such cases, it has been suggested that the authorization of some form of coercion may be justified (238). However, regardless of these circumstances, the case against coercion remains valid: all coercive practices can be contested from a legal, ethical and clinical point of view (see [Box 2](#)). Moreover, there is evidence that even when laws seek to regulate the most exceptional cases, the use of coercion is normalized and coercion rates do not decrease (92).

Against this background, governments can commit by law to a “zero coercion policy in mental health care” which addresses difficult cases individually. This individual approach is particularly important for complex situations ([Box 8](#)) such as when persons are experiencing severe crises, and where trained first responders can provide real-time support to the person and help avoid a life-threatening outcome. Similarly, through de-escalation and conflict resolution, crisis intervention services can help to eliminate the need for law enforcement in situations where a threat of violence may exist. Even where de-escalation fails and a situation of violence arises, crisis intervention teams can provide protection against interpersonal violence and support law enforcement to ensure the person is offered appropriate accommodations and support under police custody (239). Any breaches to such a policy should be assessed and used as an opportunity to improve service provision and remedy any discriminatory treatment.

To advance the prohibition of involuntary hospitalization and treatment, it is also important for countries to review their legal frameworks to repeal community treatment orders. In many countries, these orders have been introduced as a way to reduce the need for hospitalization. Community treatment orders are legal orders which mandate service users to continue outpatient mental health medication and treatment (117). However, overwhelming evidence indicates that these orders are ineffective, with no reported decrease in hospitalization or benefits for persons using mental health services (117, 240, 241). Conversely, the use of such forms of coercion raises human rights concerns and can lead to significant abuses, as documented by the UN Special Rapporteur on the rights of persons with disabilities (242) and the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (99).

While the law can play a critical role in ending coercion in mental health care, system transformation, community attitudes and access to effective mechanisms of redress and accountability are indispensable to ensure services free of coercion (see [section 2.7.3](#)).



Examples of what the law can say

- All mental health interventions and services shall be provided on the basis of persons' free and informed consent.
- In no situation shall mental health internment, hospitalization or treatment be carried out against the will of the person.
- Persons using inpatient mental health services shall not be subject to coercion or duress at any time.
- Mental health services, including hospitals and respite services, shall not use disciplinary measures, strict rules and routines, and other forms of informal coercion to achieve compliance from service users.
- The mental health authority shall develop and implement a zero-coercion policy and provide guidance on how to prevent and eliminate coercive practices.
- All staff working in mental health services and first responders shall receive mandatory training in non-coercive interventions.

Box 8

Responding to challenging and complex crisis situations

Highly unusual or difficult-to-solve cases are ill-suited to be used as the basis of general rules. Complex and challenging situations, often referred to as “hard cases”, dominate discussions around coercion to provide evidence that a total paradigm shift is not possible. These examples, regularly used in legal and clinical discussions, often include cases where an individual attempts suicide, is behaving aggressively or violently, or is experiencing “psychosis”. The traditional framing of these as “hard cases” fails to acknowledge that they are often the result of the failures of existing mental health systems, many of which have not been set up to adequately respond to trauma, distress and crisis.

The following scenarios outline how legislation can help services respond to people’s support needs in a way that is respectful of their rights and autonomy. Their purpose is not to generalize mental health practice, which may vary across services, but rather to highlight options that can be offered in some of the most difficult situations.

1. A person in crisis

When a person is in severe crisis and may be experiencing suicidal ideation, legislation may consider them at risk to themselves and therefore authorize the use of coercion. First responders, often police officers or firefighters, may intervene to contain the situation. This could include the use of physical or chemical restraints. The person may then be taken to an inpatient service where they may be involuntarily admitted and stay for many days, even weeks. At the beginning of their stay, the person could be placed in a seclusion room due to risk considerations. Involuntary administration of psychotropic medication may be also considered. The person may even be required to appear before a judge to demonstrate their ability to consent to or refuse treatment. These experiences, albeit purportedly benevolent, can have a profoundly traumatic effect on the person when what is most needed is support and understanding.

Under a human rights-based approach, first responders will be prohibited from using coercion. Instead, crisis services will be mandated to intervene, helping to de-escalate the situation and offering support. They can provide supportive communication and ensure a personal connection through active listening and practical and non-judgmental support. Once the immediate crisis is resolved, the person could be offered various care and support options, including medical and non-medical alternatives. Responses will be flexible depending on the needs of the individual, and there will be no need for judicialization. A support plan could be put in place that brings together the person and community resources, including the person’s close networks, to ensure continuity of care. Since having or lacking “mental capacity” is irrelevant for crisis support services, no individual would be left on their own based on such considerations. Moreover, this approach does not undermine trust in services, making it more likely for the person to seek support.

Box 8

Responding to challenging and complex crisis situations [cont.]

Medical emergencies associated with a suicide attempt would be dealt with as any other emergency, taking immediate action to preserve life and prevent further harm if the person is not in a position to communicate their will and preferences (e.g. the person is unconscious due to overdose or injury) (235).

2. A person who is threatening violence or behaving aggressively or violently

Due to the associations between mental health conditions and violence widely held by the general public, sometimes behaviours that occur during a crisis are seen as a risk to the physical safety of others – for example, when a person is agitated, raises their voice, paces, or slams doors. The person’s agitation is often considered as a symptom rather than a reaction to a situation, such as having control taken away from them, being treated condescendingly, not being listened to, or threatened with forcible commitment.

On rare occasions, these behaviours may involve the use of threats and violence against people or property. To respond to this, legislation on mental health often provides that those with a mental health diagnosis deemed at risk of harm to others, can be involuntarily admitted to an inpatient mental health service. Law enforcement agents may intervene, arrest, and take the person to such a facility. This could further aggravate a crisis situation leading to injuries and fatalities. Once hospitalized, the person may be restrained or isolated for several days, even weeks. Forced administration of psychotropic drugs may be considered, and legal safeguards may be triggered to review the length of the stay. In some jurisdictions, this could lead to a community treatment order. It is also possible that the police may not consider it a case of “mental health” and instead channel the person into the criminal justice system.

Under a rights-based approach, crisis services will be first to intervene to de-escalate the situation and prevent further violence, or will be immediately called by first responders when this does not happen. Experienced community-based crisis teams will engage with the person to try to establish effective dialogue and conflict resolution. These teams will be aware that aggression may be triggered by internal, interpersonal, or external experiences, including anxiety, frustration, neglect, fear, threats, and traumatic experiences. This includes the fear of being involuntarily committed to a psychiatric service. It is therefore crucial to listen carefully to the person, engage them in meaningful dialogue, and understand them and their perspectives. Crisis support services can help prevent further violence by facilitating the security of people

Box 8

Responding to challenging and complex crisis situations [cont.]

threatened by the situation of violence and cutting off access to lethal means. Once the immediate crisis is resolved, the person could be offered various care and support options, and continuity of care ensured. If the intervention is successful, the individual will not have to engage with the criminal justice system.

3. A person experiencing “psychosis”

“Psychosis” is an umbrella medical term that includes a range of experiences which can be associated with several mental health, neurological and general medical conditions. These experiences can include seeing, hearing, feeling or tasting things that other people do not, or having unusual thoughts or beliefs. Within the medical community, there is growing recognition of the role of social stressors and experience of traumatic events during childhood in leading to such experiences, as well as increased acknowledgement of the pervasive stigma associated with “psychosis” (243). Perspectives vary; some people with lived experience appreciate a medical framing of these experiences while others propose instead non-medical understandings that embrace the experiences as valid, human and meaningful (244).

People with unusual perceptions or beliefs are commonly deemed to lack the capacity to make decisions. This can lead to their legal capacity being restricted and, if medical interventions are needed, and depending on the urgency of the case, a judge, doctor or family member may be called to act as substitute decision-maker, deciding based on the person’s “best interests”. If the person disagrees, the use of force could be authorized, including physical and chemical restraints. Furthermore, given the widespread stigma associated with unusual perceptions and beliefs, people are often considered a “risk to self or to others”, and regularly committed to a psychiatric service.

Under a human rights-based approach, people would retain their legal capacity and be supported to express their will and preferences at all times, including in relation to health care decisions. Hearing voices, seeing visions, or experiencing other unusual perceptions or beliefs would not be equated to being in a crisis and requiring immediate crisis support. People would be offered various care and support options, including medical and non-medical alternatives, and have the chance to make decisions for themselves, including through supported decision-making. “Hearing voices” groups and other non-medical options would be eligible for government funding while remaining independent from formal services.

These scenarios result from complex interrelated factors, and responses need to take into account the particularities of each situation. Sometimes there will be no optimal

Box 8

Responding to challenging and complex crisis situations [cont.]

response. However, approaches should be changed to prioritize the rights of persons in crisis. By applying a paradigm shift to these difficult cases, best practices can be developed to solve them. The *WHO Guidance on community mental health services: promoting person-centred and rights-based approaches* (2021) provides examples of good practice services around the world and makes recommendations for integrating such services into national health and social care systems and services (33).

2.3.5 Eliminating seclusion and restraint

There is a growing consensus that all forms of restraint and seclusion in mental health services should be eliminated. Seclusion entails locking or confining a person to a space or room, while restraint involves several actions that control a person's physical movement or behaviour (e.g. mechanical, physical, or chemical restraint) (245). Not only are seclusion and restraint contrary to international human rights law, their use is incompatible with a recovery approach, counters the purpose of care (246), and can lead to physical and psychological harm, even death (107, 247, 248).

Legislation can prohibit the use of seclusion and restraint in any health or social care facility. For example, India, Italy, Mexico and Peru have banned the use of seclusion or solitary confinement in their mental health systems, with Mexico expressly prohibiting the use of restraints (164). To reinforce this shift, countries will need to develop and reorganize their mental health services, as it is often a lack of resources, training and awareness that lead to the use of these interventions. Service culture change, comfort rooms, de-escalation strategies and response teams could be implemented. There are always alternatives to seclusion and restraint (246).

Coercion also takes place outside hospitals in community-based mental health services, residential facilities, family homes and the community in general. The practice of shackling persons experiencing intense distress or unusual perceptions has been documented in various countries (54). Coercion within the community, including shackling, should be banned by law. For example, in India, the Mental Healthcare Act 2017 explicitly prohibits people with mental health conditions and psychosocial disabilities from being “chained in any manner or form whatsoever” (249). In Indonesia, Law No. 18 of 2014 on Mental Health considers shackling as a criminal offence (250).

Because of their prohibition, all episodes of chemical and physical restraint and seclusion should be recorded and made available to the independent monitoring body (see [section 2.7.2](#)). Debriefing of incidents of restraints and seclusions, in collaboration with persons with lived experience, should be promoted. Legal provisions can support the investigation of such incidents, including all those concerned so authorities can take corrective action, including the provision of redress.



Examples of what the law can say

- The use of any coercive measure in health services is prohibited. This includes medical and non-medical interventions without free and informed consent; the use of isolation rooms and chemical and physical restraints; and restrictions to free movement.
- The health authority shall adopt protocols and guidance to prevent and eliminate coercive practices in all health services, including de-escalation techniques and the development of comfort rooms and calming environments in emergency departments, general hospitals and other places of acute care. Health services shall conduct training to prevent and eliminate these practices.
- Health services shall set up a procedure for monitoring the non-use of seclusion and restraints. Statistics and reports shall be accessible to the authorities and the public.
- Shackling, chaining, seclusion, restraints, and any other form of violence and abuse against a person with mental health conditions and psychosocial disabilities in the community are prohibited. Local authorities shall conduct awareness training and foster collaboration with community organizations and leaders to eradicate these practices.
- Appropriate mechanisms shall be established to receive and investigate complaints regarding the ill-treatment of a person with mental health conditions and psychosocial disabilities in the community, and to provide effective redress.

2.3.6 Care process redesign

Ending all forms of coercion in mental health services requires rethinking admission and treatment processes. Traditionally, mental health care processes have been designed starting with hospital admission, which is either voluntary or involuntary. Hence, the emphasis has focused on whether conditions for voluntary or involuntary internment are met, such as diagnosis, determination of “mental capacity” or “risk to self or to others”, and availability of “less restrictive alternatives”. However, if services embrace a community-based and person-centred approach that respects legal capacity and facilitates supportive, non-coercive interventions, different admission and treatment pathways need to be envisaged.

The person’s will and preferences should guide the provision of mental health care and support. Therefore, the starting point of a new rights-based mental health care process would be the request from the person concerned, in recognition of their right to make health care decisions. In a situation of crisis, a request to intervene may come from anyone in the community, but crisis support services will reach out and offer support on the premise of, and respect for, the full legal capacity of the person concerned. No one should be forcibly admitted or treated by mental health services against their will. Supported decision-making should be available, and supporters and trusted people should be called upon if the person wishes it.

In addition, “mental capacity” and “risks assessments” should be replaced by an assessment of support needs. The purpose of such assessment should be to find out what the person wants, what support the person already has in place (e.g. if there is an advance directive or an appointed supporter for such cases), and the psychosocial and practical support the person may require in the particular situation. The assessment of social needs should also be considered. This could be conducted by the mental health or crisis support team, depending on the situation.

Based on the support needs assessment, mental health services should provide service users with a range of support and treatment options, such as crisis services, community centres, peer support, hospital-based services, or a combination. Mental health services can also provide information and offer referral to relevant services outside the health sector, including social services.



2.3.7 Decriminalization of suicide

Suicide prevention is an international priority. Worldwide, more than 700 000 people lose their life to suicide every year (251). Target 3.4 of SDG3 seeks to reduce by one third the global premature mortality rate from noncommunicable diseases by 2030 and to promote mental health and well-being. Its related indicator 3.4.2 specifically measures progress to reduce suicide rates. As part of these efforts, WHO has developed the LIVE LIFE approach to suicide prevention, which prioritizes four interventions: i) limiting access to the means for suicide; ii) interacting with the media for responsible reporting on suicide; iii) fostering social and emotional life skills in adolescents; and iv) early intervention for anyone affected by suicidal behaviours (251). It is important that all suicide prevention measures embrace a rights-based approach that address structural forms of oppression and other social determinants (252, 253).

Legislation that criminalizes suicide or suicide attempts is not only contrary to human rights, but also hampers the implementation of suicide prevention strategies and interventions. Although most countries have decriminalized suicide, it remains illegal in many, with penalties ranging from fines to imprisonment (254, 255) As a result, those who attempt suicide can be deterred from seeking support. The decriminalization of attempted suicide – introduced in several countries in recent years including India (2017), Singapore (2019), Cayman Islands (2020), Guyana (2022), Pakistan (2022) and Ghana (2023) – can help to reduce stigma, ensure appropriate support and facilitate a more accurate collection of suicide-related statistics for better informed policy responses.

There is no evidence that decriminalization increases suicides; rather, rates tend to decline in countries after decriminalization (254). Furthermore, criminalization is associated with higher suicide rates in women (256).

As with other aspects of legal reform, advancing decriminalization requires significant cooperation between parliamentarians, policy-makers, health systems, criminal justice systems, civil society organizations and people with lived experience.



Examples of what the law can say

- People attempting suicide shall not be subjected to criminal prosecution.
- Mental health systems shall plan, design, and implement rights-based suicide prevention programmes with the active involvement of persons with lived experience.

2.4 Access to quality mental health services

As mental health is integral to health, the right to mental health is equally integral to the right to health, as recognized by the International Covenant on Economic, Social and Cultural Rights (Article 12) (124). Legislation can improve the enjoyment of the right to mental health by increasing availability of services; improving the geographical, physical and financial accessibility to services, including access to information; providing services that are acceptable, respect medical ethics, are gender-responsive, culturally-appropriate and of adequate quality.

This section proposes provisions that address these issues, with a view to eliminating barriers to accessing quality mental health services and support. Most of these provisions can be integrated into general health laws and any existing stand-alone mental health legislation, as part of broader efforts to bridge the gaps between general health and mental health.

2.4.1 Parity between physical and mental health

Countries can advance affordable and equitable access to mental health care by reaffirming that mental health is as essential as physical health.

At national level, legislation can recognize the right to mental health as enforceable. This could be attained by acknowledging mental health as a component of the right to health or by explicitly recognizing a person's right to mental health. This right could then be invoked in national courts, which would be particularly relevant in legal systems where international law is not automatically applicable. In addition, recognition of a right to mental health can facilitate better protection of its essential elements (availability, accessibility, acceptability and quality of facilities, goods and services), as well as the development and implementation of policies and regulations aimed at guaranteeing access to person-centred and rights-based mental health services and approaches.

Legislation can also put mental health on par with physical health as a way to ensure equal access to mental health services and equal efforts to improve the quality of care. It can also stipulate that the quality and standards of mental health care and support should be at least equivalent to those provided by other types of medical treatments. For example, the United Kingdom Health and Social Care Act 2012 created an obligation to deliver “parity of esteem” between physical and mental health, which helped to ensure that further commitments and action for mental health would be valued equally and on the same terms as physical health (257).

Health insurances could also be required to apply equitable funding principles for mental health and physical health. For example, in the United States of America, state and federal laws have attempted to address discriminatory practices in health insurance by creating requirements around parity. In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) requiring comprehensive standards for equitable coverage of mental health care and coverage of medical/surgical treatment. The Patient Protection and Affordable Care Act of 2010 (PPACA, Public Law 111–148) further expanded the reach of the parity laws by requiring most health plans to cover mental health care and expanding the scope of MHPAEA (258).

Recognizing an unambiguous right to mental health and valuing mental health equally with physical health can be steps forward in building consensus on prioritizing mental health and ensuring that human rights obligations related to the right to mental health are taken seriously.



Examples of what the law can say

- ◉ Every person shall have a right to enjoy the highest possible level of physical and mental health, without discrimination.
- ◉ Every person shall have a right to mental health care and support being available, accessible, acceptable and of good quality.
- ◉ Mental health interventions, services and support shall ensure participation and accountability mechanisms, and address the structural, social and economic determinants of mental health.
- ◉ Mental health systems shall ensure equal access to appropriate mental health care in a manner equivalent to other aspects of health care as part of an integrated, holistic system of care.
- ◉ Mental health services shall be provided on an equal basis with other health care services and ensure, as a minimum, equivalent standards of care.
- ◉ The health authority shall report annually on measures taken to reduce inequalities related to the availability, accessibility, acceptability and quality of mental health care and support.
- ◉ The distribution and quality of mental health goods and services shall be equitable to general health goods and services.
- ◉ Health plans and insurances shall provide coverage for mental health services on an equal basis as those provided for other health services, and are prohibited from imposing limitations on benefits that are less favourable for mental health care than for other general health services.

2.4.2 Financing of mental health

Mental health remains a low priority for public financing in most health care systems. In some of the legal frameworks or legislation of countries, laws can help overcome this resource insufficiency by including specific provisions for securing and increasing the availability of public funds for mental health care. Most legislation on mental health does not deal with funding directly and is left to the domains of budget and policy; however this does not mean that legislation cannot directly influence financial allocations.

Depending on the health financing scheme of a country, legislation may establish earmarked funds for mental health care, or progressive targets in the health budget aimed at increasing mental health investment (10). For example, in Argentina, legislation specifies a minimum budget for mental health care within the general health budget, although the budget target has yet to be achieved (259, 260). While less common, legislation can also order the prioritization of investment in mental health services, parity with investments in other areas of health, or levy taxation for mental health care funding (261).

Governments should indicate where resources should be spent, thereby ensuring investments are made in services and support that align with human rights requirements and enabling adequate provision in areas such as community mental health care and services and support that address the full range of social determinants impacting on people's mental health (33). In this way, legislation may help to redirect funding from psychiatric institutions to community-based services and ensure the availability of funding for concrete strategies and action plans for deinstitutionalization (see [section 2.5.4](#)).

It is crucial to secure adequate funding for a broad spectrum of mental health support options. Health insurance often incentivizes the need for a diagnosis and promotes the use of "simple" interventions, such as psychotropic drugs, rather than more complex treatments that may be more effective (33). This can limit the treatment options available and reduce the choices that people have. For example, in many low-, middle- and some high-income countries, there is better access to psychotropic drugs at either no, or relatively low, cost compared to other forms of treatment such as psychotherapy (33).

Legislation can support mobilization of resources from international cooperation, in line with Article 2(1) of the ICESCR. It can also ensure that international cooperation, including development assistance, has a human rights-based approach to mental health; refrains from funding or implementing programmes and projects that are contrary to human rights; redirects funding from institutions to community-based services; and ensures the active participation of persons with lived experience in all efforts concerning health, including through formal consultative mechanisms.

Although legislators may be cautious about the financial implications of adopting legislation that increases resources for mental health, there is, nonetheless, a strong economic argument for mental health investment. Without countries having explicit financing mechanisms in place, mental health will lag behind other health priorities.



Examples of what the law can say

- Budget allocation for mental health shall increase through deliberate, concrete, and targeted measures, to the maximum of its available resources, within a clear time frame.
- Funding for mental health shall be included in the budget lines of each level of government (e.g. local and regional authorities).
- Budget increases in mental health funding shall be targeted towards community-based services and support.
- Budget allocation for mental health shall reflect a balanced funding portfolio of community-based services and support options, including psychosocial interventions and non-medical support.
- Budget allocation for services and interventions contrary to international human rights standards is prohibited.
- Budget allocation shall ensure that relevant programmes consider and incorporate activities addressing social determinants of mental health.
- Budget allocation shall be governed by mechanisms of transparency, accountability and participation.
- International development cooperation and international humanitarian aid concerning mental health shall be based on the principle of respect for human rights and directed to community-based and person-centred responses.

2.4.3 Affordable and equitable access to mental health care

Legislation can play an important role in ensuring affordable and equitable access to mental health care. Disparities in service provision and access are widespread within and among countries. Socioeconomic status, which often intersects with identity and demographic factors, such as race, ethnicity, sex, gender identity or expression, age, disability, sexual orientation, sex characteristics, nationality, migration status, and geographic location, can all affect a person's ability to access mental health care.

Legislation can function as an enabler for UHC for mental health. For example, laws can mandate the inclusion or expansion of rights-based mental health coverage as part of national efforts towards UHC (e.g. inclusion in national health insurance schemes or entitlement packages). Laws can set and enforce fair rules and incentives to ensure that the health system and its actors perform consistently with the goals of UHC for mental health; they can further provide a means for implementing and monitoring such policies and programmes (262).

Disparities in access to mental health care can be addressed by legislation establishing criteria for a needs-based allocation of services and mandating that mental health services and support be available, accessible and acceptable and of good quality for specific groups such as children, adolescents, women, and older persons, as well as persons with disabilities, Indigenous Peoples, minorities, migrant workers, migrants in irregular situations, refugees, asylum seekers, internally-displaced persons, and persons deprived of their liberty.

Targeted fee exemptions can be also used to counter the negative financial impacts of out-of-pocket payments.



Examples of what the law can say

- ◉ Mental health shall be integrated into all strategies and policies for universal health care and shall be cost-free or affordable to all.
- ◉ National insurance schemes shall guarantee access to person-centred and rights-based mental health services and support.
- ◉ All health insurance plans, regardless of insurance company, shall cover mental health services, including community-based support, outpatient and inpatient services, drug dependence treatment, care related to suicide attempts or self-inflicted injuries, and access to psychosocial interventions, psychological therapies, and psychotropic drugs.
- ◉ Persons living in poverty, destitution or who are homeless shall be entitled to mental health services and support at no financial cost.
- ◉ Non-citizens including migrant workers, refugees and asylum seekers shall be, regardless of their migration status, entitled to access to mental health services and support on an equal basis with nationals.

2.4.4 Gender-responsive mental health care

Gender differences can impact the experience of mental health conditions and care in mental health services (263). Legislation can help to promote gender-responsive services by requiring that people working in mental health care are informed of issues such as how gender and sexuality norms and stereotypes shape life experiences (e.g. violence and abuse); day-to-day social, cultural, and family realities; expressions and experiences of mental distress; and care and support requirements and responses.

For example, the law may recognize gender equality as a basic principle in the provision of mental health services. Likewise, it can adopt actions to respond to gender differences and individual requirements, upholding an individual's physical, personal and emotional safety at all times. It can further mandate the provision of care, support and referrals for survivors of gender-based violence, including through comprehensive and gender-responsive mental health services, and information about rights, entitlements, and other services.

Legislation can also ban harmful and discriminatory practices that are based on gender, sexual orientation, gender identity and expression, and sex characteristics in the context of mental health service provision, including forced sterilization, forced abortion, forced contraception, and menstrual suppression. "Conversion therapies" to change a person's sexual orientation, gender identity, or gender expression should be also banned. Mental health services should not serve as a gatekeeper for the restriction of sexual and reproductive health and rights.



Examples of what the law can say

- No one shall be discriminated against with respect to community-based support, outpatient and inpatient mental health services, or mental health treatment, based on their sex, gender identity or expression, sexual orientation, sex characteristics, age, actual or perceived diagnosis, membership to a minority or any other ground.
- Mental health services shall uphold the right of service users, wherever possible, to request a staff member of their preferred gender, if desired.
- Inpatient mental health services shall provide gender safe spaces where service users can spend time away from others whose presence can lead to them feeling unsafe, or to potential revictimization, harassment or abuse.
- Mental health services shall respect the gender identity and expression of service users.
- The sexual and reproductive health and rights of service users shall be respected and fulfilled in all circumstances, and be free from discrimination, including discrimination based on gender and SOGIESC.



- Pregnant persons who use mental health services have the right to receive support to exercise their sexual and reproductive health and rights; this includes information and support for monitoring or discontinuing the pregnancy, and harm-reduction related to the use of psychotropic drugs during the periods of pregnancy, postpartum and lactation.
- Mental health services shall provide accommodations for parenting responsibilities.
- Sterilization without the free and informed consent of the person is prohibited.
- Therapies and interventions to change a person's sexual orientation, gender identity, or gender expression are prohibited.
- Persons who are victims of sexual and gender-based violence and discrimination shall be provided with immediate appropriate, accessible, adequate and holistic trauma recovery support and information and referrals to programmes that could assist them.

2.4.5 Age-appropriate mental health care

Legislation can contribute to ensuring age-appropriate mental health care and support, which are necessary to safeguard the rights of children, adolescents, and older persons. Legislation can provide for mental health services that distinguish between the needs of adults of all ages, including older persons, and those of children and youth, allowing age-appropriate services and environments, for example, access to suitable recreational activities for children and adolescents, and facilitation of social interaction in the community, physical accessibility, and other specific services for older persons. It can also ensure access to services and programmes targeted at protecting children who are being subjected to, or are at risk of, adverse childhood experiences.

Admission to a mental health service can be a stressful experience for children and their families and should be avoided. Instead, children and adolescents should be provided care at home and within their communities through the availability of community-based support.



Examples of what the law can say

- ◉ Procedures and criteria shall be adopted to provide guidance to health workers in the area of mental health care, for assessing the best interests of the child and respecting their views.
- ◉ A variety of person-centred and rights-based community-based crisis services shall be devised to better support children and their families in crises, including crisis hotlines, mobile crisis teams, respite facilities, in-home treatment, and observation and brief inpatient services.
- ◉ A child or an adolescent shall never be admitted to a psychiatric or social care institution. Inpatient care of children and adolescents shall be avoided to the maximum extent possible, and be limited in time and to exceptional circumstances. Their views shall be heard and given due weight in accordance with their age and maturity.
- ◉ Inpatient care for a child or adolescent, including during crisis situations, shall be provided in a community-based mental health service for the shortest number of days possible and will be separate from adults. Where there is no evidence of likely harm to the child or adolescent, the parents or guardians shall be provided unrestricted access and be actively involved for the duration of their stay.
- ◉ Mental health services shall respect and support the autonomy and independence of older persons.
- ◉ Appropriate community-based services shall be developed and/or strengthened to prevent violence, neglect, and abuse of older persons with mental health conditions and psychosocial disabilities.
- ◉ The health authority shall determine the list of person-centred and rights-based community-based services that meet the conditions for observation and brief inpatient stays. These services should meet strict quality standards and be centred on recovery and community inclusion; they should not serve as new forms of institutionalization.
- ◉ Mental health systems shall adequately coordinate transitions between services for children, adults and older persons.

2.4.6 Culturally-appropriate mental health care

The understandings of mental health and well-being are culturally bound (264) and influenced by cultural factors, such as beliefs, values, and traditions. For example, some communities, may have unique concepts and understandings of mental health and well-being which may differ from the dominant Western perspective. What is considered to be “mental illness” in Western medicine may have traditional or spiritual associations in other cultures. The legacy of colonialism and the expansion of Western mental health models across the world, often dominated by biomedical interventions, threaten the mental health and well-being of different communities and the continuity of traditional healing practices. Colonialism and colonial laws, including outdated or “exported” mental health laws, continue to harm, oppress and discriminate against Indigenous Peoples whose cultural understandings and approaches to issues such as mental health have been overlooked, medicalized and sometimes criminalized. This has impacted their mental health and well-being, and rates of mental health conditions and suicide among these peoples are frequently higher than those of other populations.

In the case of Indigenous Peoples, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (265) affirms the rights of Indigenous Peoples to be actively involved in developing and determining their health programmes; to maintain their use of traditional medicines and health practices; to access, without discrimination, all social and health services; and to enjoy equal rights to the highest attainable standard of physical and mental health (UNDRIP Articles 23 and 24). Although not legally binding, UNDRIP reinforces international obligations to ensure health services and care are culturally appropriate and take into account traditional practices and medicines (266).

In respecting the rights of Indigenous Peoples to self-determination, legislation can mandate governments to provide adequate resources for these communities to create and operate their own health care and support initiatives (266). Legislation can also support the engagement of leaders of Indigenous, ethnic and religious groups in raising community awareness on human rights-based practices relating to mental health care and support. Indigenous approaches to mental health represent a viable alternative to Western psychiatry, offering individuals and families a framework to navigate mental distress and crisis, while also promoting a positive cultural identity by celebrating Indigenous narratives and healing practices that were marginalized by colonization (267).

Additionally, legislation is pivotal to promoting culturally safe and appropriate responses to mental health care within Western mental health systems. Laws can provide for information, support, and services that are tailored to the cultural needs of different communities. The consideration of cultural differences when providing mental health care is important not only for Indigenous Peoples but also for ethnic and religious minorities, as well as migrants, refugees and asylum seekers, who are often denied support that takes into account their specific cultural values and experiences.



Examples of what the law can say

- Indigenous Peoples and other relevant communities, as appropriate, shall be meaningfully engaged and consulted in the design and implementation of mental health services.
- Budget allocations for mental health shall consider adequate funding for culturally-appropriate mental health care initiatives for Indigenous Peoples and other relevant groups who may be members of a minority.
- Mental health services shall provide care and support that is appropriate to, and consistent with, people's cultural and religious beliefs and practices, including to those with minority religious beliefs and non-religious people.
- Mental health services shall provide care and support which respect people's freedom of opinion as well as their religious and philosophical convictions, and under conditions which are culturally appropriate.
- Culturally-appropriate advocacy support shall be provided for service users of all ethnic backgrounds and communities.
- Access to mental health care shall be provided in a language understood by the individual and, where necessary, assisted by the provision of interpretation services, including sign language or augmentative and alternative communication. This obligation includes psychosocial interventions.
- A person admitted to inpatient services shall be able to continue religious or spiritual practices.

2.4.7 Anti-racist mental health care and support

Systemic racism against people of African descent, Indigenous Peoples, and racial and ethnic minorities is embedded in mental health systems, as it is in many other areas of society. Racism infuses policies and practices, creating barriers and disadvantaging these groups, leading to unequal access to care, unequal treatment and outcomes, and biased assumptions and stereotypes (268). For example, racial and ethnic minorities may have difficulty accessing mental health services due to factors such as lack of insurance, language barriers, or lack of culturally-competent providers (269). Bias and stereotypes may also affect how mental health staff interact with and perceive service users, leading to unequal treatment and outcomes (270). Coercive practices, such as involuntary detention and treatment, as well as interventions within the criminal justice system during crisis, are disproportionately experienced by racial and ethnic minorities in mental health care settings (271, 272).

Racism and trauma are closely connected. Experiences of racism, including discrimination, harassment, violence and institutional racism, can have a long-term effect on people's mental health and well-being and span generations (273). It is important for mental health providers to recognize the relationship between racism and trauma and address it through person-centred responses that support healing and well-being.

Legislation can play a role in addressing systemic racism in mental health systems by setting standards for mental health provision and holding providers accountable for any discriminatory practices. Laws can ensure that all individuals have equal access to mental health services, regardless of their racial and ethnic background (see [section 2.1.1](#)). They can also require the training of mental health staff in cultural competency and provision of care that is free from bias and discrimination. Additionally, legislation can establish mechanisms for addressing incidents of discrimination (see [section 2.7](#)). However, these efforts need to be accompanied by a range of policy responses that address the systemic and institutional barriers that perpetuate racism in society, including in education, housing, health care, and the criminal justice system.



Examples of what the law can say

- ◉ The health authority shall implement the training of health staff to combat racial and ethnic bias and stereotyping.
- ◉ The health authority shall implement increased affirmative recruitment and training of mental health and social care staff who represent racial and ethnic groups that have historically been marginalized.
- ◉ The mental health authority shall actively engage and collaborate with organizations that represent racial and ethnic minority populations to understand and address health equity issues in these communities.
- ◉ Mental health systems shall collect disaggregated data and information on service use, outcomes and disparities to identify and address any disparities or inequities. Data collection policies should be implemented in close consultation with organizations that represent racial and ethnic minority populations.

2.4.8 Training for health care and social care providers

Training is an important investment for developing person-centred and rights-based mental health services and support. Human rights education and training can help health care and social care providers to align with a rights-based approach. It could cover essential topics, such as those in the right to health framework (see [section 1.4](#)) (125), international human rights standards, the recovery approach, the respect for legal capacity, and the elimination of coercion. The WHO QualityRights initiative has produced evidence-based materials with a rights-based perspective, for training, guidance and the transformation of mental health services (32). It has also developed an e-training programme on mental health, recovery and inclusion, which should be completed by all health and social care providers (274).

Legislation can mandate training on mental health and human rights for all persons working in health care and social care services and emergency response teams. It can also stipulate an obligation for the provision of ongoing mandatory training, and request the meaningful participation and involvement of persons with mental health conditions and psychosocial disabilities in the development and delivery of such training.

Regulation can also be a useful vehicle for improving the training and standards of education of health care professionals, including pre-service curricula and continuing professional development. For example, regulatory systems for establishing standards required to become a registered or licensed health care professional (e.g. doctor, nurse, midwife), may prescribe mandatory training on human rights, mental health awareness, person-centred, community approaches and the social determinants of health. Similar measures can be taken in other professions related to mental health, such as social work, occupational therapy and police enforcement (see [section 2.8.2](#)).



Examples of what the law can say

- Mental health professionals, workers, and other service providers shall undergo capacity-building, reorientation, or training to develop their ability to deliver evidence-based, age- and gender-responsive, culturally-appropriate and human rights-based mental health services which emphasize person-centred, recovery models, human rights, and the community and public health aspects of mental health.
- The curricula of professional and technical medical education programmes that cover health care and social work, shall include mandatory training on human rights and the human rights-based approach to mental health care and support.
- Persons with lived experience shall be directly involved in the co-development and delivery of training.

2.5 Implementing mental health services in the community

Legislation plays a major role in promoting person-centred and rights-based community mental health and support services. When mental health care is provided in the community, it can be more easily accessed, connected to, and coordinated with other services. Person-centred approaches are better suited to meet people's support needs and to ensure a range of services and interventions to meet the different requirements. In this way, people remain connected to their social networks, and supported to continue with their lives and participate in their communities.

This section proposes provisions for transforming service provision and implementing person-centred and rights-based community mental health and support services. Again, these provisions could be integrated in general health laws or any existing stand-alone legislation on mental health, as part of broader efforts in achieving a paradigm shift in mental health. They need to be complemented with provisions as described in other sections, particularly those concerning promoting independence and community inclusion, since trauma and crisis require responses beyond the scope of the health sector (see [section 2.8.1](#)).

2.5.1 Integration of mental health in general health care settings

Legislation can reinforce the introduction of mental health interventions, services and support in the first levels of health care, particularly primary health care, that are consistent with the principle that mental health should be considered as equal to physical health.

Primary health care is most often the first level of contact with the national health system for individuals, the family and community. Integrating mental health into primary health care is the most viable strategy for improving access for underserved populations, and ensuring that any person can access mental health services at an early stage and near to their homes and communities (10, 275). This increases the likelihood of recovery and promotes community inclusion. It can also help in reducing stigma associated with seeking help from centralized and institutional mental health services (276, 277). The law can help ensure access to mental health services in the community by mandating the provision of person-centred and human rights-based mental health approaches in primary health care.

Legislation can also help to improve the availability of specific mental health goods and services at the primary care level. For example, it can ensure that psychotropic drugs are as available and accessible as other medications, while securing higher standards for free and informed consent and safe prescribing, communication regarding all available alternative treatment, care and support options, and support for discontinuing psychotropic drugs (see [section 2.3.1](#)). Similarly, legislation can help to improve access to psychosocial interventions such as counselling, specific psychological interventions, peer support, and social services delivered at primary care level. Legislation can also address the often neglected mental health care aspects of health care in such areas as antenatal and postnatal care, by providing options for mental health and well-being multidisciplinary assessment and support during planned or routine care visits. WHO has developed a range of tools to provide guidance on these aspects of treatment, care and support as part of the WHO QualityRights and mhGAP initiatives (278–280).

Legislation can promote the creation of mental health services in general hospitals. In many countries, such hospital-based services have historically been provided in large, inpatient facilities such as psychiatric and social care institutions. People in such facilities often stay for extended periods of time, sometimes for many years. Moreover, these settings are often isolated from other general health services and from the rest of the community and associated with extensive coercive practices and human rights violations. When provided as part of a range of services and support in the community, mental health services in general health hospitals can ensure that people receive care and support that are responsive to their requirements and respect their human rights. It is important to ensure, however, that these services do not replicate institutional practices contrary to human rights and inclusion.

Legislation alone will not give effect to these provisions unless the necessary policy, infrastructure and personnel have been prepared and put in place. Indeed, many of these reforms do not require a legislative mandate, although the law can establish concrete obligations to move them forward.



Examples of what the law can say

- Integration of person-centred and rights-based mental health care in primary health care and general hospitals shall be undertaken.
- Person-centred and rights-based inpatient mental health services shall be provided in community-based facilities and general hospitals.
- Primary health care shall set up multidisciplinary mental health teams comprising professionals and practitioners from different relevant disciplines or fields, as well as persons with lived experience.
- Mental health systems shall ensure the availability of psychosocial interventions and psychotropic drugs in primary care settings and general hospitals. Psychosocial interventions should be the first-line treatment options.
- Mental health and well-being multidisciplinary assessment and support should be offered in planned antenatal and postnatal care visits.

2.5.2 Developing person-centred and rights-based community mental health services

While integration of mental health in general health systems is important, the paradigm shift from a biomedical model towards a human rights model requires the transformation of service provision to develop a range of holistic community-based, person-centred, recovery-oriented options. In contrast to hospital-centred models, community-based care services are more accessible, efficient and effective (281, 282). Governments can promote or reinforce these processes by embedding them into legislation.

Indeed, in many countries, legislation has initiated service transformation, with laws mandating the reform of mental health systems towards a community-based model. In Brazil, for example, Act No. 10.216, of 6 April 2001 which “Provides for the protection and rights of people with mental disorders and redirects the mental health care model”, was critical in redirecting resources from psychiatric institutions to the community.

Legislation can also promote the development of person-centred and rights-based community services by stipulating that a range of mental health and support services be made available in the community. For example, the law can provide for the implementation of community mental health centres, which offer support outside of an institutional setting and in proximity to people’s homes; crisis response services, which help to support people experiencing acute mental distress (see [section 2.3.3](#)); community outreach services; and peer support services (see [section 2.5.3](#)). All these need to adopt a rights-based approach.

In some countries, legislation establishes that mental health care should first be provided at community level and, if options at this level are not feasible or have previously failed, that inpatient services can be offered, but only with the informed consent of the individual concerned. In Vermont, in the United States of America, the Department of Mental Health is obliged under state law to report annually regarding the extent to which persons using mental health services receive care in the community.

Legislation can uphold person-centred and recovery approaches by recognizing these as essential principles of mental health care; people are placed at the centre of the service and acknowledged as persons rather than “patients” (283). In contrast to biomedical approaches, attention is focused on the “whole person”, not their mental health diagnosis. Therefore, support should be tailored to their needs and unique circumstances, guided by what the person wants out of life. This allows for trauma-informed approaches when responding to racial, gender and other forms of injustice.

Likewise, services adopting a recovery approach are not focused primarily on “curing” or making people “healthy” or “normal again”; rather on supporting people to identify what recovery means to them. In this way, people are supported in gaining or regaining control of their identity and life, have hope for the future, and live a life that has meaning for them. Moreover, this acknowledges that mental health and well-being do not depend on being “symptom free”; that people can experience distress and trauma and still enjoy a rich and full life (33). Through adopting such approaches, human rights can be upheld.



Examples of what the law can say

- The health authority shall initiate a process of reform of the mental health care system in order to implement a community-based model of care. Resources from psychiatric institutions and hospitals shall be progressively reoriented to community mental health services.
- Mental health care shall be carried out primarily at the community level, and not in inpatient settings, to avoid the removal of people from their communities and to facilitate recovery and social inclusion.
- The creation and development of person-centred and rights-based community mental health centres, crisis response services, community outreach services, peer support services, and other community-based services and support shall be prioritized.
- Inpatient care in general hospitals shall be provided only when it offers greater therapeutic benefits than interventions that can be provided within home settings, in community or social environments, and based on the free and informed consent of the person concerned.
- Mental health services shall be person-centred and guided by the principles of recovery, participation, community inclusion, non-coercive approaches and respect for legal capacity.
- Mental health services shall collaborate with other sectors to provide a holistic approach and facilitate access to social services and support.

2.5.3 Integration of peer-led and peer-run services

Peer-involvement in the provision of support is a touchstone for the transformation of mental health systems: people with lived experience bring understanding, trust and hope to the services. Peer support services can help individuals achieve and maintain health and well-being and social inclusion, and to navigate the mental health and social system more efficiently (284). Depending on the country context, peer-involvement can take many forms, from peer-support specialists to independent peer-run services.

While peer-led and peer-run services are not the sole purview of the health sector, legislation can help to create and integrate them into mental health and related social systems and provide an enabling environment for their establishment and sustained functioning. Often peer services face obstacles in accessing and securing sustainable funding due to the lack of awareness of their importance. They may encounter barriers in obtaining accreditation and operating licences because of expensive and bureaucratic procedures, and their work may be curtailed by regulations around safety management which may force them to not accept people deemed as a risk to self or to others. In this regard, legislation can help to eliminate all these legal obstacles to facilitate the establishment and sustained functioning of peer support.

Legislation can also support the development of peer support services by providing for their financing.



Examples of what the law can say

- Mental health systems shall promote and support peer involvement in the provision of mental health and related services.
- Mental health systems shall promote and support training and certification of peer workers.
- Peer workers shall have the same working conditions as other staff and be supported in the carrying out of their tasks.
- Peer workers shall be represented in the boards and governance structures of mental health services.
- Independent peer-run organizations operating alongside government mental health services shall be recognized.
- A policy framework shall be adopted that is favourable to establishing and sustaining the operation of peer-run services, while respecting their autonomy and independence.
- Peer-run support services shall be able to access funding mechanisms, including public funding and international cooperation.

2.5.4 Deinstitutionalization

Deinstitutionalization is an important aspect of the transformation of mental health systems. It involves the closure of all forms of institutions, including psychiatric institutions and related social care institutions, and replacing these with inclusive community support systems and mainstream services, such as community-based services, income support, housing assistance, peer support, and other support networks (10, 285).

In some countries, the processes of deinstitutionalization in the realm of mental health have been initiated or reinforced through legislation. In Italy, the aforementioned law known as Basaglia Law, strengthened the deinstitutionalization process initiated during the 1960s by establishing a ban on building new psychiatric hospitals and on admitting new patients to existing ones. More recently, legislation in Argentina, Mexico and Uruguay prohibited the creation of new psychiatric institutions in an effort to shift towards community mental health (164, 286, 287).

Legislation can promote the adoption of deinstitutionalization action plans with clear timelines and responsibilities as well as concrete benchmarks and budget lines. Deinstitutionalization strategies require a cross-governmental approach and the direct involvement of persons with lived experience, particularly survivors of institutionalization (288). An explicit prohibition of institutionalization can serve as an important deterrent against trans-institutionalization, or moving persons from one institution to another under the guise of deinstitutionalization. Provisions that facilitate or enable institutionalization should be also abolished.

Legislative measures needed for deinstitutionalization can include the obligation to ensure access to the necessary community-based services and networks to realize the right to live independently and be included in the community (see [section 2.8.1](#)). Legislative recognition of their right to legal capacity, equality and non-discrimination, access to justice, and liberty and security of person are also preconditions to enable full inclusion.

Governments should adopt a person-centred approach, so community services and individualized support are in place to take on people leaving institutions. Experience shows that ill-conceived and underresourced deinstitutionalization processes could be counterproductive and detrimental to human rights (289).

Legislation can also facilitate the creation of mechanisms for redress and reparations of survivors of institutionalization and guarantee the availability of effective legal remedies against institutionalization (see [section 2.7.3](#)) (290).

The Committee on the Rights of Persons with Disabilities has issued guidelines on deinstitutionalization, including in emergencies (285), which are intended to guide and support countries in their efforts to realize the right of persons with disabilities to live independently and be included in the community, and to serve as the basis for the planning of deinstitutionalization processes and the prevention of institutionalization.



Examples of what the law can say

- The creation of any form of institution is prohibited; this includes new asylums, psychiatric hospitals, neuropsychiatric hospitals or monovalent institutions, and public or private social care institutions.
- A multisectoral commission shall be established to develop and implement a policy for deinstitutionalization, including the adoption of a plan of action with clear timelines and responsibilities, concrete benchmarks, an adequate budget, a moratorium on new admissions, and the development of adequate community support.
- Persons with lived experience, particularly survivors of institutionalization, should be involved with and consulted at all stages of deinstitutionalization.
- Existing institutions must shift their operations to facilitate deinstitutionalization, and until their definitive replacement, restore the autonomy and choice of residents, and ensure the objectives and principles of person-centred and rights-based community support.
- Mental health systems shall collect disaggregated information from mental health and related social care services to facilitate the design of policies, plans and programmes for deinstitutionalization, and enable the measurement and tracking of progress.

2.5.5 Redistributing financial and human resources

Deinstitutionalization and the development of a robust set of community-based mental health services involves more than simply relocating individuals into the community. It demands adequate person-centred and rights-based community support and services for which the redistribution of public funds from institutions to the community is required. The WHO *Mental health atlas 2020* reports that over 70% of budgets for mental health in low- and middle-income countries, and 35% in high-income countries, are allocated to mental hospitals (45). Analysis has also shown that costs of hospitalization often exceed those of “equivalent” treatment, care and support in the community (33). In this context, legislation can help to underpin the redistribution of financial and human resources from institutions to community services.

Legislation can introduce financial incentives for the development of person-centred and rights-based community mental health services, as well as reduce or eliminate them for long-term inpatient care or services delivered by psychiatric and social care institutions. Financial incentives can also help to eliminate coercive practices such as seclusion and restraints (33).

Legislation can also help correct distortions created by health insurances. For example, health insurances may not include coverage for psychosocial interventions, community-based services, inpatient services, drug dependence services, or care related to suicide attempts or self-inflicted injuries. If an insurance policy covers medication but not therapies (the former being less costly than the latter), a perverse incentive is created to choose pharmacological treatment over therapy. Likewise, if health insurance finances inpatient services only, there is little chance of community-based services being developed. Other perverse incentives include case-based payments or reimbursements for inpatient stays, but per capita funding for community mental health services.

It is important that different types of interventions are covered in order to have quality care.



Examples of what the law can say

- The health authority, in coordination with other relevant sectors, shall review funding and reimbursement mechanisms in the health and social care sector to introduce financial incentives for the development of person-centred and rights-based community-based mental health services.
- The health authority shall reallocate budget to community-based services within and across different sectors as part of deinstitutionalization processes.
- The health authority, in coordination with other relevant sectors, shall adopt detailed plans and specifications for progressive shifts of funds from institutions to person-centred and rights-based community mental health services.
- Health insurance schemes shall be reviewed to create incentives for providing treatment and support in person-centred and rights-based community-based mental health services.

2.5.6 Implementation within humanitarian contexts and emergencies

Many people affected by conflict and humanitarian emergencies experience trauma and psychological distress as a result of related stressful events such as violence and loss, as well as poverty, discrimination, overcrowding in prisons and detention facilities, and food and resource insecurity (291). Persons with mental health conditions and psychosocial disabilities are particularly vulnerable to these negative psychosocial effects; the cumulative impact of the structural discrimination and social exclusion faced can curtail their access to basic needs and support. This is particularly relevant for those placed in institutions, who are often unable to leave during humanitarian crises, and whose situation tends to become more restrictive and precarious in such times. For example, the COVID-19 pandemic showed that, apart from the

increased risk of infection, people in psychiatric and social care institutions experienced a higher risk of confinement, overmedication, minimized human contact, no social visits, and no monitoring by independent bodies (292, 293).

Governments can improve the mental health and psychosocial well-being of all affected people by integrating rights-based mental health and psychosocial support into humanitarian and emergency responses (294). Legislation can help to ensure that appropriate support is available in emergencies, for example, during conflict, disaster situations, pandemic outbreaks, and other complex situations. Countries are being urged to continue and accelerate their efforts for deinstitutionalization during emergencies, and to take immediate action to include people in institutions in all evacuation, humanitarian relief and recovery measures (295–297).

In some countries, refugees and asylum seekers may also receive inappropriate mental health care and support and, for example, not be granted the same coverage or quality of services as citizens of the host country. This may amount to discrimination and violates Article 12 of the ICESCR, which “recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Legislation can stipulate that migrants, refugees and asylum seekers are entitled to the same mental health care as all citizens.

Countries should also consider mental health when advancing post-conflict legislation.



Examples of what the law can say

- Mental health systems shall ensure the availability and continuity of person-centred and rights-based mental health and psychosocial support responses in emergency settings, across different sectors.
- Mental health and psychosocial support in emergency settings shall cover various levels of support, including equal access to basic services and security, strengthening social cohesion, community and family support, and individual, family and group interventions.
- Mental health and psychosocial support interventions in emergency settings shall be respectful of human rights and promote and protect the rights of service users.
- Mental health systems shall guarantee and provide quality mental health services and related services to migrants, asylum-seekers, refugees and stateless persons.
- Migrants, asylum-seekers, refugees and stateless persons shall enjoy access to mental health services and support and treatment and care equivalent in quality to that provided to nationals with respect to mental health and related services.
- Mental health systems shall ensure the full respect for the cultural identity of asylum-seekers, refugees and stateless persons in the provision of mental health and related services.

2.6 Ensuring full and effective participation in public decisions

Participation, as a human right, involves the direct or indirect involvement of stakeholders in public decision-making about legislation, policies and programmes in which they have an interest. Participation is a key component of good governance as it helps to arrive at better public decisions, making government action more responsive to the actual experiences of those whom it should serve.

The transformation of mental health systems requires recognizing all members of society as rights-holders and ensuring that all persons with lived experience, including those with mental health conditions and psychosocial disabilities, have the opportunity to contribute to making mental health care and support more responsive to their needs and hold authorities accountable for upholding their rights.

This section proposes key legislative provisions to recognize and support the right of people with lived experience to participate in all public decision-making processes concerning mental health systems. These provisions can be included in disability laws, laws on civil participation, as well as general health acts and any existing mental health laws.

2.6.1 Recognizing the right to actively participate in decision-making

As set out in Article 4(3) of the CRPD, governments have an obligation to consult closely with, and actively involve, persons with disabilities through their representative organizations in decision-making processes concerning issues relating to them. This includes the participation of persons with mental health conditions and psychosocial disabilities whether they identify as having a disability or not. To fulfil this obligation in the context of mental health care, countries can adopt legal and regulatory frameworks to ensure the full and effective involvement of people with lived experience and their representative organizations in public decisions concerning issues such as mental health provision, legislation, policies, strategies and action plans.

Legislation can explicitly require that government authorities consult closely with, and ensure the active participation of, people with lived experience in the development, implementation and monitoring of legislation and policies concerning mental health care and support. This can include open consultations and direct engagement with people with lived experience and their representative organizations. Countries should not require an organization of people with lived experience to be registered as a legal entity as a prerequisite for engaging or taking part in consultation processes (159).

Furthermore, countries can adopt legislative provisions granting organizations of persons with lived experience seats on, for example, mental health standing committees, temporary task forces, or monitoring bodies (see [section 2.7.2](#)). In this way, persons with lived experience not only provide feedback, but also engage in the definition of priorities and actions.

To facilitate participation and meaningful engagement, legislation can prioritize the views of organizations of persons with lived experience when addressing issues related to mental health (298).



Examples of what the law can say

- Authorities shall actively involve and closely consult persons with lived experience and their representative organizations in the development, implementation and monitoring of legislation and policies concerning mental health care and support.
- Authorities shall actively involve and closely consult people using services in planning, service delivery, and evaluation of mental health care and support programmes and services.
- Consultation processes shall be developed under the principles of accessibility, good faith, opportunity and transparency.
- Authorities shall facilitate awareness, training and support to maximize the involvement and participation of persons with lived experience.
- Policies and procedures to ensure the participation of persons with lived experience in relevant committees, task forces and monitoring bodies, including adequate funding and compensation, shall be adopted.
- Registration as a legal entity should not be a precondition for organizations of persons with lived experience to take part in consultation processes.

2.6.2 Implementing accessible and fair consultations

Simply recognizing the rights of persons with lived experience to participate in decision-making is not sufficient; consultation processes must be accessible and fair and guarantee that their voices will be heard.

Legislation can regulate proper and transparent procedures to consult persons with lived experience in decision-making processes at the different branches and levels of government. For example, legislation can establish requirements for accessibility and transparency, as well as provide for principles of good faith, mutual respect and meaningful dialogue.

Countries can adopt legislation that ensures the views of persons with lived experience are given due weight and heard not only as a tokenistic approach to consultation (299). For this purpose, legislation can mandate that the results of consultations be taken into account and reflected in the decisions adopted, and furthermore to inform of the outcome of consultations and duly motivate public decisions. Consultations should consider intersectionality and aim to ensure representation of

diversity among persons with lived experience, particularly the victims and survivors of human rights violations in the mental health system. In acknowledgement of their time and expertise in consultations, participants with lived experience could be compensated for their inputs and covered for any direct costs, such as out-of-pocket expenses linked to participation. While there are promising practices in this regard, they are still in their early stages and warrant further discussion.



Examples of what the law can say

- ◉ Consultations shall be based on principles of transparency, mutual respect, meaningful dialogue and a genuine desire to reach a consensus.
- ◉ No one shall be excluded from participation in consultations on the basis of discriminatory criteria, such as disability, race, sex, gender identity or expression, sexual orientation, sex characteristics, origin, opinion, migration or other status.
- ◉ Authorities shall guarantee the accessibility of all facilities and procedures related to public decision-making and consultations.
- ◉ Invitations and documents for consultation shall be sent as far as possible in advance so that participants can make arrangements to attend and prepare appropriately.
- ◉ Reasonable accommodation shall be provided in all dialogue and consultation processes.
- ◉ Children with lived experience shall be provided with disability and age-appropriate assistance to allow them to participate in decision-making processes.

2.7 Ensuring accountability

Accountability is critical for ensuring both efficiency and a human rights-based approach in mental health care. It obliges duty bearers to take responsibility for their actions, to be transparent and answer to those concerned, and to ensure that appropriate corrective and remedial action is taken (300). Holding mental health systems accountable to the people using the services helps to ensure consistency and performance with a rights-based approach.

This section proposes legislative provisions that ensure and enforce accountability within mental health systems. Most of these provisions could be introduced in general health laws, patients' rights laws, disability legislation or any existing mental health acts.

2.7.1 Information systems

Information systems can guarantee that both access to information and privacy are protected. Governments have an obligation to proactively put in the public domain information of public interest and ensure its easy, prompt, effective and practical access (301). This is important for accountability and transparency in decision-making, as well as for empowering individuals in their roles as sources of information and as active participants in advocating for change.

Legislation can ensure mental health services collect, analyse, and disseminate data and information to assess their own performance and identify areas for improvement. These data can also be used to understand the social determinants of mental health and promote community inclusion. At the same time, they can help individuals access information from their own records (see [section 2.1.5](#)), as well as information about decision-making and practices by public authorities. In many countries, such requests can be submitted through freedom of information requests.

The WHO *Guidance on community mental health services: promoting person-centred and rights-based approaches* (2021) provides a series of indicators at population, service and individual levels, both within and outside the health sector (33). In addition, OHCHR has developed human rights indicators on the CRPD as a tool to facilitate understanding and implementation of its provisions, which can serve as a reference to guide actions and measures to be taken in implementing a rights-based mental health system (302).



Examples of what the law can say

- Data should be collected, disaggregated, compiled and disseminated, including in accessible formats, on the use and range of mental health services.
- Data on social determinants of health should be collected in a consistent manner across systems and used in accordance with data protection rules.
- Every person has the right to request information or to consult or obtain a copy of documents concerning public mental health authorities, bodies or services.
- Information on decision-making by public authorities concerning mental health and related services should be made available including transparency of reasons behind decisions, submissions and inputs considered and participation in decision-making.
- The mental health authority shall develop indicators designed to measure and assess the performance and impact of mental health systems at the national and subnational levels, as well as progress towards implementing person-centred and human rights-based approaches.

2.7.2 Independent monitoring bodies

Monitoring is an important component of accountability. Countries may have different frameworks to monitor the rights of people using mental health services, such as mental health review bodies, national human rights institutions, national preventive mechanisms, and bodies created under Article 33(2) of the CRPD.

Legislation can determine the mandate and composition of these mechanisms to ensure institutional, financial and political independence. Governments should also consider whether to have a framework with national jurisdiction or to have a number of bodies functioning at local, district or regional levels based on existing administrative boundaries. To advance the objective of eliminating involuntary admission and treatment in mental health services, it is important for countries to review the functions of existing monitoring bodies as well as the courts which oversee such processes.

The functions of these mechanisms are likely to vary among countries and may, in some jurisdictions, complement rather than replace the role of the court. The following, however, are important roles for independent monitoring bodies:

- Conduct regular and unannounced inspections of mental health settings or services, public and private, as deemed necessary. During such visits, there should be unrestricted access to all parts of the health service and service users' medical records, as well as the right to interview any person in the service in private.
- Periodically receive and review copies of unusual incident reports and death records from mental health services to permit review of institutional practices.
- Provide guidance on eliminating coercion in mental health services and monitor the implementation of such guidance.
- Collect data and statistics on service provision, for example on the duration of hospitalizations, the use of specific treatments and interventions, physical comorbidities, suicide, and natural or accidental deaths.
- Monitor de-institutionalization plans in mental health and related social services.
- Monitor treatment and support provided in the community; for example, by crisis response services and respite services.
- Monitor the practice of major, invasive or irreversible interventions; if permitted, ensure these are undertaken only with free and informed consent; where necessary, strengthen protections.
- Maintain registers of mental health settings accredited for outpatient and inpatient treatment, and outline and enforce quality and human rights standards for such accreditation.
- Propose administrative and financial penalties for breach of legislative provisions, including the withdrawal of accreditation and closure.
- Report directly to the appropriate government minister(s) responsible for mental health services.
- Make recommendations to the minister(s) with regard to improvements required, either through amendments to the legislation or to the code of practice.
- Raise awareness about the human rights-based approach to mental health and support training programmes for this purpose.
- Publish findings on a regular basis as specified by the legislation.
- Report to regional and international human rights mechanisms on the implementation of human rights in the context of mental health.

Countries will determine the composition and number of representatives of these mechanisms based on the functions assigned to them and the availability of human and financial resources. Given the nature of the work, they should include, among others, persons with lived experience, particularly victims and survivors of human rights violations in mental health services; persons with diverse professional experience (e.g. in mental health, human rights, legal and social work); and community advocates. Women and representatives from minority groups should be adequately represented.

2.7.3 Implementing effective remedies and redress

Current and former service users should have the right to issue complaints and initiate legal proceedings concerning any aspect of mental health provision, including treatment, behaviour, or conduct. Effective remedies should be available to challenge any human rights violation committed in the context of such services, including deprivation of liberty, institutionalization, and other coercive practices.

Legislation can outline the procedures for the submission, investigation and resolution of complaints mechanisms. Such mechanisms should be accessible, easy to use, expeditious, transparent, and effective. Information about complaints procedures should be prominently disseminated so that all persons using mental health services, their families and advocates are informed of its relevance, applicability, and how and where to lodge a complaint.

Complaint mechanisms and investigations should be responsive to each individual, taking into account their gender, age, disability and membership to marginalized groups, to guarantee that victims and survivors of violence and abuse are able and willing to come forward safely (303). Specific measures, training and guidance should be in place to enable reporting and filing of complaints and to prevent their dismissal by law enforcement authorities based on any biases, including those relating to gender, disability or age. Investigations and ensuing proceedings must be conducted in an environment that provides support and accommodations so that the complainant can participate throughout the processes without risk of revictimization and retraumatization.

Current and former service users should have the right to choose and appoint a personal representative or a legal counsel to represent them in any complaints or legal proceedings. Free legal assistance can be provided when the complaint concerns the rights to legal capacity, liberty, personal integrity, or other fundamental rights (see [section 2.8.2](#)). Complainants should also have access to support and procedural accommodations throughout all stages of the procedure, if necessary. Where appropriate, complaint mechanisms should provide for anonymity and confidentiality.

Legislation can also ensure that complaint adjudicators, such as national human rights institutions or courts, provide remedies that are individually tailored and include redress and reparation for the harm suffered. In addition to having access to adequate care and services, victims and survivors should be entitled to restitution, compensation, rehabilitation and guarantees of non-repetition (304). The decisions arising from these mechanisms should also be expressed in accessible language and formats, and copies given to service users and their counsel. When publicizing the decisions of the complaints, due consideration should be given to respecting the right to privacy of complainants and third parties. Current and former service users should have the right to appeal.

In addition, countries should consider establishing national frameworks for reparation and other assistance to victims and survivors of human rights violations in mental health services. Such frameworks can facilitate the independent investigation of human rights violations, the identification of underlying justice problems, awareness-raising activities, formal public apologies, and reparations (285).⁹ All measures should be adopted and implemented with the active involvement of persons with lived experience.

⁹ For further information see Guidelines on deinstitutionalization, including in emergencies, CRPD/C/5, 2022.



Examples of what the law can say

- Any current or former mental health service user, or the representative they themselves have nominated, shall have the right to complain about failures in the provision of care, treatment and services to: (a) the medical officer or mental health professional in charge of the service; and if not satisfied with the response, to: (b) the monitoring body; and, if not satisfied with the response, to: (c) the health authority – without prejudice to the right of the person to seek any judicial remedy.
- Any current or former service user is entitled to a judicial remedy for any violation of their rights in a mental health service.
- Complaint mechanisms apply to violations of individual or collective rights in a mental health service or by any mental health staff.
- Service users shall be provided with reasonable and procedural accommodations and support to access complaint mechanisms.
- Current or former service users shall receive free legal assistance in all complaints and legal proceedings concerning legal capacity, liberty, personal integrity, and other human rights.
- If a person receiving treatment at a mental health service dies or is the subject of an injury or a notifiable incident, an independent inquiry into the circumstances of the death, injury or incident shall be conducted immediately.
- Complaint adjudicators shall provide adequate remedies, redress and reparations to victims.

2.7.4 Professional responsibility and liability

Service providers play an important role in transforming mental health for all and ensuring a rights-based approach is embraced across the system. As part of their role, service providers have an obligation to respect both the rights of persons using mental health services and the existing legal framework. When a law is transgressed, legislation should provide for effective civil, administrative or criminal sanctions and reparations. Such sanctions should be proportional to the gravity of the offence, the severity of the harm, and the circumstances of each case. It is the responsibility of each country to determine the system adopted in their national legislation for health and non-health related offences and penalties. The determination of such sanction systems must be accompanied by education on the responsibilities and obligations of service providers, including health professionals, while taking into account the need for training in human rights (see [section 2.4.8](#)).

Legislation on professional liability has important implications for mental health provision. While professional liability for medical malpractice can help ensure that health providers meet an adequate standard of care and respect people's rights, inadequate liability regulation can hamper efforts to eliminate coercive practices in mental health services. For example, liability for malpractice can make service providers err on the side of caution and thereby resort to coercive practices. Likewise, health professionals facing potential liability may choose not to work with individuals considered to be at high risk of suicide, thereby compromising their access to appropriate mental health services and support.

In this regard, it is important that legislation creates incentives for the provision of mental health services from a rights-based perspective. It should be made clear in legislation on professional liability and other relevant laws, that health professionals will not be held liable for the acts of a person when they implement evidence-based, non-coercive practices in good faith and in line with the law; neither should they be held responsible for following a valid advance directive. However, legislation can clarify that the duty of care applies when health professionals do not offer available non-coercive alternatives and should thus be held responsible for failing to do so.



Examples of what the law can say

- ◉ A health practitioner or a mental health professional shall not be held liable for any unforeseen consequences as a result of following national procedures to implement non-coercive evidence-based interventions.
- ◉ A health practitioner or a mental health professional shall not be held liable for any unforeseen consequences upon following a valid advance directive.

2.8 Cross-sectoral reform for holistic service provision

As highlighted above, mental health and well-being are influenced by multiple social, political, economic and environmental factors, and have far-reaching consequences in all aspects of people's lives. As such, mental health systems alone are insufficient in bringing about true transformation in the lives of people experiencing mental distress (33). Reform is needed across several areas of law to address the root causes of mental distress, trauma and crisis, which include:

- racism and xenophobia
- sexism, homophobia and transphobia
- ableism
- ageism
- childhood abuse, trauma, or neglect
- violence, abuse and crime, including bullying and gender-based violence
- poverty, food insecurity and social disadvantage
- poor quality health care
- unemployment and lack of decent work
- homelessness or inadequate housing
- poor transport infrastructure
- lack of community support to persons with disabilities and carers
- climate change.

Undertaking such reforms is the responsibility of various government sectors and agencies, including those working on infrastructure, education, health, employment, housing, social services, social protection, justice, and the environment. Without high-level commitment to tackling the social determinants of mental health, the impact of investments addressing these will always be limited and unsustainable.

Legislation on mental health can help ensure cross-sectoral coordination so that people using mental health services can receive the support they need from other sectors. Many people experiencing mental distress live in poverty, have fewer opportunities for education and employment, and face discrimination regarding housing, social protection, and access to justice. As such, it is important to develop mental health services that engage with these important life issues in a substantial way and ensure that all non-medical social needs are supported simultaneously (33).

In this regard, this section proposes important legislative provisions which deal with the interface between mental health and other sectors. However, as highlighted above, other legislative reforms are necessary to address all social determinants of mental health.

2.8.1 Promoting community inclusion

Living independently and being included in the community is a human right which most people take for granted. However, many people are denied this right systematically, either because they live in an institution or because they have no appropriate support to participate in social and public life.

Article 19 of the CRPD recognizes the equal right of all persons with disabilities, including people with mental health conditions and psychosocial disabilities, to live in the community, and have choices equal to others. It calls on governments to take effective and appropriate measures to facilitate the full enjoyment of this right for all persons with mental health conditions and psychosocial disabilities, as well as their full inclusion and participation in the community. Most of the measures needed to achieve this fall outside the scope of mental health services and relate to other sectors and programmes. Nonetheless, it is important to recognize that mental health laws, policies and programmes have often hindered independent living and community inclusion by limiting choices and access to services in the community. This has resulted in a history of institutional care, isolation, segregation and the perpetuation of stigma and discrimination against persons using mental health services. Mental health systems should therefore prioritize as essential goals community inclusion and independent living, and contribute proactively to their implementation.

The following subsections propose legislative provisions with these aims. Many of these provisions can be located in legislation on disability, social care, local development, or social protection, and should be complemented by wider legislative efforts to implement Article 19 of the CRPD.

Recognition of the right to live independently and be included in the community

Adopting legislative measures to recognize the right of persons with mental health conditions and psychosocial disabilities to live independently and be part of the community is also important, including provisions ensuring that people can choose where and with whom they live, and that they are not to be forced into a particular living arrangement such as a psychiatric or social care institution.

Fulfilling the right to live independently and to be included in the community should be a multisectoral responsibility. Mental health systems have an obligation to respect and protect this right, in addition to taking positive action to fulfil its enjoyment. The explicit recognition of this right is not only a fundamental condition for its justiciability, but a gateway for communities to seek and develop alternative services and support for their members, based in the community.

Legislation can also facilitate access to community-based services and support outside the health system. For example, in Israel, the Rehabilitation in the Community of Persons with Mental Disabilities Law of 2000 provides a package of services and programmes which includes housing, employment, adult education, social and leisure-time activity, assistance to families, dental care and case management. Legislation can further ensure that persons with mental health conditions and psychosocial disabilities are not discriminated against when using any services, programmes or facilities in the community.



Examples of what the law can say

- Persons with mental health conditions and psychosocial disabilities have the right to live independently and be included in the community, with choices equal to others.
- The provision of mental health services shall be designed to facilitate and support service users to live, work and actively participate in the community, with choices equal to others.
- The Ministry of Social Affairs and other related ministries shall implement and adequately fund a range of community support services and programmes to support the independence and community inclusion of persons with mental health conditions and psychosocial disabilities. These services and programmes shall be designed to enable direct choice and control of service users over the care and support they receive.

Multisectoral coordination and action for mental health

The lack of support and services in the community, along with the critical gap in addressing the social determinants of mental health, are the main reasons for institutionalization. The fragmentation in support and services and, particularly, the strict separation between health and social care, often leads some people, especially those belonging to disadvantaged or marginalized groups, to be left behind.

Due to the existing correlation between mental health conditions and disadvantage, including poverty, unemployment, and homelessness (305), many countries have developed programmes that seek to address these issues through their mental health systems (10, 306, 307). Many of the programmes are successful; however there is always the risk that interventions, being anchored in the health system, are permeated with a medicalized approach. In addition, in many cases, such services are segregated and, although they may solve urgent support needs, do not promote the active participation of persons with mental health conditions and psychosocial disabilities in all areas of community life.

A cornerstone of a mental health system based on choice and human rights is the existence of a range of community services and support; these include, but are not limited to, programmes relating to housing, employment and social protection, as well as child protection services and support services for survivors of violence. They should be provided by the respective sectors and integrate a right to health perspective. In this way, mental health and well-being are protected and promoted across the work of the State as a whole, and programmes and initiatives from different sectors can contribute to creating a society that values, promotes, and supports mental health and well-being, and embraces psychosocial diversity.

The law can help to refine sectoral responsibilities, mechanisms for collaboration, and coordination structures, to implement a holistic approach to mental health. Collaboration and coordination across different sectors are crucial for systemic change since no one sector alone can deal with the social determinants of mental health. Legal reform can be instrumental in facilitating the coordination and action needed to ensure all sectors - including health, education, housing, disability, labour, and social care – work together towards a common goal.

In addition, legislation can help to clarify the role of the health sector in relation to the unmet non-medical needs of persons using mental health services. The law can help to ensure that people are referred to other support and social services with proper follow-up and monitoring. Multisectoral coordination in the provision of holistic care and support can help to better respond to people’s changing needs and goals, improve transitions of care, and maximize available resources. The involvement of implementation and monitoring bodies created under Article 33 of the CRPD can help generate a paradigm shift in care and support.



Examples of what the law can say

- ◉ All sectors have a responsibility to promote and support mental health and well-being.
- ◉ Mental health objectives shall be integrated into pertinent sectoral policies and programmes.
- ◉ The national government shall establish and create a multisectoral committee to enable cross-sectoral collaboration on mental health.
- ◉ Mental health systems shall coordinate with other sectors and relevant local authorities to ensure the provision of holistic, integrated care and support services in the community.
- ◉ The Ministry of Social Affairs and other related ministries shall promote access to a range of social protection programmes and benefits for persons with mental health conditions and psychosocial disabilities.

Supporting organizations of persons with lived experience

Organizations of persons with mental health conditions and psychosocial disabilities play an important role in expressing, promoting, representing and defending the rights and interests of persons with lived experience. They can operate as individual organizations, coalitions, or as part of an umbrella organization of persons with disabilities.

Legislation can create an enabling legal framework for their establishment and functioning; this includes providing cost-free and accessible registration systems; the provision of financial and other support; and the establishment of formal mechanisms to enable participation and to be consulted. In providing such support, countries must respect the independence of such organizations and refrain from obstructing the exercise of their right to freedom of association in law or in practice.

Persons with mental health conditions and psychosocial disabilities may be inadequately represented by existing disability organizations in a given country due to the significant challenges they face in participating in public life. Therefore, legislation can include provisions for the implementation of outreach strategies aimed at enabling the direct and voluntary participation of persons with mental health conditions and psychosocial disabilities in public decision-making processes.



Examples of what the law can say

- Organizations of persons with mental health conditions and psychosocial disabilities shall be provided access to appropriate and sufficient funding to support their activities.
- Organizations of persons with mental health conditions and psychosocial disabilities shall be able to register as legal entities on an equal basis with other organizations.

Supporting families

Families have a significant impact on the lives of persons with lived experience. In many contexts families are the main source of support, and in some cases the sole advocates. Nonetheless, family support often comes at a high cost. Unpaid family support can affect social relationships, income levels and the general well-being of the household (308). This disproportionately affects women and girls who are generally the main providers of support. In addition, when families are the sole source of support, due to a lack of alternatives, persons with mental health conditions and psychosocial disabilities may have no choice or control over the support they receive.

Legislation can create an obligation for families providing informal support to be offered information and services. Families may need support to understand mental distress and diversity in a positive way, and to know how to support a family member who has a mental health condition or psychosocial disability, and respect their will and preferences.

Legislation can also mandate governments to establish specific support services for families, such as financial assistance, respite services, support groups, counselling or training. However, it is important that support for families does not replace support for the individual, and that individuals with a mental health condition or psychosocial disability have access to support that serves their own interests and requirements in accordance with their will and preferences and independent from those of their family.



Examples of what the law can say

- Governments shall provide adequate support services to family and non-kin carers of persons with mental health conditions and psychosocial disabilities. Such services shall include advice, guidance, training, respite, support groups, counselling, and social and financial assistance, and shall not replace nor exclude direct support to the individual, in accordance with their will and preferences.

2.8.2 Access to justice

Far too many people with mental health conditions and psychosocial disabilities are denied equal access to justice. Many are prosecuted and imprisoned, often for relatively minor offences; others are denied the opportunity to seek justice in court for violations of their human rights. In general, they are regularly afforded less substantive and procedural due process protection, which often results in denial of justice, incarceration, and forced treatment (309).

Transforming the justice system so that people with mental health conditions and psychosocial disabilities can exercise their rights on an equal basis with others is an objective beyond the scope of this Guidance. However, mental health and justice systems indisputably intertwine, particularly in the context of criminal law. In most countries, persons with mental health conditions and psychosocial disabilities are overrepresented in the criminal justice system and prisoners with mental health conditions and psychosocial disabilities are often victimized by other prisoners and prison staff (310, 311). People of African descent, Indigenous Peoples and racial, religious, and ethnic minorities with mental health conditions and psychosocial disabilities, in particular, face significant disparities in the criminal justice system (312). Moreover, those deemed “unfit to stand trial”, or of comprehending their criminal actions are usually placed in mental health facilities, without due process and under strict regimes, sometimes indefinitely. Legislation on mental health often lays down procedures for dealing with such situations, including within forensic mental health systems.

This section aims to reflect on these challenges and intersections, and proposes legislative provisions to ensure that persons with mental health conditions and psychosocial disabilities are guaranteed the right to a fair trial on an equal basis with others, and the right to receive appropriate accommodations and support in the justice system, including access to legal aid and quality mental health services. Nonetheless, further research and development are needed in this area to better obtain evidence-based recommendations.

Recognizing and supporting legal capacity to access justice

Effective access to justice requires courts to recognize the full capacity and right of individuals to participate in all legal proceedings. In most jurisdictions, terms such as “cognitive incapacity” and “mental incapacity” are used to restrict a person’s right to initiate proceedings or stand trial. This “incapacity” is often determined or informed by mental health professionals through functional or mental status assessments.

In the context of a criminal proceeding, the evaluation of “mental fitness” to stand trial often occurs before the start of trial, but can take place at any point during the trial. If a person is found unfit to stand trial, the law empowers the court to transfer the person to a mental health facility for treatment. Criminal proceedings may not commence until the person regains fitness, which may be an indeterminate period.

The notion of “fitness to stand trial” is intended to ensure fair trial, so that no one faces trial without understanding the nature, object, and consequences of the legal proceedings, or the ability to adequately defend themselves. However, this can lead to persons with mental health conditions and psychosocial disabilities being denied the right to access justice on an equal basis with others and to prove their innocence. Furthermore, it subjects them to an alternative track with fewer substantive and procedural guarantees, where they can be subjected to measures entailing deprivation of liberty and involuntary treatment, often indefinitely or for significantly longer periods of time than if they had been convicted of a crime in accordance with due process guarantees.

In this regard, it is important for the justice system and criminal law to recognize and assume the full legal capacity and right of persons with mental health conditions and psychosocial disabilities to participate in the proceedings of all courts and tribunals. This would involve repealing provisions that establish and apply doctrines of “unfitness to stand trial” and “incapacity to plead”, which prevent persons with mental health conditions and psychosocial disabilities from participating in legal processes.

To ensure their effective participation in all legal proceedings, legislation can establish an enforceable right to receive individually determined procedural accommodations. These are the necessary and appropriate modifications and adjustments in the context of access to justice, where needed in a particular case, to ensure the participation of persons with mental health conditions and psychosocial disabilities on an equal basis with others (313). Unlike “reasonable accommodations”, “procedural accommodations” are not limited by the concept of “disproportionate or undue burden” (313).

In this way, people can rely on the necessary adjustments and support to: i) understand the nature and object of the legal proceedings; ii) understand the possible consequences of the proceedings; and iii) communicate effectively with legal counsel. For example, intermediaries or facilitators can enhance clear communication among and between persons with mental health conditions and psychosocial disabilities and the courts, tribunals and law enforcement agencies to ensure safe, fair and effective engagement and the opportunity to fully participate in legal processes (314).

The International Principles and Guidelines on Access to Justice for Persons with Disabilities (August 2020), gives examples on how to provide procedural accommodations within the criminal justice system (9).

To guarantee the right to a fair trial, legislation can also ensure free or affordable legal assistance to persons with mental health conditions and psychosocial disabilities in all legal procedures related to their fundamental rights (315). Legal assistance should be competent and available in a timely manner.



Examples of what the law can say

- ◉ All persons with mental health conditions and psychosocial disabilities shall have access to justice on an equal basis with others. No one shall be denied access to justice on the basis of mental health status or psychosocial disability.
- ◉ Persons with mental health conditions and psychosocial disabilities shall enjoy legal capacity on an equal basis with others with equal standing in courts and tribunals.
- ◉ All people subject to criminal proceedings shall receive the same treatment and have the same opportunities to respond to an accusation or present a defence.
- ◉ Where necessary, persons with mental health conditions and psychosocial disabilities shall be provided with appropriate individualized procedural accommodations to exercise their legal capacity and guarantee their access to justice.
- ◉ Procedural accommodations shall include the provision of intermediaries or facilitators, procedural adjustments and modifications, adjustments to the environment, and communication support to ensure access to justice.
- ◉ All participants to legal proceedings shall be informed of the availability of procedural accommodations.
- ◉ No person shall be deprived of mental health care and support during criminal procedures or investigations against them.
- ◉ Persons with mental health conditions and psychosocial disabilities shall be entitled to receive free legal assistance in all legal procedures and proceedings concerning both criminal and civil matters that involve the rights to life, legal capacity, liberty, personal integrity, adequate housing, and family integrity.



- Persons with mental health conditions and psychosocial disabilities have the right to participate in the administration of justice on an equal basis with others, including as judges, lawyers, prosecutors, witnesses, jurors, experts and court officials.
- In cases involving children and adolescents with mental health conditions and psychosocial disabilities, courts shall initiate a process for determining the need for procedural accommodations and their provision. Safeguards shall be established, where necessary, according to the evolving capacities of the child or adolescent and their right to have their views heard.

Police involvement

Legislation can assist in ensuring a constructive and helpful role for the police with respect to people experiencing intense distress and crisis. The police have a primary responsibility for maintaining public order while upholding the human rights of all citizens. In the fulfilment of their role, police officers often intervene at the scene of an emergency or crisis to provide assistance. Violent incidents may occur, with persons experiencing intense distress, or being seriously or fatally injured, especially among those who belong to ethnic and racial minorities.

Legislation can help to limit police intervention in crises and, when unavoidable, ensure that it is free from discrimination and the discriminatory use of force based on actual or perceived mental health conditions or psychosocial disability. For example, legislation can mandate the creation of crisis response services to provide adequate support that is unrelated to and independent of police or law enforcement involvement (see [section 2.3.3](#)).

Legislation can also increase safety in encounters with law enforcement by mandating the provision of procedural accommodations to persons experiencing distress or unusual perceptions at the time of police intervention in the criminal justice process, including during an arrest. Accommodations should include procedural adjustments and communication support. Police intervention should also be guided by trauma-informed, de-escalation and anti-racist principles, with easy access to a crisis support service for advice.

In many jurisdictions, legislation mandates the police to take a person to an inpatient mental health service during a crisis, the aim being to avoid the intense distress often experienced when entering police custody and the criminal justice system. However, as discussed in the following section, mental health diversion practices need to be implemented in line with the standards of the CRPD.



Examples of what the law can say

- Police intervention must respect the rights and dignity of persons with mental health conditions and psychosocial disabilities.
- Persons with mental health conditions and psychosocial disabilities have the right to be free from discrimination and any use of force or coercion based on mental health or psychosocial disability during police intervention.
- Police officers shall ensure the provision of procedural accommodations to persons with mental health conditions and psychosocial disabilities during any police intervention.
- Police officers shall receive appropriate training and assistance to de-escalate difficult situations involving persons with mental health conditions and psychosocial disabilities, and minimize the need for utilizing the criminal justice system.

Diversion from the criminal justice system

There is a growing global concern regarding the overrepresentation of persons with mental health conditions and psychosocial disabilities in places of deprivation of liberty, especially among those who belong to ethnic and racial minorities. Far too many are prosecuted and imprisoned, often for relatively minor offences. This is a by-product of many factors including, among others, the existence of discriminatory legislation establishing less substantive and procedural guarantees; the implementation of laws criminalizing nuisance behaviour; the widespread misconceptions about mental health and violence; intolerance in society for different, difficult or disturbing behaviour; the unavailability or reduced availability of support services; and systemic discrimination against marginalized groups.

Many countries have adopted legislation that diverts offenders who have mental health conditions and psychosocial disabilities away from the traditional criminal system pathway to the mental health system. These initiatives provide treatment alternatives to criminal sanctions for persons with mental health conditions and psychosocial disabilities who have come into conflict with the law. The rationale behind this is to reduce incarceration rates, as well as the likelihood of criminal recidivism.

While a wide range of mental health diversion models exist across jurisdictions, they can be broadly categorized as pre-booking diversion programmes and post-booking diversion programmes (316). The former involve diversion before the laying of a criminal charge, thus the individual is not charged with an offence but rather is diverted to mental health services without further criminal justice involvement. The latter involves diversion after an individual has been arrested and jailed or charged with a criminal offence. Mental health systems are instrumental in the operation of both types of programmes (316).

The development of diversion programmes is still relatively new and there is insufficient evidence on their effects on reducing recidivism and incarceration among people with mental health conditions and psychosocial disabilities (316–318). However, there is increasing concern that such diversion programmes fail to address the underlying structural inequalities leading to criminalization (e.g. stigma, ableism, racism, poverty, lack of community support, etc.) and often resort to medicalized approaches and coercive practices which are contrary to human rights (319). People may stay out of prison, but nevertheless be subjected to control and coercion, such as community treatment orders. Indeed, in many diversion schemes, if individuals do not comply with the treatment orders imposed, they may return to the criminal justice system. There is thus a risk of increasing, rather than decreasing, the number of persons with mental health conditions and psychosocial disabilities under state control.

There is an urgent need to rethink how the detention of people with mental health conditions and psychosocial disabilities in police custody or in prison can be avoided, while at the same time addressing stigmatization and practices contrary to human rights. Countries should give careful consideration to the potential benefits and harms of implementing diversion programmes within their jurisdictions, and with the active involvement of persons with lived experience (see [section 2.6](#)). However, where viewed as an integral part of broader efforts to adopt anti-carceral strategies, legislation should ensure that diversion programmes:

- (i) are used only when there is sufficient evidence that the individual committed the alleged offence (i.e. there are reasonable grounds, based on the available evidence);
- (ii) are provided on a free and voluntary basis, based on adequate information about the nature, content and duration of the programme;
- (iii) are oriented towards the provision of person-centred and rights-based community support and restorative justice; and
- (iv) do not entail coercive mental health care or social control.

Preventing “at-risk” people with mental health conditions and psychosocial disabilities from entering the criminal justice system requires long-term systemic change to redress the accumulated disadvantages and inequitable outcomes affecting these groups. It is also important that countries review their criminal legislation to ensure that atypical behaviours (e.g. “meltdowns”, stimming, yelling or self-injury) and behaviours arising from, and perpetuated by, poverty or homelessness (e.g. begging, sleeping in public spaces, loitering) are not treated as criminal activity (320). The relationship between poverty, homelessness and mental health conditions is well recognized.

Criminal responsibility

To date, the impact of the CRPD on criminal responsibility remains significantly underexamined within both disability and legal discourses. This is an area of frequent interaction between persons with mental health conditions and psychosocial disabilities, the criminal justice system, and mental health systems.

In most countries, legislation takes into account the mental state of the accused at the time of the offence when determining criminal responsibility. If the court finds that the accused did not appreciate the nature and consequences of their actions due to a mental health condition or impairment, they may be declared not guilty. However, legislation may still order a “security measure” involving admission to a forensic facility or mandatory community treatment, often based on considerations of “dangerousness” (309). This seemingly

contradicts the principle of no punishment without guilt, and, in reality, those subject to security measures may spend longer periods of deprivation of liberty than those found guilty of the same crimes.

For these reasons, several stakeholders have called for a review of legislation on criminal responsibility and security measures to ensure that persons with mental health conditions and psychosocial disabilities enjoy the same substantive and procedural guarantees as every other person (321, 322). This includes repealing declarations of “insanity” and “non-responsibility on grounds of disability” and their corresponding security measures (323–326). Some human rights experts have proposed replacing them with the use of general criminal defences and prerequisites of criminal responsibility, such as “mistake of fact” or “duress” (321, 322, 327). Restorative justice schemes and non-custodial measures have also been suggested as an alternative (321).

Although people are increasingly speaking out for this to be addressed, there is no consensus on how to legislate systems of attribution of criminal responsibility adequately, so that they are responsive to the rights of persons with mental health conditions and psychosocial disabilities (328). This is an area that requires careful attention and discussion, as well as significant input from people with lived experience. Meanwhile, it is crucial to ensure that persons with mental health conditions and psychosocial disabilities enjoy all substantive and procedural safeguards recognized in international law, on an equal basis with others.

Prisoners with mental health conditions and psychosocial disabilities

Legislation can play a critical role in recognizing the obligation to provide prisoners who have mental health conditions and psychosocial disabilities with appropriate accommodations and support, including access to mental health and psychosocial support. Prisoners, including people in immigration detention facilities, should enjoy the same standards of health care that are available to others in the community, and should have access to services free of charge and without discrimination (329). This includes having the right to provide their free and informed consent prior to any medical intervention, make advance directives, and to access supported decision-making mechanisms. Visiting prisons and other detention centres should be standard practice for community teams to ensure equitable access to person-centred care and therapeutic continuity.

Legislation may also contain provisions guaranteeing prompt access to medical attention in urgent cases (330). Prisoners with mental health conditions and psychosocial disabilities who require specialized treatment or surgery should be transferred to other health facilities if they cannot be treated adequately, and on an equal basis as others, within the prison. Such measures should be based on prisoners’ free and informed consent.

Any prisoner transferred from prison to a hospital and then back to prison should have the time spent in hospital included as part of their sentence. Furthermore, such prisoners should only be detained in the hospital for the duration of their sentence. An independent monitoring body should regularly monitor the situation of persons with mental health conditions and psychosocial disabilities in prisons and other detention centres in accordance with Article 16(3) of the CRPD and the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. Persons with mental health conditions and psychosocial disabilities should be part of such monitoring mechanisms.

Training for the administration of justice

Countries can adopt legislation that guarantees training on rights-based mental health for all justice officials, including the police, judicial officers, lawyers, health professionals, forensic experts, victim service professionals, social workers, and probation, prison and youth detention staff.

Legislation can create a requirement for people working in the administration of justice to participate in training that is human rights-based, and that includes the rights of persons with mental health conditions and psychosocial disabilities, as well as the provision of procedural accommodations. Legislation can further ensure that persons with lived experience and their representative organizations participate in the development and presentation of such training.



Examples of what the law can say

- All justice officials and staff working in the justice system shall be provided with awareness-raising and training programmes that address the human rights-based approach to mental health.
- All police officers shall receive specific training in: i) combating implicit bias, stereotyping and profiling on the basis of gender, ethnic or national origin and race, and disability; ii) de-escalation principles and techniques; and iii) procedural and age-appropriate accommodations.
- Persons with mental health conditions and psychosocial disabilities and their representative organizations shall participate in the development and delivery of all training. Funding for mental health awareness and training shall be included in the budget of the justice system.

Chapter 3

Developing, implementing and evaluating rights-based legislation on mental health

Introduction

The processes for developing and implementing legislation on mental health are as crucial for human rights as the content of the law itself. Chapter 3 explains how a human rights-based approach can be incorporated into legislation, and outlines the steps countries should take before embarking on the drafting, adoption, implementation and evaluation processes. Emphasis is placed on the obligation of each country to actively involve and consult persons with lived experience and their representative organizations.

The chapter stresses the importance of comprehending the framework of international human rights law prior to initiating a reform process. It also offers guidance on conducting a thorough review of legislation on mental health, and assessing the primary barriers to achieving rights-based mental health care. Insights are provided on drafting and debating a legislative proposal; identifying entry points for advocacy and mobilization; and ensuring collaboration and engagement among diverse stakeholders. Additionally, the chapter considers the implementation and evaluation of the law, highlighting vital considerations for these processes.

It is important to note that the practices outlined and discussed serve only as a guiding reference: the processes for legislation will depend on national norms, customs and contexts.

3.1 Stakeholder engagement and consensus-building

The process of fostering inclusive collaboration and consensus is paramount to effective legislation on mental health. This section outlines two aspects: actively involving all relevant stakeholders, including persons with lived experience; and building consensus and political will among these diverse participants. By incorporating a wide range of perspectives and cultivating a shared understanding of goals and values, policy-makers can ensure that the resulting legal framework is not only comprehensive and well-informed, but also enjoys strong support from all parties involved, ultimately promoting effective implementation and positive outcomes for the community.

3.1.1 Actively involving all relevant stakeholders, including persons with lived experience

While initiatives may be spearheaded by a range of governmental, legal, professional and civil society bodies, persons with lived experience and other individuals or groups, it is nevertheless important to engage as wide a range of stakeholders as possible. Stakeholders may include politicians, policy-makers, government ministries (health, social welfare, law and finance), persons with lived experience, professionals (psychiatrists, psychologists, psychiatric nurses and social workers), family members, advocacy organizations, service providers, nongovernmental organizations, civil rights groups, faith-based organizations, congregations of particular communities, and academic and research institutions. In some countries it may also be necessary to include community leaders and traditional healers.

The active involvement of persons with lived experience, including the victims and survivors of human rights abuses by mental health services, is particularly important at each legislative stage. Stakeholders should strive for the highest possible level of participation from the outset, including in the co-planning and co-design of activities. The direct involvement of these groups helps to ensure that any legislative reform is built from first-hand experience, and benefits from their collective insights and expertise.

When involving persons with lived experience in the reform process, it is crucial to engage directly with their representative organizations as these organizations serve as intermediary bodies and play a major role in advocating for their rights (331). Although umbrella organizations of persons with disabilities or national human rights institutions can assist in identifying organizations of persons with mental health conditions and psychosocial disabilities, it is important nonetheless to keep in mind that civil society organizations which provide services or advocate on their behalf do not qualify as such (332).

In countries where gaps in representation exist, stakeholders should directly approach individuals and groups of persons with mental health conditions and psychosocial disabilities, and collaborate with national, regional and international organizations of persons with disabilities, which may have members or contacts at the local level (333). It is essential to give space to the diverse voices of persons with lived experience.

Some individuals may need support to actively engage in the reform process. They may be unfamiliar with legislative procedures or legal terminology, or feel uncomfortable expressing opinions publicly due to traumatic experiences, societal marginalization or the presence of mental health professionals. To facilitate participation, it is important to create safe and supportive spaces, address power imbalances, and take deliberate action to equalize influence. Capacity-building and financial support may also be necessary to ensure meaningful participation.

3.1.2 Building consensus and political will

The process of building consensus for legislation on mental health should begin as early as possible so that different views can be incorporated, and subsequent implementation facilitated. Consensus around the issues at stake is critical for the success of any legal reform.

Not only are consensus-building and negotiation important for drafting legislation, they also ensure its implementation once adopted. Broad consensus is also necessary because a human-rights based approach to legislation related to mental health is bound to fail unless societal misconceptions, fears and ableist views relating to mental health conditions and psychosocial disability are addressed. Unfortunately, considerable stigma and discrimination surrounding mental health continues, which, if left unaddressed will hamper implementation. As part of the process of building consensus and trust across stakeholders, it is therefore important to publicly acknowledge the harm caused to persons with mental health conditions and psychosocial disabilities by mental health systems. Recognizing the negative legacy of the multiple human rights violations that have occurred in these spaces will help to advance the eradication of the underlying values and practices.

In many countries, a lack of understanding among stakeholders of the CRPD and the human rights-based approach may lead to resistance in advancing reforms, opposition to the legislation while being processed, and even undermining of the legislation once passed. It is therefore essential that all principal stakeholders – mental health professionals, health workers, public and private service providers, the police and judicial actors, the media, communities and families – are appropriately informed and educated about the human rights-based approaches to mental health. Dedicating time and resources in this well in advance of efforts to reform law, facilitates all legislative processes.

3.2 A rights-based analysis of existing law and policy

Before embarking on drafting the legislation, four preliminary steps can be useful in deciding the content: i) studying the latest developments related to international human rights conventions and standards; ii) examining the existing legal framework to analyse how it upholds or falls short of international human rights standards, while identifying specific elements that are lacking or in need of reform; iii) understanding the country's mental health-related needs and barriers to the implementation of rights-based mental health policies, plans and programmes; and iv) learning from the lessons and experiences of other countries.

3.2.1 Studying obligations under international conventions and standards

An initial step in the process of legislation is for countries to understand their obligations under international human rights law ([Box 9](#)). Countries that ratified international human rights treaties have committed to protect, respect and fulfil these rights (see [section 1.4](#)) and must take their obligations into account fully during the planning of any legislation related to mental health. It is therefore important that training is provided on a human rights-based approach to mental health for all involved actors.

Box 9

Human rights obligations concerning mental health

Core human rights instruments:

- International Convention on the Elimination of All Forms of Racial Discrimination.
- International Covenant on Civil and Political Rights.
- International Covenant on Economic, Social and Cultural Rights.
- Convention on the Elimination of All Forms of Discrimination against Women.
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
- Convention on the Rights of the Child.
- Convention on the Rights of Persons with Disabilities.
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.
- International Convention for the Protection of All Persons from Enforced Disappearance.

Human Rights Council resolutions:

- Resolution A/HRC/32/18, mental health and human rights, adopted by the Human Rights Council on 1 July 2016.
- Resolution A/HRC/RES/36/13, mental health and human rights, adopted by the Human Rights Council on 28 September 2017.
- Resolution A/HRC/RES/43/13, mental health and human rights, adopted by the Human Rights Council on 19 June 2020.
- Resolution A/HRC/RES/52/12, Mental health and human rights, adopted by the Human Rights Council on 3 April 2023.

UN special procedures mandate holders:

- UN Special Rapporteur on the rights of persons with disabilities.
- UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.

Box 9

Human rights obligations concerning mental health [cont.]

UN entities:

- Office of the United Nations High Commissioner for Human Rights (OHCHR).
- World Health Organization (WHO).
- United Nations Children’s Fund (UNICEF).
- United Nations High Commissioner for Refugees (UNHCR).
- United Nations Department of Economic and Social Affairs (UN DESA).
- United Nations Special Envoy of the Secretary-General on Disability and Accessibility.

3.2.2. Identifying barriers to rights-based mental health care

A second step is to obtain reliable information about the country’s principal concerns relating to mental health, as well as any existing or likely barriers to implementing rights-based mental health policies, plans and programmes. There are many sources of information and evidence on the situation of a given country:

- Disaggregated data by country from national health information systems.
- National quantitative or qualitative studies, e.g. community-based epidemiological studies.
- Reports from national human rights institutions, other monitoring bodies, and domestic court decisions related to mental health.
- Reports from civil society organizations, including organizations of persons with mental health conditions and psychosocial disabilities.
- Other relevant reports, e.g. national reporting to treaty bodies as well as reports from the treaty body system or the Human Rights Council’s Special Procedures mandate holders.
- UN country reports, e.g. from human rights mechanisms, country teams or UN entities.

A critical evaluation of existing literature is necessary to recognize and address biases and power imbalances in research, which often favour high-income countries, biomedical, quantitative and non-lived experience perspectives (334). Understanding barriers and obstacles faced by persons with mental health conditions and psychosocial disabilities is also essential. While legislation related to mental health cannot ensure CRPD implementation, identifying barriers and restrictions in other laws is important when seeking legal solutions to mental health-related challenges. [Box 5](#) illustrates examples of the challenges that can be addressed through legislative efforts, and identifies priority areas for broader legal reform.

Conducting focus group discussions with people with lived experience and other stakeholders can help identify and comprehend critical challenges and gaps, in particular where data are sparse or significant information gaps exist.

3.2.3 Comprehensive review of national legislation

The third step involves conducting a comprehensive review of national legislation to determine the need for new laws and to identify those that require review or repeal due to inconsistencies with human rights obligations. Any review should be rigorous and comprehensive, and acknowledge the interdependence and indivisibility of human rights. Depending on the country's political system, this may be led by different bodies, such as a special independent commission, a national human rights institution, or a parliamentary committee (335).

The mapping of existing legislation varies significantly across countries. Some will have a long history of legislation on mental health, while others may be developing theirs for the first time. Existing stand-alone mental health laws must be carefully examined against the latest human rights standards, in particular the CRPD. In addition, components of other laws, as they relate to mental health, need to be identified and assessed. This comprehensive review will provide an overview of the different sectors contributing to rights-based mental health policies and programmes, and help determine which laws may need revision.

Although some countries may have adequate provisions in existing legislation, implementation may be lacking. In such instances, it may be necessary to analyse why this is so, and whether accountability, monitoring and complaints systems within the law need be strengthened or created. At other times, implementation issues may stem from insufficient allocated resources, which may also necessitate legislative changes.

The checklist on rights-based legislation on mental health (provided at the end of this Guidance), is a useful tool to determine the strengths and weaknesses of existing legislation, and to identify which provisions need to be considered for inclusion in new laws.

3.2.4 Reviewing legislation and good practices in other countries

Reviewing other countries' legislation related to mental health and disability helps to identify components typically covered by law, as well as good practices and effective measures. However, it is important to consider the specific social, economic and cultural variables of a country, as certain provisions may not be applicable, or require modification. Maintaining a focus on human rights compliance throughout is essential.

Many countries continue to have outdated legislation that does not reflect the latest human rights obligations. Any review should therefore focus on countries with progressive legislation that incorporates international human rights standards and current knowledge in the area of mental health care and support, as outlined throughout this Guidance. It should also fully examine the impact of the legislation on improving the situation for persons with mental health conditions and psychosocial disabilities in those countries. Reasons for failure may include poorly-drafted legislation or difficulties in implementation stemming from legislative provisions that do not take into account the practical realities nor the lived experiences of rights-holders in the country.

A useful resource for accessing mental health-related legislation from different countries is the WHO MiNDBank,¹⁰ an online platform that brings together country and international resources, legislation and policies covering mental health, substance abuse, disability, general health, human rights and development. The UN Department of Economic and Social Affairs has also systematized disability laws and acts by country (336). It should be taken into account that available legislation in databases may not reflect the latest human rights standards.

3.3 Drafting legislation

Upon acquiring a thorough understanding of both the international and national legal frameworks, as well as the country's specific mental health challenges, it will become necessary to determine whether to proceed with drafting legislation. The drafting process may be conducted by a parliamentary committee or working group, or led by a government department, contingent on the legislative practices within each jurisdiction. Regardless of the leading body, it is vital to consult extensively on the draft proposal with various stakeholders, particularly those with lived experience.

This section addresses these two critical activities: i) the drafting process itself, which differs across countries; and ii) broadly consulting on the draft proposal with different stakeholders.

3.3.1 The drafting process

The process of drafting new legislation varies across countries depending on the particular legislative, administrative and political structures. Generally, these will be well-established and should be followed when developing legislation.

In some countries, a dedicated committee is appointed by the legislature or the relevant ministry to draft the law; in others, a law commission or similar body takes on this responsibility. In countries without clearly-defined structures for drafting new legislation, the ministries of health or justice can assume a significant facilitative role. Moreover, certain jurisdictions have provisions in place for civil society to introduce a citizens' initiative via a petition endorsed by a designated number of registered voters, allowing for greater public involvement in shaping mental health policies.

¹⁰ See: <https://extranet.who.int/mindbank/>.

The presence of considerable and diverse expertise is pivotal to the drafting process and ensures that the resulting law is comprehensive, adheres to a human rights-based approach, considers all relevant information and perspectives fully, and is tailored to local circumstances. If a committee or group of experts is appointed to draft the legislation, it is essential to involve a wide range of stakeholders, including organizations of persons with lived experience, and to provide a mandate to engage others who possess the necessary expertise and represent different interests.

3.3.2 The consultation process

The consultation process follows the drafting process and allows for additional input from stakeholders to influence the final legislation. Consultation helps identify potential weaknesses; resolve conflicts with existing legislation or local practices; address issues that may have been omitted inadvertently; and identify solutions to practical difficulties in implementation.

The different forms of consultation can range from statutory to informal. A time-bound process following three stages is recommended:

1. Publication of the draft document in the government gazette or the parliament's official website, inviting comments and contributions from the public. This step should include direct invitations to key stakeholders for written inputs (Box 10).
2. Holding national and regional public consultation meetings and workshops to analyse and discuss important and frequently-raised objections or suggestions regarding the draft legislation. Adequate human and financial resources will be required to ensure the consultation process is inclusive, accessible and open. Due to power imbalances between people with lived experience and mental health professionals, it is important to create safe spaces for people with lived experience to share their comments confidentially. All feedback received must be carefully considered and appropriate changes made.
3. After the consultation process, the drafting body should publish a report documenting suggestions, objections and queries received, as well as their responses. The views of people with lived experience, particularly those victims and survivors of human rights abuses in mental health systems, should be given significant weight. The documentation of these inputs and exchanges will help clarify the background and rationale of the final legislative provisions.

Box 10

Examples of stakeholders to be invited for consultation on proposed legislation on mental health

- Persons with mental health conditions and psychosocial disabilities and their representative organizations.
- Governmental agencies, including ministries of health, justice, finance, education, employment, social welfare and housing.
- Academic institutions, professional bodies and associations representing professionals such as psychiatrists, psychologists, social workers, psychiatric nurses, general practitioners, emergency workers, paramedics, first responders, and other professionals who interact with the mental health system.
- National human rights institutions and other monitoring bodies.
- Organizations of persons with disabilities.
- Civil society organizations, including organizations advocating for the rights of persons with mental health conditions and psychosocial disabilities.
- Organizations representing older persons.
- Representatives of families and carers.
- The private sector and civil society organizations providing mental health, social and legal services.
- Politicians, legislators and opinion-makers.
- Law enforcement agencies such as the police and prison officials.
- Judicial authorities, including lawyers and legal representatives.
- Organizations representing minorities and other disadvantaged groups.
- Wider community groups, including community-based organizations and associations such as employee unions, staff welfare associations, employer groups, resident welfare associations, religious groups and congregations of particular communities.

A well-planned and systematically-executed consultation process can positively influence the adoption and implementation of the proposed legislation. Consultation raises public awareness about mental health and the rights of service users; it involves the community, and enhances understanding of community- and human rights-based approaches to mental health. Broad consultation processes can also foster partnerships, increasing the likelihood of effective implementation once enacted.

Legislation should be written in a manner that is easily accessible to as many people as possible. Countries typically have language and accessibility requirements for legislation. It is important to have easy-to-read versions so that everyone, including persons with intellectual disabilities, can understand the law and participate in discussions.

3.4 The legislative process

After making revisions based on feedback from the consultation process, the draft law is submitted to the designated body to be passed. This stage can be time-consuming and involve renegotiation of the proposed legislation. It is essential to persuade politicians and key members of the executive branch of government and the legislature of the need and reasons for updated legislation, as well as the importance of devoting adequate legislative time to this process.

Even with prior government support for a new law, competing political priorities can cause delays, especially since mental health remains a low political priority in many countries.

The process for adopting new laws varies across countries, depending on their legal traditions and political systems. The following sections provide a general overview of the process and potential challenges that may arise.

3.4.1 Responsibility for adopting legislation

Parliament or another sovereign law-making body is typically responsible for adopting national legislation. However, in countries that have a federal political system, states or provinces may also have the authority to make laws in addition to the national legislature. In such cases, laws related to mental health could be subject to national or regional jurisdictions, or both, depending on the local regulations.

Generally, a law must be passed in legislature and promulgated before entering into force. However, in some countries, constitutions allow changes in laws through executive ordinances or decrees issued by the government. Occasionally, these orders require prior authorization from parliament and must be ratified within a specified time frame; if they lapse, the previous legislation stands. Such provisions can sometimes expedite the adoption of legislation on mental health.

3.4.2 Debate of draft legislation and its adoption

Legislatures often have subcommittees that examine the laws before introducing them into the main legislative body. These committees may seek a variety of perspectives, hold public hearings, request inputs, or require clarification on different aspects of the law.

The debate and adoption stage can be lengthy and labour-intensive. Legislators may propose amendments, and the decision to include or reject these falls on the sovereign body. Those responsible for the drafting may have to provide substantial guidance to law-makers about the effects of the proposed amendments. Active participation of persons with mental health and psychosocial disabilities is vital to ensure a human rights-based approach.

After having considered the legislation and amendments, the legislative body (which possibly consists of multiple levels or houses) either passes or rejects it. In most countries, this concludes the legislative process, and the adopted law is ready to be sanctioned (see [section 3.4.3](#)). However, in many countries the executive branch has the power to reject or propose changes to the approved legislation. If vetoed by the head of state, the proposal returns to the legislative body for reconsideration.

3.4.3 Sanction, promulgation and publication of new legislation

Through sanctioning, publication and promulgation, the adopted law becomes publicly known and officially announced. Although such terms may differ across countries, their functions are generally similar. Sanctioning the law is the prerogative of the head of state which usually involves signing the official text. Promulgation is the official announcement by the government of the adopted law; this is typically through an order on official publication of the law. Publication refers to printing of the text of the law in the official government gazette, a necessary stage before the adopted law can come into force. Following publication, and usually after a period of 10 to 20 days, the new law comes into force. A longer period may be established in the text of the law or set by the executive branch for more comprehensive preparation.

Delays can occur at all stages, from sanctioning to promulgation and publication. Those responsible for carrying forward the law must follow up with the relevant authorities to ensure that the passed legislation becomes legally enforceable.

3.4.4 Mobilizing debate and engaging public opinion

Mobilizing debate and engaging public opinion is critical for encouraging legislators to debate and pass proposed legislation. Initiating consultations, media strategies and other activities early in the procedure can raise public awareness about the proposed legislation. Workshops and seminars for key groups and organizations can be organized for discussing and explaining the main components of the new legislation.

Persons with lived experience should play an active role in these activities. Developing a new law is a valuable opportunity to provide visibility and support to persons with lived experiences and their representative organizations; moreover the legislative process can educate, influence social attitudes and facilitate social change.

It is important to engage with members of the executive branch and the legislature from all political parties. They should be informed of issues such as the challenges and gaps in existing legislation; the implications for rights enjoyment and exercise; the background of the proposed law; the concerns and demands of persons with mental health conditions and psychosocial disabilities; and the human rights obligations and political commitments enshrined in the international human rights and sustainable development framework.

While it is critical to mobilize debate and engage public opinion, human rights obligations and commitments must not be made contingent on majority approval.

3.5 Implementation

The process leading up to implementation effectively starts from the point of conception of the reform process. Identifying and addressing potential difficulties in implementation during the drafting and consultation phases can help ensure a smoother transition once the legislation is enacted.

There is usually a short period between the passage of legislation and its enactment, and sometimes a longer period before enforcement; this allows authorities to establish the necessary infrastructure for implementation. This crucial period allows time for finalizing regulations, setting up monitoring bodies, providing training, and ensuring that all relevant parties are prepared to implement the legislation.

Governments should evaluate how any new legislation on mental health fits within existing policies and make necessary adjustments to ensure compliance with new legal requirements. This includes reviewing budget allocations and national mental health plans or policies.

3.5.1 Importance, role and composition of bodies responsible for implementation

The significance of bodies responsible for overseeing implementation cannot be overemphasized. Implementation is not the responsibility of the health sector alone: different functions of the legislation may be undertaken and monitored by different entities. For example, if a monitoring body has been established, it is likely to be compelled, through its given functions, to oversee certain legislative requirements (see [section 2.7.1](#)). This should not, however, preclude the government itself from setting norms, standards, and indicators to monitor and evaluate whether the legislation is being effectively implemented. If not, necessary steps must be taken.

Any agency or body overseeing implementation should have a set timetable, measurable targets, and the necessary administrative and financial powers to ensure the process is effective and speedy. The agency may require the mandate, authority, and adequate financial resources to, for example:

- develop regulations, rules and procedures for implementation;
- prepare standardized documentation instruments for recording and monitoring implementation;
- ensure a proper process for the training of mental health, social care and other professionals, introducing certification procedures if necessary;
- address human resource issues; and
- monitor implementation.

In addition, it is important to establish and implement complaint procedures promptly and effectively as provided in the legislation. In particular, mental health services should make persons with mental health conditions and psychosocial disabilities aware of their rights as recognized in the law, and of the means for using the complaints procedures for redress.

The overseeing or implementation body should work closely with organizations of people with lived experience, including in setting targets and measuring indicators for monitoring implementation.

3.5.2 Developing regulations and other guidance

The laws in many countries often require regulations to be effectively applied and operational in practice. Regulations, published by executive branch, ministries or agencies, provide guidance on how to interpret and implement the law in real-life situations. While not all laws require regulations to be enforced, their absence may hinder the appropriate implementation of new legislation.

The process of adopting regulations varies across countries. Ideally, to ensure a transparent and participatory process, the ministry in charge first publishes, for public comment, proposed regulations, to be co-developed with experts from the main stakeholder groups, including persons with lived experience. This allows any member of the public to provide input and suggest changes. The ministry then engages with all the stakeholder groups to carry out consultation meetings and receive feedback. After the comment period closes, the ministry analyses the feedback received and, where necessary, makes changes to the proposal to address the comments submitted. Once the changes are made, the ministry or the executive branch publishes the final regulations in the official gazette.

Formal guidance to professionals, such as a code of practice, can also be useful in ensuring that legislation is properly implemented. Such guidance complements regulations and can re-emphasize the values and principles underpinning the legislation, explain aspects of the legislation's objectives, provide detailed practical guidance on complying with legal obligations, and include good practices, case law, and other resources for further information and guidance. It can also guide individuals, service providers, families and others, on the rights of persons with mental health conditions and psychosocial disabilities.

Responsible ministries may publish guidance or other policy statements to further clarify how an agency understands and implements existing laws and regulations. This guidance may also describe suggested or recommended actions for local authorities and professionals.

All regulations, guidance, and codes of practice should be consistent with the text of the law.

3.5.3 Public education and awareness

The general public, professionals, persons with lived experience and advocacy organizations working on their behalf, are often poorly informed about the changes brought about by new legislation. Even if well informed, they may remain unconvinced of the reasons for the changes and choose not act in accordance with the law. This is especially true for legislation that requires significant changes to customary practices related to mental health.

The stigma, myths and misconceptions associated with mental health conditions and psychosocial disability can represent obstacles to the effective implementation of rights-based legislation. Hence, changing public attitudes constitutes an important component in implementing legislation. Disseminating information about mental health, including about the rights provided in new legislation, can help to change public attitudes. Public awareness programmes need to explain why a human rights-based approach is important and how it applies to every person, not only those with mental health conditions and psychosocial disabilities. The media can play a valuable role in this process, highlighting the importance of respecting the human rights of persons with lived experience and assisting in educating the public about the new approaches to mental health care and support, particularly the importance of community-based approaches.

It is critical to create opportunities for persons with lived experience to learn about new or reformed legislation. They need to be well-informed on the legislative content and aware of the provision of their rights within it. While organizations representing persons with mental health conditions and psychosocial disabilities may have been actively involved throughout the entire legislative process, not all persons with lived experience will have participated, and all will need to be informed, even after the law has been passed.

Publications in simplified and accessible formats can be developed for key actors such as health practitioners and persons with lived experience. These can help clarify aspects of the legislation that may be difficult to understand, and provide detailed guidance on interpretation. Diagrams can also be used to clearly illustrate processes, such as complaint procedures.

All education and awareness-raising initiatives should be designed and implemented with the participation of persons with lived experience and their representative organizations. Budget allocation is needed for this purpose.

3.5.4 Training of stakeholders in mental health and social care systems, other sectors and the community

A comprehensive knowledge of the new legislation by health and other professionals is critical for its effective implementation. Even with meticulous drafting, legislation may contain ambiguous clauses or provisions that are not fully understood. Training and discussions can facilitate an in-depth exploration of each provision and foster clearer understanding of meanings and implications.

It is therefore necessary to promote training for all involved, including health professionals and staff, law-enforcement agencies (the police and judicial system), lawyers, social workers, teachers and human resource administrators. Joint training forums, where professionals from health and non-health disciplines interact, can create a better understanding of the human rights of persons with mental health conditions and psychosocial disabilities. The training of health professionals and staff in issues regarding legal capacity and eliminating coercive practices is particularly important.

Education on ensuring a human rights-based approach to mental health should be incorporated into human rights education programmes in schools. It should also be included as a core compulsory component of tertiary and vocational education, as well as in specialized training for health and legal professionals, police, and judiciary to combat discrimination and negative stereotypes. The training of traditional healers and

faith-based organizations is also necessary in situations where they play an important role in providing health care and support.

3.5.5 Resource allocation

The speed and effectiveness of implementing rights-based legislation depends largely on the availability of adequate financial resources. Activities that require funding include making changes to the mental health and social services as required by the legislation; providing a holistic, rights-based approach that adequately addresses the social determinants of health; setting up and operationalizing monitoring bodies; and training professionals and persons with lived experience in using the legislation. Further funding will also be necessary for activities related to the changes from institutional mental health services to person-centred and rights-based community services. Negotiation for funding should occur simultaneously while drafting, reviewing or adopting legislation.

Although the reallocation of funds from institutions to community-based services is feasible in the long term, this will take time, and until all resources currently held in institutions are released, the costs for running both will have to be covered (33, 95).

Adequate human resources are of particular importance for the implementation of legislation. The workforce in health and social care sectors is critical for delivering effective mental health care and support in the community. Without sufficient staff or adequate training, person-centred and human rights-based approaches will fail. Moreover, investment should be made in training all people involved in implementing the law (such as the judiciary and police) to ensure that they understand all aspects of the legislation and their roles and responsibilities in putting its provisions into practice.

The allocation of resources should be based on the varying needs of different groups, such as women, children, young people, and people living in remote areas. Ensuring the participation of rights-holders in budget decisions helps to incorporate their views concerning the services and resources they need.

The effective implementation of new legislation will generally require an increased allocation of resources for mental health and social care. It is therefore important to “ring-fence” or protect any new funds for mental health against those released from institutions for community-based services. An efficient and effective execution of resources will be needed, with adequate mechanisms for transparency, monitoring and accountability. The WHO *Guidance on community mental health services: promoting person-centred and rights-based approaches* (2021) provides information and guidance on taking finance-related actions (33).

3.6 Evaluation

Complaints about poor implementation or the minimal impact of laws are common; however, governments devote little effort to evaluating these concerns. Most activities conducted relate to the work of monitoring bodies or legislative committees in addressing either compliance with legal obligations, or gaps and contradictions in the legal system. It is important to periodically evaluate the adopted or reformed legislation on mental health to establish if it responds effectively to the original objectives and needs.

3.6.1 Importance of evaluation

Both anecdotal evidence and empirical research suggest that many mental health-related laws are ineffective: community-based services and support have not expanded; access to quality mental health care has not increased; coercive practices have not been reduced; and the rights and living conditions of persons with mental health conditions and psychosocial disabilities have not improved.

Post-evaluation of legislation informs parliaments, governments and society on whether the adopted laws are fit for purpose, achieve the desired changes to mental health and social care services, and uphold the rights and expectations of persons with mental health conditions and psychosocial disabilities. While the legislative process can help to identify potential problems of implementation or preventable negative effects, ex-post evaluation can identify and track faulty or malfunctioning provisions within the law, which may require modification or abolition (337). In addition, effective implementation may be impeded by other laws or regulations, and evaluation can pinpoint tensions which need to be resolved through harmonization with other legislation. Such evaluation also helps governments determine the need for new legislation, new regulations, policy innovations or corrections.

3.6.2 Systemic and regular review of legislation

Several factors determine the frequency and methods of evaluating legislation. Legislation should be reviewed on a regular basis, for example every 5 to 10 years; however, if there are problems with the content or implementation of the current law, a review should be conducted as soon as possible. In some countries, the law includes a “power to remove difficulties” that allows certain changes to be made without having to engage in a formal legislative process. The Mental Healthcare Act in India, for example, states: “If any difficulty arises in giving effect to the provisions of this Act, the Central Government may, by order, published in the Official Gazette, make such provisions, not inconsistent with the provisions of this Act, as may appear to be necessary or expedient for removing the difficulty” (338).

National legislation may provide for statutory procedures for periodic evaluation. Such provisions can be included in legislation to ensure a participative evaluation on mental health after a fixed period, with the active engagement of organizations of persons with mental health conditions and psychosocial disabilities. National monitoring mechanisms created under Article 33(2) of the CRPD could also be involved.

Authorities responsible for monitoring legislation on mental health can contribute to evaluation by reporting on the law’s functionality and proposing appropriate changes.

3.6.3 Evaluation criteria and strategies

A comprehensive evaluation of legislation on mental health can assess, among other aspects:

- **impact:** what the results and effects of the law are;
- **relevance:** whether the law responds to peoples' needs;
- **effectiveness:** whether the law is achieving its objectives;
- **efficiency:** what the costs and benefits are;
- **coherence:** how well it works with other actions;
- **equity:** whether the law reduces or increases inequality; and
- **participation:** how the perspectives of service users and other stakeholders have been received and incorporated.

Regardless of the evaluation's scope, health and social information systems are essential. Comprehensive data collection can provide valuable insights about needs and outcomes, services, compliance with quality and human rights standards, and inform improvements and future courses of action (33). Hence, it is important to have adequate structural, process, and outcome indicators to track the progress of implementation and the law in the future (see [section 2.7.4](#)).

Quantitative and qualitative studies can also be used to measure “what happened” and “why and how”, providing a broader picture of whether goals and objectives are being achieved.

Checklist for assessing rights-based legislation on mental health

This checklist provides a simple, direct and practical way to assess the compliance of mental health-related legislation, or draft bill, with international human rights obligations, as part of legal harmonization efforts. It serves to assist stakeholders in identifying the most important issues that need to be addressed to ensure rights-based legislation. The questions are not exhaustive, and the main content of the Guidance should be referred to during completion.

The checklist uses a five-point scale (1–5) to allow gradation in the evaluation:

- 1** Not at all
- 2** Minimally
- 3** Moderately
- 4** Significantly
- 5** Fully

Rating 1–5



The checklist includes a comment box for the user to add a justification for their choice of rating, and to provide further information or suggest remedial actions. Countries and civil society organizations are encouraged to adapt the checklist to their national context and priorities.

1. Legislative approach

Question

Rating 1–5



Comments

1. Does the legislation enable a cross-sectoral approach to mental health?



2. Does the legislation challenge stigma and discrimination associated with mental health?



3. Does the legislation enable access to quality care and support that is person-centred and rights-based?



4. Does the legislation enable the transition towards community-based mental health care and support?



5. Does the legislation ensure the respect for legal capacity and informed consent and the elimination of coercion?



2. Legislative content

2.1 Ensuring equality and non-discrimination

Question

Rating 1–5



Comments

1. Does the legislation prohibit all forms of discrimination in mental health care, including in mental health services?



2. Does the legislation ensure the provision of reasonable accommodation in mental health services?



3. Does the legislation prevent discrimination in obtaining adequate health insurance from public and private health insurance providers?



4. Does the legislation prohibit health insurance companies from discriminating on the basis of pre-existing mental health conditions?



5. Does the legislation repeal inappropriate, stigmatizing and outdated terminology related to mental health and marginalized groups?



2.1 Ensuring equality and non-discrimination [cont.]

Question	Rating 1–5	Comments
	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	
<p>6. Does the legislation mandate awareness-raising activities to combat stigma and discrimination associated with mental health?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>7. Does the legislation afford persons using mental health services the same rights as persons using general health services?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>8. Does the legislation guarantee persons using mental health services the right to access information about their diagnosis and treatment?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>9. Does the legislation guarantee persons using mental health services the right of confidentiality of information about themselves and their diagnosis and treatment?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>10. Does the legislation guarantee persons using mental health services the right to privacy within those services?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

2.1 Ensuring equality and non-discrimination [cont.]

Question

Rating 1–5



Comments

11. Does the legislation guarantee persons using mental health services the right to communicate with any person they choose?



12. Does the legislation guarantee that persons using mental health services are given information about their rights in mental health services in an accessible manner?



13. Does the legislation guarantee the provision of safe, hygienic and comfortable mental health services?



14. Does the legislation guarantee the accessibility of facilities, services and information for persons with disabilities?



2.2 Respecting personhood and legal capacity

Question	Rating 1–5	Comments
<p>1. Does the legislation mandate the respect and protection of the right to legal capacity of all persons using mental health services, including those with psychosocial, intellectual and developmental disabilities?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>2. Does the legislation repeal legal provisions which authorize restrictions to legal capacity and substituted decision-making in mental health services?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>3. Does the legislation make supported decision-making available for persons using mental health services?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>4. Does the legislation include safeguards to ensure respect for the rights, will and preferences of the individual being supported in the exercise of their legal capacity, as well as to prevent abuse in the provision of supported decision-making?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>5. Does the legislation provide for children’s evolving capacities to be taken into consideration in mental health-related decision-making?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

2.3 Informed consent and eliminating coercive practices

Question	Rating 1–5	Comments
	<input checked="" type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	
<p>1. Does the legislation uphold the right to free and informed consent within mental health services so that all support and treatment is provided voluntarily?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>2. Does the legislation grant children and adolescents a right to consent to, or refuse, treatment in accordance with their age and maturity?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>3. Does the legislation provide for safeguards to ensure full free and informed consent, and prevent coercion and potential abuses in the use of specific interventions, such as the prescription of psychotropic drugs and electroconvulsive therapy?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>4. Does the legislation prohibit all forms of coercive practices within mental health services, including seclusion and physical and chemical restraints?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>5. Does the legislation prohibit medical or scientific research or experimentation on a person with mental health conditions and psychosocial disabilities, without their informed consent?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

2.4 Access to high quality mental health services

Question

Rating 1–5



Comments

1. Does the legislation provide for an enforceable right to mental health?



2. Does the legislation consider mental health as being equal to physical health in terms of coverage and quality of services?



3. Does the legislation include or expand mental health coverage as part of national efforts towards universal health coverage?



4. Does the legislation establish criteria for a needs-based allocation of services?



5. Does the legislation institute earmarked funds for mental health, or progressive targets in their health budget, aimed at increasing mental health investment?



2.4 Access to high quality mental health services [cont.]

Question	Rating 1–5	Comments
<p>6. Does the legislation contribute to ensuring that mental health services are gender-responsive?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>7. Does the legislation contribute to ensuring that mental health services are age-appropriate?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>8. Does the legislation contribute to ensuring that mental health services are culturally-appropriate?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>9. Does the legislation address the rights and needs of marginalized groups, including those experiencing systemic discrimination?</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>10. Does the legislation provide for the training of health care and social care providers</p>		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

2.5 Implementing mental health services in the community

Question	Rating 1–5	Comments
	<input checked="" type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	
<p>1. Does the legislation provide for the integration of mental health in primary health care and general hospitals?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>2. Does the legislation improve the availability of mental health goods and services at the primary care level?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>3. Does the legislation provide for the transformation of mental health service provision towards community-based, person-centred responses?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>4. Does the legislation provide for the development of rights-based services in the community, including community mental health centres, crisis response services, community outreach services, among others?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>5. Does the legislation provide for the development of peer support services?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<hr/> <hr/> <hr/> <hr/>

2.5 Implementing mental health services in the community [cont.]

Question

Rating 1–5



Comments

6. Does the legislation allow for the creation of peer-led and peer-run services and for their operations to run alongside mental health services?



7. Does the legislation provide for a deinstitutionalization policy with a clear action plan?



8. Does the legislation provide for the redistribution of financial and human resources from institutions to community services?



9. Does the legislation ensure that community-based mental health services and support are available in emergency situations and humanitarian contexts?



10. Does the legislation stipulate that refugees, asylum-seekers and migrants are entitled to the same mental health care as citizens of the host country?



2.7 Ensuring accountability

Question

Rating 1–5



Comments

1. Does the legislation recognize the right to request information or to consult or obtain a copy of documents concerning public mental health authorities, bodies or services?



2. Does the legislation establish an independent monitoring framework to monitor the situation of the rights of persons using mental health services?



3. Does the legislation grant persons using mental health services the right to report complaints and initiate legal proceedings concerning any aspect of mental health care?



4. Does the legislation ensure that complaint adjudicators, such as national human rights institutions or courts, provide remedies that are tailored to the individual and include redress and reparation?



2.7 Ensuring accountability [cont.]

Question

Rating 1–5



Comments

5. Does the legislation on professional liability provide for effective civil, administrative or criminal sanctions and reparations?



6. Does the legislation mandate the adoption of indicators to measure, evaluate and review both the performance and impact of mental health systems, and the progress towards implementing human rights in the context of mental health?



2.8 Cross-sectoral reform for holistic service provision

a) Promoting community inclusion

Question

Rating 1–5



Comments

1. Does the legislation recognize the right of persons with mental health conditions and psychosocial disabilities to live independently in the community?



2. Does the legislation provide for access of persons with mental health conditions and psychosocial disabilities to community-based services and support?



3. Does the legislation ensure mental health services facilitate and support service users to live, work and actively participate in the community?



4. Does the legislation promote the integration of mental health into pertinent sectoral policies and programmes?



2.8 Cross-sectoral reform for holistic service provision [cont.]

a) Promoting community inclusion

Question

Rating 1–5



Comments

5. Does the legislation create an enabling legal framework for the establishment and functioning of organizations of persons with mental health conditions and psychosocial disabilities?



6. Does the legislation provide for access to information and services for families of persons with mental health conditions and psychosocial disabilities?



2.8 Cross-sectoral reform for holistic service provision

b) Access to justice

Question

Rating 1–5



Comments

1. Does the legislation recognize the full capacity of persons with mental health conditions and psychosocial disabilities to participate in all legal proceedings?



2. Does the legislation establish a right for persons with mental health conditions and psychosocial disabilities to receive individually-determined procedural accommodations in all legal proceedings?



3. Does the legislation ensure that all substantive and procedural safeguards are afforded to persons with mental health conditions and psychosocial disabilities on an equal basis with others?



4. Does the legislation ensure cost-free or affordable legal assistance to persons with mental health conditions and psychosocial disabilities in all legal procedures related to their fundamental rights?



3. Drafting and legislative processes

Question

Rating 1–5



Comments

1. Do the drafting and legislative processes involve active representation from all principal stakeholder groups, including persons with mental health conditions and psychosocial disabilities and their representative organizations?



2. Are people involved in the drafting process informed and trained to understand human rights obligations under international law, including the CRPD obligations?



3. Are people involved in the drafting process reliably informed of their country's situation, and of barriers to implementing rights-based mental health responses?



4. Has a rigorous and comprehensive review of national legislation been carried out in light of international human rights obligations?



	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

4. Implementation and evaluation

Question

Rating 1–5



Comments

1. Has an agency been appointed to oversee the implementation of legislation?



2. Have regulations or other guidance been adopted to guide the implementation of legislation?



3. Have awareness-raising actions been carried out to ensure that stakeholders have knowledge of, and understand, the legislation?



4. Has training been provided to all stakeholders involved in the implementation of legislation?



5. Have the maximum possible financial resources been allocated for the implementation of legislation?



Question

Rating 1–5

Comments



6. Have evaluations been conducted to assess the implementation of legislation?





References

1. Deacon BJ. The biomedical model of mental disorder: a critical analysis of its validity, utility, and effects on psychotherapy research. *Clin Psychol Rev.* 2013;33:846–61. doi: [10.1016/j.cpr.2012.09.007](https://doi.org/10.1016/j.cpr.2012.09.007).
2. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Dainius Pūras, 28 March 2017 (A/HRC/35/21). Geneva: United Nations, Human Rights Council 2017 (<https://undocs.org/en/A/HRC/35/21>, accessed 31 May 2023).
3. Convention on the Rights of Persons with Disabilities, preamble, para. 5 (A/RES/61/106). New York: United Nations, General Assembly; 2006 (<https://undocs.org/en/A/RES/61/106>, accessed 31 May 2023).
4. Convention on the Rights of Persons with Disabilities (A/RES/61/106). New York: United Nations, General Assembly; 2006 (<https://undocs.org/en/A/RES/61/106>, accessed 31 May 2023).
5. Human rights-based approach. In: United Nations Sustainable Development Group [website]. New York: United Nations Sustainable Development Group; n.d. (<https://unsdg.un.org/2030-agenda/universal-values/human-rights-based-approach>, accessed 31 May 2023).
6. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 12 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
7. Marginalized groups. In: Glossary & Thesaurus [website]. Vilnius: European Institute for Gender Equality; n.d. (<https://eige.europa.eu/thesaurus/terms/1280?lang=en>, accessed 31 May 2023).
8. Recovery and the right to health. WHO QualityRights core training: mental health and social services. Course guide. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329611>, accessed 31 May 2023).
9. International principles and guidelines on access to justice for persons with disabilities. Geneva: United Nations, Human Rights Special Procedures; 2020 (<https://www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/GoodPracticesEffectiveAccessJusticePersonsDisabilities.aspx>, accessed 31 May 2023).
10. World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/356119>, accessed 31 May 2023).
11. Policy guidelines for inclusive Sustainable Development Goals. Good health and well-being; p 35. Geneva: United Nations High Commissioner for Human Rights; 2020 (<https://www.ohchr.org/Documents/Issues/Disability/SDG-CRPD-Resource/policy-guideline-good-health.pdf>, accessed 31 May 2023).
12. Guidelines on deinstitutionalization, including in emergencies (2022) (CRPD/C/5); para. 76. Geneva: United Nations, Committee on the Rights of Persons with Disabilities; 2022 (<https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>, accessed 31 May 2023).
13. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; p. 27 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
14. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 29 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
15. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar, 12 December 2017; para. 27 (A/HRC/37/56). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/en/A/HRC/37/56>, accessed 31 May 2023).

16. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Dainius Pūras, 28 March 2017; para. 8 (A/HRC/35/21). Geneva: United Nations, Human Rights Council 2017 (<https://undocs.org/en/A/HRC/35/21>, accessed 31 May 2023).
17. Carr D. Mental health is political. In: Opinion Essay [website]. New York: New York Times; 2022 (<https://www.nytimes.com/2022/09/20/opinion/us-mental-health-politics.html>, accessed 31 May 2023).
18. Global mental health and human rights: history and the need for change. In: Special Rapporteur handover dialogues 2020–2021. Boston: HHR Journal; n.d. (<https://www.hhrjournal.org/special-rapporteur-handover-dialogues-2020-2021/>, accessed 31 May 2023).
19. Mental health atlas 2020; pp 37–45. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345946>, accessed 31 May 2023).
20. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Dainius Pūras, 28 March 2017; paras. 18–20 (A/HRC/35/21). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/A/HRC/35/21>, accessed 31 May 2023).
21. Summary of the outcome of the consultation on ways to harmonize laws, policies and practices relating to mental health with the norms of the Convention on the Rights of Persons with Disabilities and on how to implement them. Report of the United Nations High Commissioner for Human Rights. Geneva: United Nations, Human Rights Council; 2022 (<https://undocs.org/A/HRC/49/29>, accessed 31 May 2023).
22. Drew N, Funk M, Tang S, Lamichhane J, Chávez E, Katontoka S et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *Lancet*. 2011;378:1664–75. doi: 10.1016/S0140-6736(11)61458-X.
23. Mental health and human rights. Report of the United Nations High Commissioner for Human Rights (A/HRC/34/32). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/A/HRC/34/32>, accessed 31 May 2023).
24. Statement by Mr. Gerard Quinn, United Nations Special Rapporteur on the Rights of Persons with Disabilities. Human Rights Council Intersessional one-day consultation on mental health and human rights (Human Rights Council Resolution 43/13). In: Office of the High Commissioner for Human Rights [website]. Geneva: Office of the High Commissioner for Human Rights; n.d. (<https://www.ohchr.org/en/health/mental-health-and-human-rights>, accessed 31 May 2023).
25. Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345301>, accessed 31 May 2023).
26. WHO resource book on mental health, human rights and legislation. Geneva: World Health Organization; 2005.
27. Committee on Economic, Social and Cultural Rights (CESCR). General comment no. 3: The nature of states parties' obligations (art. 2, para. 1, of the covenant) adopted at the fifth session of the Committee on Economic, Social and Cultural Rights, on 14 December 1990 (contained in document e/1991/23). Geneva: Committee on Economic, Social and Cultural Rights (CESCR); 1990 (<https://www.ohchr.org/en/documents/general-comments-and-recommendations/e199123-committee-economic-social-and-cultural>, accessed 31 May 2023).
28. Resolution A/HRC/RES/43/13, mental health and human rights, adopted by the Human Rights Council on 19 June 2020. Geneva: United Nations, Human Rights Council; 2020 (<https://undocs.org/A/HRC/RES/43/13>, accessed 31 May 2023).
29. Resolution A/HRC/RES/47/15. Accelerating efforts to eliminate all forms of violence against women and girls: preventing and responding to all forms of violence against women and girls with disabilities; adopted by the Human Rights Council on 13 July 2021; para. 8(g). Geneva: United Nations, Human Rights Council; 2021 (<https://undocs.org/A/HRC/RES/47/15>, accessed 31 May 2023).
30. Resolution A/HRC/32/18, mental health and human rights, adopted by the Human Rights Council on 1 July 2016. Geneva: United Nations, Human Rights Council; 2016 (<https://undocs.org/A/HRC/RES/32/18>, accessed 31 May 2023).
31. Resolution A/HRC/RES/36/13, mental health and human rights, adopted by the Human Rights Council on 28 September, 2017. Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/A/HRC/RES/36/13>, accessed 31 May 2023).

32. QualityRights materials for training, guidance and transformation. In: World Health Organization [website]. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools>, accessed 31 May 2023).
33. Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341648>, accessed 13 November 2022).
34. Call for inputs: draft guidance on Mental Health, Human Rights, and Legislation published jointly by WHO and OHCHR. In: Office of the High Commissioner for Human Rights [website]. Geneva: Office of the High Commissioner for Human Rights; n.d. (<https://www.ohchr.org/en/calls-for-input/calls-input/draft-guidance-mental-health-human-rights-legislation-who-ohchr>, accessed 31 May 2023).
35. Corstens D. The Maastricht approach: social and personal perspectives on hearing voices. In: Parker I, Schnackenberg J, Hopfenbeck M, editors. *The practical handbook of hearing voices: therapeutic and creative approaches*. Monmouth: PCCS Books; 2021:13–23.
36. Jarrett C. The helpful delusion. Evidence is growing that mental illness is more than dysfunction, with enormous implications for treatment. In: aeon [website]. Melbourne: aeon; 2022 (<https://aeon.co/essays/evidence-grows-that-mental-illness-is-more-than-dysfunction>, accessed 31 May 2023).
37. Mead S. Crisis as an opportunity for growth and change. In: Intentional Peer Support [website]. Chesterfield: Intentional Peer Support n.d. (<https://www.intentionalpeersupport.org/articles/?v=b8a74b2fbcbb>, accessed 31 May 2023).
38. Lund C, Breen A, Flisher AJ, Kakuma R, Corrigall J, Joska JA et al. Poverty and common mental disorders in low and middle income countries: a systematic review. *Soc Sci Med*. 2010;71:517–28. doi: 10.1016/j.socscimed.2010.04.027.
39. Hert MDE, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. 2011;10:52–77. doi: 10.1002/j.2051-5545.2011.tb00014.x.
40. Special initiative for mental health (2019–2023): universal health coverage for mental health. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/310981>, accessed 31 May 2023).
41. McKinnon B, Gariépy G, Sentenac M, Elgar FJ. Adolescent suicidal behaviours in 32 low- and middle-income countries. *Bull World Health Organ*. 2016;94:340–50F. doi: 10.2471/BLT.15.163295.
42. Roberts B, Browne J. A systematic review of factors influencing the psychological health of conflict-affected populations in low- and middle-income countries. *Glob Public Health*. 2011;6:814–29. doi: 10.1080/17441692.2010.511625.
43. Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry*. 2016;3:415–24. doi: 10.1016/S2215-0366(16)30024-4.
44. McDaid D, Park AL, Wahlbeck K. The economic case for the prevention of mental illness. *Annu Rev Public Health*. 2019;40:373–89. doi: 10.1146/annurev-publhealth-040617-013629.
45. Mental health atlas 2020; p 54. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345946>, accessed 31 May 2023).
46. Lovett A, Kwon HR, Kidia K, Machando D, Crooks M, Fricchione G et al. Mental health of people detained within the justice system in Africa: systematic review and meta-analysis. *Int J Ment Health Syst*. 2019;13:31. doi: 10.1186/s13033-019-0273-z.
47. Prins SJ. Prevalence of mental illnesses in US State prisons: a systematic review. *Psychiatr Serv*. 2014;65:862–72. doi: 10.1176/appi.ps.201300166.
48. Hossain MM, Sultana A, Tasnim S, Fan Q, Ma P, Lisako E et al. Prevalence of mental disorders among people who are homeless: an umbrella review. *Int J Soc Psychiatry*. 2020;66:528–41. doi: 10.1177/0020764020924689.
49. Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, McLean R et al. Stigma in health facilities: why it matters and how we can change it. *BMC Med*. 2019;17:25. doi: 10.1186/s12916-019-1256-2.

50. Turnpenny A, Petri G, Finn A, Beadle-Brown J, Nyman M. Mapping and understanding exclusion: institutional, coercive and community-based services and practices across Europe. Brussels: Mental Health Europe; 2017 (<https://mhe-sme.org/wp-content/uploads/2018/01/Mapping-and-Understanding-Exclusion-in-Europe.pdf>, accessed 31 May 2023).
51. Gleerup CS, Østergaard SD, Hjuler RS. Seclusion versus mechanical restraint in psychiatry – a systematic review. *Acta Neuropsychiatr*. 2019;31:237–45. doi: 10.1017/neu.2019.22.
52. Chow WS, Priebe S. How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. *BMJ Open*. 2016;6:e010188. doi: 10.1136/bmjopen-2015-010188.
53. Shen GC, Eaton J, Snowden LR. Mainstreaming mental health care in 42 countries. *Health Syst Reform*. 2017;3:313–24. doi: 10.1080/23288604.2017.1356424.
54. Living in chains. Shackling of people with psychosocial disabilities worldwide. New York: Human Rights Watch; 2020 (https://www.hrw.org/sites/default/files/media_2020/10/global_shackling1020_web_1.pdf, accessed 31 May 2023).
55. Gender and mental health. Geneva: World Health Organization; 2002 (<https://apps.who.int/iris/handle/10665/68884>, accessed 31 May 2023).
56. Khalifeh H, Moran P, Borschmann R, Dean K, Hart C, Hogg J et al. Domestic and sexual violence against patients with severe mental illness. *Psychol Med*. 2015;45:875–86. doi: 10.1017/S0033291714001962.
57. Practices of so-called “conversion therapy”. Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, Victor Madrigal-Borloz, 1 May 2020 (A/HRC/44/53) Geneva: United Nations, Human Rights Council; 2020 (<https://undocs.org/en/A/HRC/44/53>, accessed 31 May 2023).
58. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P et al. The Lancet Commission on global mental health and sustainable development [published correction appears in *Lancet*. 2018 Oct 27;392(10157):1518]. *Lancet*. 2018;392:1553–98. doi: 10.1016/S0140-6736(18)31612-X.
59. Noble P. Mental health services and legislation – an historical review. *Med Sci Law*. 1981;21:16–24. doi: 10.1177/002580248102100105.
60. Gooding P. A new era for mental health law and policy: supported decision-making and the UN Convention on the Rights of Persons with Disabilities; p 23. Cambridge: Cambridge University Press; 2017.
61. Ndeti DM, Muthike J, Nandoya ES. Kenya’s mental health law. *BJPsych Int*. 2017;14:96–7. doi: 10.1192/s2056474000002117.
62. Perlin ML. The use of mental disability law to suppress political dissent. In: *International human rights and mental disability law: when the silenced are heard*. Oxford: Oxford University Press; 2011:59–80.
63. *Ilmseher v. Germany* [GC], 2018; §127. European Court of Human Rights.
64. *Stanev v. Bulgaria* [GC], 2012; §145. European Court of Human Rights.
65. *D.D. v. Lithuania*, 2012; §156. European Court of Human Rights.
66. *Kallweit v. Germany*, 2011; §45. European Court of Human Rights.
67. *Shtukatorov v. Russia*, 2008; §114. European Court of Human Rights.
68. *Varbanov v. Bulgaria*, 2000; §45. European Court of Human Rights.
69. *Winterwerp v. Netherlands* 6301/73 [1979]; §39. European Commission of Human Rights 4.
70. Principles for the protection of persons with mental illness and the improvement of mental health care, adopted by General Assembly resolution 46/119 of 17 December 1991. New York: United Nations; 1991 (<https://digitallibrary.un.org/record/162032?ln=en>, accessed 31 May 2023).
71. Legge 23 Dicembre 1978; n. 833 ‘Istituzione del Servizio Sanitario Nazionale’ [act number 833 of 23 December 1978 ‘Establishment of the National Health Service’]. *Gazzetta Ufficiale della Repubblica*; 28 Dicembre 1978, n. 360. Rome; 1978 (<https://www.gazzettaufficiale.it/eli/gu/1978/12/28/360/so/0/sg/pdf>, accessed 31 May 2023).

72. The Caracas Declaration. Adopted on 14 November 1990 by the Regional Conference on the Restructuring of Psychiatric Care in Latin America; convened in Caracas, Venezuela. Caracas: Pan American Health Organization/ World Health Organization; 1990.
73. Lei nº. 10.216 – Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental (act no. 10,216 – provides for the protection and rights of people with mental disorders and redirects the mental health care model). Brasília: Presidency of the Republic; 2001 (http://www.planalto.gov.br/ccivil_03/leis/leis_2001/l10216.htm, accessed 31 May 2023).
74. Ley Nacional de Salud Mental (2010). Ley nº 26.657 y su decreto reglamentario nº 603/13. In: Buenos Aires. Ministerio de Salud; 2010 (<https://bancos.salud.gob.ar/recurso/ley-nacional-de-salud-mental-ndeg26657-y-decreto-reglamentario-6032013>, accessed 31 May 2023).
75. Ley de Salud Mental (2017). Ley nº 19529. Montevideo: Ministry of Public Health/Secretary-General Directorate; 2017 (<https://www.gub.uy/ministerio-salud-publica/sites/ministerio-salud-publica/files/2022-01/Res%201165%202021.pdf>, accessed 31 May 2023).
76. Ley de Salud Mental (2019). Ley nº 30947. Lima: El Congreso de la República; 2019 (<https://busquedas.elperuano.pe/normaslegales/ley-de-salud-mental-ley-n-30947-1772004-1/>, accessed 31 May 2023).
77. Ley Nº 21331 (2021), Del reconocimiento y protección de los derechos de las personas en la atención de salud mental. Santiago: Ministerio de Salud; 2021 (<https://www.bcn.cl/leychile/navegar?idNorma=1159383>, accessed 31 May 2023).
78. Mental health atlas 2020; p 37. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345946>, accessed 31 May 2023).
79. Convention on the Rights of Persons with Disabilities. Concluding observations on the combined second and third periodic reports of Argentina (CRPD/C/ARG/CO/2–3); 24 March 2023; paras. 29–31. Geneva: Committee on the Rights of Persons with Disabilities; 2023. (https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FARG%2FCO%2F2-3&Lang=en, accessed 23 October 2023)
80. Convention on the Rights of Persons with Disabilities. Concluding observations on the combined second and third periodic reports of Peru (CRPD/C/PER/CO/2–3); 24 March 2023; paras. 28–29. Geneva: Committee on the Rights of Persons with Disabilities; 2023 (https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FPER%2FCO%2F2-3&Lang=en, accessed 31 May 2023).
81. Convention on the Rights of Persons with Disabilities. Concluding observations on the initial report of the Republic of Korea (CRPD/C/KOR/CO/1); 29 October 2014; paras. 31–32. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/KOR/CO/1>, accessed 31 May 2023).
82. Convention on the Rights of Persons with Disabilities. Concluding observations on the initial report of India (CRPD/C/IND/CO/1); 29 October 2019; paras. 27, 30–31. Geneva: Committee on the Rights of Persons with Disabilities; 2019 (<https://undocs.org/CRPD/C/IND/CO/1>, accessed 31 May 2023).
83. Convention on the Rights of Persons with Disabilities. Concluding observations on the initial report of the Philippines (CRPD/C/PHL/CO/1); 16 October 2018; paras. 28–29. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/PHL/CO/1>, accessed 31 May 2023).
84. Gooding P. A new era for mental health law and policy: supported decision-making and the UN Convention on the Rights of Persons with Disabilities; pp 70–113. Cambridge: Cambridge University Press; 2017.
85. Kay W. Mental health law: abolish or reform? Oxford: Oxford University Press; 2021.
86. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, 15 April 2020 (A/HRC/44/48). Geneva: United Nations, Human Rights Council; 2020 (<https://undocs.org/en/A/HRC/44/48>, accessed 31 May 2023).
87. Gooding P. A new era for mental health law and policy: supported decision-making and the UN Convention on the Rights of Persons with Disabilities; p 104. Cambridge: Cambridge University Press; 2017.
88. Szmukler G. Compulsion and “coercion” in mental health care. *World Psychiatry*. 2015;14:259–61. doi: 10.1002/wps.20264.

89. Gooding P, McSherry B, Roper C, Grey F. Alternatives to coercion in mental health settings: A literature review. Melbourne: Melbourne Social Equity Institute, University of Melbourne; 2018 (https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf, accessed 31 May 2023).
90. Arboleda-Flóres J. Psychiatry and the law – do the fields agree in their views on coercive treatment? In: Kallert TW, Mezzich E, Monahan J, editors. Coercive treatment in psychiatry: clinical, legal and ethical aspects; first edition. Hoboken: Wiley; 2011:83.
91. Wasserman D, Apter G, Baeken C, Bailey S, Balazs J, Bec C et al. Compulsory admissions of patients with mental disorders: state of the art on ethical and legislative aspects in 40 European countries. *Eur Psychiatry*. 2020;63:e82. doi: 10.1192/j.eurpsy.2020.79.
92. Sheridan Rains L, Zenina T, Dias MC, Jones R, Jeffreys S, Branthonne-Foster S et al. Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study. *Lancet Psychiatry*. 2019;6:403–17. doi: 10.1016/S2215-0366(19)30090-2.
93. Sashidharan SP, Mezzina R, Puras D. Reducing coercion in mental healthcare. *Epidemiol Psychiatr Sci*. 2019;28:605–12. doi: 10.1017/S2045796019000350.
94. Chow WS, Priebe S. Understanding psychiatric institutionalization: a conceptual review. *BMC Psychiatry*. 2013;13:169. doi: 10.1186/1471-244X-13-169.
95. Knapp M, Cyhlarova E, Comas-Herrera A, Lorenz-Dant K. Crystallising the case for deinstitutionalisation: COVID-19 and the experiences of persons with disabilities. London: LSE, Care Policy and Evaluation Centre; 2021 (<https://www.lse.ac.uk/cpec/assets/documents/CPEC-Covid-Desinstitutionalisation.pdf>, accessed 31 May 2023).
96. Hellum Braathen S, Rohleder P, Azalde G. Literature review: sexual and reproductive health and rights of girls with disabilities. Trondheim: SINTEF Technology and Society Department of Health; 2017 (<https://www.sintef.no/en/projects/2017/literature-review-sexual-and-reproductive-health-a/>, accessed 31 May 2023).
97. Noroozi M, Singh I, Fazel M. Evaluation of the minimum age for consent to mental health treatment with the minimum age of criminal responsibility in children and adolescents: a global comparison. *Evid Based Ment Health*. 2018;21:82–6. doi: 10.1136/ebmental-2018-300032.
98. Relatório da inspeção nacional em comunidades terapêuticas – 2017. Brasília: Conselho Federal de Psicologia; Mecanismo Nacional de Prevenção e Combate à Tortura; Procuradoria Federal dos Direitos do Cidadão/Ministério Público Federal; 2018 (https://site.cfp.org.br/wp-content/uploads/2020/02/Livro_Relatorio_espanhol_web.pdf, accessed 31 May 2023).
99. Miller PS, Levine RL. Avoiding genetic genocide: understanding good intentions and eugenics in the complex dialogue between the medical and disability communities. *Genet Med*. 2013;15:95–102. doi: 10.1038/gim.2012.102.
100. Zuber AL. Implications for healing, transformation and prosperity: historical and cultural trauma and people with intellectual and developmental disabilities. Minnesota: University of Minnesota Digital Conservancy; 2018 (<https://hdl.handle.net/11299/201570>, accessed 31 May 2023).
101. Sugiura K, Mahomed F, Saxena S, Patel V. An end to coercion: rights and decision-making in mental health care. *Bull World Health Organ*. 2020;98:52–8. doi: 10.2471/BLT.19.234906.
102. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. General Comment no. 2 (2008). CAT/C/G/2; 24 January 2008. Geneva: Committee Against Torture; 2008 (<https://undocs.org/CAT/C/GC/2>, accessed 31 May 2023).
103. United Nations Human Rights Office of the High Commissioner. Information on Special Procedures of the Human Rights Council [website]. n.d. (<https://www.ohchr.org/EN/HRBodies/SP/Pages/Introduction.aspx>, accessed 31 May 2023).
104. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, 1 February 2013, para. 89(b) (A/HRC/22/53). Geneva: United Nations, Human Rights Council; 2013 (<https://undocs.org/A/HRC/22/53>, accessed 31 May 2023).

105. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Nils Melzer, 20 March 2020; para. 37 (A/HRC/43/49). Geneva: United Nations, Human Rights Council; 2020 (<https://undocs.org/en/A/HRC/43/49>, accessed 31 May 2023).
106. Funk M, Drew N. Practical strategies to end coercive practices in mental health services. *World Psychiatry*. 2019;18:43–4. doi: 10.1002/wps.20600.
107. Kersting XAK, Hirsch S, Steinert T. Physical harm and death in the context of coercive measures in psychiatric patients: A systematic review. *Front Psychiatry*. 2019;10:400. doi: 10.3389/fpsy.2019.00400.
108. Nelstrop L, Chandler-Oatts J, Bingley W, Bleetman T, Corr F, Cronin-Davis J et al. A systematic review of the safety and effectiveness of restraint and seclusion as interventions for the short-term management of violence in adult psychiatric inpatient settings and emergency departments. *Worldviews Evid Based Nurs*. 2006;3:8–18. doi: 10.1111/j.1741-6787.2006.00041.x.
109. Large M, Kaneson M, Myles N, Myles H, Gunaratne P, Ryan C. Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: heterogeneity in results and lack of improvement over time. *PLoS One*. 2016;11:e0156322. doi: 10.1371/journal.pone.0156322.
110. Ribeiro J, Franklin J, Fox KR, Bentley K, Kleiman EM, Chang B et al. Self-injurious thoughts and behaviors as risk factors for future suicide ideation, attempts, and death: a meta-analysis of longitudinal studies. *Psychol Med*. 2016;46:225–36. doi: 10.1017/S0033291715001804.
111. Handley T, Rich J, Davies K, Lewin T, Kelly B. The challenges of predicting suicidal thoughts and behaviours in a sample of rural Australians with depression. *Int J Environ Res Public Health*. 2018;15:928. doi: 10.3390/ijerph15050928.
112. Large MM. The role of prediction in suicide prevention. *Dialogues Clin Neurosci*. 2018;20:197–205. doi: 10.31887/DCNS.2018.20.3/mlarge.
113. Halle C, Tzani-Pepelasi C, Pylarinou N, Fumagalli A. The link between mental health, crime and violence. *New Ideas Psychol*. 2020;58:1–8. doi: 10.1016/J.NEUIDEAPSYCH.2020.100779.
114. Varshney M, Mahapatra A, Krishnan V, Gupta R, Deb KS. Violence and mental illness: what is the true story? *J Epidemiol Community Health*. 2016;70:223–5. doi: 10.1136/jech-2015-205546.
115. Fusar-Poli P, Sunkel C, Larrauri CA, Kéri P, McGorry P, Thornicroft G et al. Violence and schizophrenia: who is the perpetrator and who is the victim? In: *World Psychiatry*. 2023 (https://kclpure.kcl.ac.uk/portal/files/193273821/Fusar_Poli_Violence_and_schizophrenia.pdf, accessed 31 May 2023).
116. Wynn R. Coercion in psychiatric care: clinical, legal, and ethical controversies. *Int J Psychiatry Clin Pract*. 2006;10:247–51. doi: 10.1080/13651500600650026.
117. Rugkåsa J. Effectiveness of community treatment orders: The international evidence. *Can J Psychiatry*. 2016;61:15–24. doi: 10.1177/0706743715620415.
118. Watts J, Priebe S. A phenomenological account of users' experiences of assertive community treatment. *Bioethics*. 2002;16:439–54. doi: 10.1111/1467-8519.00301.
119. Seikkula J, Aaltonen J, Alakare B, Haarakangas K, Keränen J, Lehtinen K. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: treatment principles, follow-up outcomes, and two case studies. *Psychother Res*. 2006;16:214–28. doi: 10.1080/10503300500268490.
120. Nationaler Vergleichsbericht 2018. Bern: Nationaler Verein für Qualitätsentwicklung in Spitälern und Kliniken; 2019 (https://www.anq.ch/wp-content/uploads/2019/09/ANQpsy_EP_Nationaler-Vergleichsbericht_2018.pdf, accessed 31 May 2023).
121. Beavan V, de Jager A, dos Santos B. Do peer-support groups for voice-hearers work? A small scale study of Hearing Voices Network support groups in Australia. *Psychosis*. 2017;9:57–66. doi: 10.1080/17522439.2016.1216583.
122. The Universal Declaration of Human Rights (Resolution 217A (III)), 10 December 1948. New York: United Nations, General Assembly; 1948 (<http://www.un.org/en/universal-declaration-human-rights/>, accessed 31 May 2023).

123. International Covenant on Civil and Political Rights, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. Geneva: United Nations, General Assembly; 1976 (<http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>, accessed 31 May 2023).
124. International Covenant on Economic, Social and Cultural Rights, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. Geneva: United Nations, General Assembly; 1976 (<https://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>, accessed 31 May 2023).
125. Human rights treaties. In: Office of the High Commissioner for Human Rights [website]. Geneva: Office of the High Commissioner for Human Rights n.d. (<https://www.ohchr.org/en/instruments-listings>, accessed 31 May 2023).
126. Constitution of the World Health Organization. Geneva: World Health Organization; 1946 (<https://www.who.int/about/governance/constitution>, accessed 31 May 2023).
127. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Dainius Pūras, 28 March 2017; para. 6 (A/HRC/35/21). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/A/HRC/35/21>, accessed 31 May 2023).
128. International Covenant on Economic, Social and Cultural Rights. General comment n°14 (2000). The right to the highest attainable standard of health (art. 12); para. 12 (E/C.12/2000/4); 25 April–12 May 2000. Geneva: Committee on Economic, Social and Cultural Rights; 2000 (<https://digitalibrary.un.org/record/425041?ln=en>, accessed 31 May 2023).
129. Mental health and human rights. Report of the United Nations High Commissioner for Human Rights; para. 22 (A/HRC/34/32). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/A/HRC/34/32>, accessed 31 May 2023).
130. Degener T. Disability in a human rights context. *Laws*. 2016;5:35. doi: 10.3390/laws5030035.
131. Beresford P, Perring R, Nettle M, Wallcraft J. From mental illness to a social model of madness and distress. London: Shaping Our Lives; 2016 (<https://shapingourlives.org.uk/report/from-mental-illness-to-a-social-model-of-madness-and-distress/>, accessed 31 May 2023).
132. Convention on the Rights of Persons with Disabilities. General Comment n°6 (2018) on equality and non-discrimination; para. 8 (CRPD/C/GC/6); 14 February–9 March 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/6>, accessed 31 May 2023).
133. Discussion paper. A rights-based approach to disability in the context of mental health; p 13. New York: United Nations Children's Fund (UNICEF); 2021 (<https://www.unicef.org/documents/rights-based-approach-disability-context-mental-health>, accessed 31 May 2023).
134. Convention on the Rights of Persons with Disabilities. General Comment n°6 (2018) on equality and non-discrimination; para. 11 (CRPD/C/GC/6); 14 February–9 March 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/6>, accessed 31 May 2023).
135. Report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, 20 December 2016 (A/HRC/34/58). Geneva: United Nations, Human Rights Council; 2016 (<https://undocs.org/en/A/HRC/34/58>, accessed 5 September 2020).
136. Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant) Adopted at the Fifth Session of the Committee on Economic, Social and Cultural Rights, on 14 December 1990 (Contained in Document E/1991/23). Geneva: Committee on Economic, Social and Cultural Rights (CESCR); 1990 (<https://www.ohchr.org/en/documents/general-comments-and-recommendations/e199123-committee-economic-social-and-cultural>, accessed 31 May 2023).
137. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), article 12: Equal recognition before the law; para. 15 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
138. Report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, 12 December 2017 (A/HRC/37/56). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/en/A/HRC/37/56>, accessed 31 May 2023).

139. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 17 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
140. Convention on the Rights of Persons with Disabilities. Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities. The right to liberty and security of persons with disabilities. Geneva: Committee on the Rights of Persons with Disabilities; 2015 (www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc, accessed 31 May 2023).
141. Report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, 11 January 2019 (A/HRC/40/54). Geneva: United Nations, Human Rights Council; 2019 (<https://undocs.org/en/A/HRC/40/54>, accessed 31 May 2023).
142. United Nations basic principles and guidelines on remedies and procedures on the right of anyone deprived of their liberty to bring proceedings before a court. Report of the Working Group on Arbitrary Detention; 6 July 2015 (A/HRC/30/37). Geneva: United Nations, Human Rights Council; 2015 (<https://undocs.org/en/A/HRC/30/37>, accessed 31 May 2023).
143. Women deprived of liberty. Report of the Working Group on the issue of discrimination against women in law and in practice, 15 May 2019 (A/HRC/41/33). Geneva: United Nations, Human Rights Council; 2019 (<https://undocs.org/en/A/HRC/41/33>, accessed 31 May 2023).
144. Reform of mental health services: an urgent need and a human rights imperative. In: Council of Europe [website]. Strasbourg: Council of Europe; 2021 (<https://www.coe.int/en/web/commissioner/-/reform-of-mental-health-services-an-urgent-need-and-a-human-rights-imperative>, accessed 31 May 2023).
145. Ending coercion in mental health: the need for a human rights-based approach. Recommendation 2158 (2019). Strasbourg: Parliamentary Assembly; 2019 (http://www.europeanrights.eu/public/atti/COE_2158_Recommandations_ENG.pdf, accessed 31 May 2023).
146. Ending coercion in mental health: the need for a human rights-based approach. Resolution 2291. Brussels: Parliamentary Assembly. Council of Europe; 2019 (<http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=28038>, accessed 31 May 2023).
147. International Covenant on Civil and Political Rights. General comment n°35: Article 9 (liberty and security of person) (CCPR/C/GC/35); 7–31 October 2014. Geneva: Human Rights Committee; 2014 (<https://undocs.org/CCPR/C/GC/35>, accessed 31 May 2023).
148. Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent; 26 January 2016 (CAT/OP/27/2). Geneva: Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; 2016 (<https://undocs.org/en/CAT/OP/27/2>, accessed 31 May 2023).
149. Gooding P. 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; 2017.
150. Convention on the Rights of Persons with Disabilities, General Comment n°1 (2014), Article 12: Equal recognition before the law, para. 42 (CRPD/C/GC/1), 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
151. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, 1 February 2013 (A/HRC/22/53). Geneva: United Nations, Human Rights Council; 2013 (<https://undocs.org/A/HRC/22/53>, accessed 31 May 2023).
152. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Nils Melzer, 20 March 2020 (A/HRC/43/49). Geneva: United Nations, Human Rights Council; 2020 (<https://undocs.org/en/A/HRC/43/49>, accessed 31 May 2023).
153. Convention on the Rights of Persons with Disabilities. General Comment n°5 (2017) on living independently and being included in the community; para. 8 (CRPD/C/GC/5). Geneva: Committee on the Rights of Persons with Disabilities; 2017 (<https://undocs.org/CRPD/C/GC/5>, accessed 31 May 2023).

154. Appelbaum PS. Civil mental health law: its history and its future. *Mental and Physical Disability Law Reporter*. 1996;20:599–604. (<http://www.jstor.org/stable/20784735>, accessed 31 May 2023).
155. Warburton K, Stahl SM. Balancing the pendulum: rethinking the role of institutionalization in the treatment of serious mental illness. *CNS Spectr*. 2020;25:115–8. doi: 10.1017/S1092852920000176.
156. Convention on the Rights of Persons with Disabilities. General Comment n°5 (2017) on living independently and being included in the community; para. 58 (CRPD/C/GC/5). Geneva: Committee on the Rights of Persons with Disabilities; 2017 (<https://undocs.org/CRPD/C/GC/5>, accessed 31 May 2023).
157. Convention on the Rights of Persons with Disabilities (A/RES/61/106). Article 3(c): General principles. New York: United Nations, General Assembly; 2006 (<https://undocs.org/en/A/RES/61/106>, accessed 31 May 2023).
158. Policy guidelines for inclusive Sustainable Development Goals. Foundations. Geneva: United Nations High Commissioner for Human Rights; 2020 (<https://www.ohchr.org/Documents/Issues/Disability/SDG-CRPD-Resource/policy-guideline-foundations.pdf>, accessed 31 May 2023).
159. Convention on the Rights of Persons with Disabilities. General comment n°7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention; para. 44 (CRPD/C/GC/7); 27 August–21 September 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/7>, accessed 31 May 2023).
160. Mental health and human rights. Report of the United Nations High Commissioner for Human Rights; para. 44 (A/HRC/34/32). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/A/HRC/34/32>, accessed 31 May 2023).
161. Convention on the Rights of Persons with Disabilities, General Comment n°5 (2017) on living independently and being included in the community (CRPD/C/GC/5). Geneva: Committee on the Rights of Persons with Disabilities; 2017 (<https://undocs.org/CRPD/C/GC/5>, accessed 31 May 2023).
162. Policy guidelines for inclusive Sustainable Development Goals. Foundations; p 45. Geneva: United Nations High Commissioner for Human Rights; 2020 (<https://www.ohchr.org/Documents/Issues/Disability/SDG-CRPD-Resource/policy-guideline-foundations.pdf>, accessed 31 May 2023).
163. Policy guidelines for inclusive Sustainable Development Goals. Foundations; p 44. Geneva: United Nations High Commissioner for Human Rights; 2020 (<https://www.ohchr.org/Documents/Issues/Disability/SDG-CRPD-Resource/policy-guideline-foundations.pdf>, accessed 31 May 2023).
164. DECRETO por el que se reforman, adicionan y derogan diversas disposiciones de la Ley General de Salud, en materia de Salud Mental y Adicciones, 15 May 2022. Mexico City: The Secretary of the Interior; 2022 (https://www.dof.gob.mx/nota_detalle.php?codigo=5652074&fecha=16/05/2022#gsc.tab=0, accessed 31 May 2023).
165. Mental health and human rights. Report of the United Nations High Commissioner for Human Rights; para. 9 (A/HRC/34/32). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/A/HRC/34/32>, accessed 31 May 2023).
166. Convention on the Rights of Persons with Disabilities. General Comment n°6 (2018) on equality and non-discrimination; paras. 23–27 (CRPD/C/GC/6); 14 February–9 March 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/6>, accessed 31 May 2023).
167. Mental Health Act. Republic Act No. 11036, Article 4 (e). Manila: Republic of the Philippines; 2017 (https://lawphil.net/statutes/repacts/ra2018/ra_11036_2018.html accessed 31 May 2023).
168. Convention on the Rights of Persons with Disabilities. General Comment n°6 (2018) on equality and non-discrimination; para. 48 (CRPD/C/GC/6); 14 February–9 March 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/6>, accessed 31 May 2023).
169. Convention on the Rights of Persons with Disabilities. General Comment n°6 (2018) on equality and non-discrimination; para. 50 (CRPD/C/GC/6); 14 February–9 March 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/6>, accessed 31 May 2023).

170. Rights of Persons with Disabilities Act 2015 (P.L. 2015–51) [26 MIRC], §1117. Majuro: Nitijeļā of the Republic of the Marshall Islands; 2015 (https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2019/12/Marshall-islands_Rights-of-Persons-with-disabilities-Act-2015.pdf, accessed 31 May 2023).
171. Appelbaum PS, Parks J. Holding insurers accountable for parity in coverage of mental health treatment. *Psychiatr Serv.* 2020;71:202–4. doi: 10.1176/appi.ps.201900513.
172. Affording protection: mental health and insurance. Research Report. London: Mental Health UK; 2020 (<https://mhukcdn.s3.eu-west-2.amazonaws.com/wp-content/uploads/2020/07/29173911/Affording-protection-mental-health-and-insurance.pdf>, accessed 31 May 2023).
173. International Covenant on Economic, Social and Cultural Rights. General comment n°14 (2000). The right to the highest attainable standard of health (art. 12); para. 19 (E/C.12/2000/4); 25 April–12 May 2000. Geneva: Committee on Economic, Social and Cultural Rights; 2000 (<https://digitallibrary.un.org/record/425041?ln=en>, accessed 31 May 2023).
174. Report of the Office of the United Nations High Commissioner for Human Rights. Awareness-raising under Article 8 of the Convention on the Rights of Persons with Disabilities. 17 December 2019; para. 55 A/HRC/43/27. Geneva: United Nations, Human Rights Council; 2019 (<https://undocs.org/en/A/HRC/43/27>, accessed 31 May 2023).
175. Kvaale EP, Gottdiener WH, Haslam N. Biogenetic explanations and stigma: a meta-analytic review of associations among laypeople. *Soc Sci Med.* 2013;96:95–103. doi: 10.1016/j.socscimed.2013.07.017.
176. Pescosolido BA, Martin JK, Long JS, Medina TR, Phelan JC, Link BG. “A disease like any other”? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *Am J Psychiatry.* 2010;167:1321–30. doi: 0.1176/appi.ajp.2010.09121743.
177. Virginia Legislative Senate: Bill 953. New York State Assembly; A03887 memo; Florida session: Bill 7030; State of New Jersey: Bill A4500/4446. Albany: New York State Assembly; 2021 (https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A08320&term=2021&Text=Y, accessed 31 May 2023).
178. Link BG, Phelan JC. Conceptualizing stigma. *San Mateo: Annual Review of Sociology;* 2001:27 (<http://www.jstor.org/stable/2678626>, accessed 31 May 2023).
179. Suite DH, La Bril R, Primm A, Harrison-Ross P. Beyond misdiagnosis, misunderstanding and mistrust: relevance of the historical perspective in the medical and mental health treatment of people of color. *J Natl Med Assoc.* 2007;99:879–85. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2574307/>, accessed 31 May 2023).
180. Bhui K, Bhugra D, Goldberg D, Dunn G, Desai M. Cultural influences on the prevalence of common mental disorder, general practitioners’ assessments and help-seeking among Punjabi and English people visiting their general practitioner. *Psychol Med.* 2001;31:815–25. doi: 10.1017/s0033291701003853.
181. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, 28 March 2017; para. 18. (A/HRC/35/21). Geneva: United Nations, Human Rights Council 2017 (<https://undocs.org/en/A/HRC/35/21>, accessed 31 May 2023).
182. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, 28 March 2017; para. 48 (A/HRC/35/21). Geneva: United Nations, Human Rights Council 2017 (<https://undocs.org/en/A/HRC/35/21>, accessed 31 May 2023).
183. Thompson S. The diagnosis debate. *Lancet Psychiatry.* 2014;1:498–9. doi: 10.1016/S2215-0366(14)00065-0.
184. Report of the Special Rapporteur on the right to privacy; Joseph A Cannataci, 5 August 2019; para. 6 (A/74/277). New York: General Assembly; 2019 (<https://undocs.org/en/A/74/277>, accessed 31 May 2023).
185. Report of the Special Rapporteur on the right to privacy; Joseph A Cannataci, 5 August 2019; para. 8.3 (A/74/277). New York: General Assembly; 2019 (<https://undocs.org/en/A/74/277>, accessed 31 May 2023).
186. Report of the Special Rapporteur on the right to privacy; Joseph A Cannataci, 5 August 2019; para. 9.1 (A/74/277). New York: General Assembly; 2019 (<https://undocs.org/en/A/74/277>, accessed 31 May 2023).

187. Report of the Special Rapporteur on the right to privacy; Joseph A Cannataci, 5 August 2019; para. 9.2 (A/74/277). New York: General Assembly; 2019 (<https://undocs.org/en/A/74/277>, accessed 31 May 2023).
188. Report of the Special Rapporteur on the right to privacy; Joseph A Cannataci, 5 August 2019; para. 40.2 (A/74/277). New York: General Assembly; 2019 (<https://undocs.org/en/A/74/277>, accessed 31 May 2023).
189. Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; Manfred Nowak, 28 July 2008; para. 52 (A/63/175). New York: General Assembly; 2008 (<https://undocs.org/A/63/175>, accessed 31 May 2023).
190. WHO QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities. Geneva: World Health Organization; 2012 (<https://apps.who.int/iris/handle/10665/70927>, accessed 31 May 2023).
191. WHO QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities, annex 4. Geneva: World Health Organization; 2012 (<https://apps.who.int/iris/handle/10665/70927>, accessed 31 May 2023).
192. Transforming services and promoting human rights: WHO QualityRights training and guidance: mental health and social services. Course guide. Geneva: World Health Organization; 2019 (License: CC BY-NC-SA 3.0 IGO; <https://apps.who.int/iris/handle/10665/329611>, accessed 31 May 2023).
193. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 7 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
194. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar, 12 December 2017; para. 38 (A/HRC/37/56). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/en/A/HRC/37/56>, accessed 31 May 2023).
195. Supported decision-making and advance planning. WHO QualityRights specialized training. Course slides. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329647>, accessed 31 May 2023).
196. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar, 12 December 2017; para. 40 (A/HRC/37/56). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/en/A/HRC/37/56>, accessed 31 May 2023).
197. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 27 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
198. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 28 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
199. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar, 12 December 2017; para. 41 (A/HRC/37/56). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/en/A/HRC/37/56>, accessed 31 May 2023).
200. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 29(e) (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
201. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar, 12 December 2017; para. 45 (A/HRC/37/56). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/en/A/HRC/37/56>, accessed 31 May 2023).
202. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 29(h) (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
203. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 29(g) (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).

204. Convention on the Rights of Persons with Disabilities, General Comment n°1 (2014), Article 12: Equal recognition before the law, para. 22 (CRPD/C/GC/1), 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
205. Convention on the Rights of Persons with Disabilities, General Comment n°1 (2014), Article 12: Equal recognition before the law (CRPD/C/GC/1), 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
206. Guidelines on deinstitutionalization, including in emergencies (2022) (CRPD/C/5); para. 55. Geneva: United Nations, Committee on the Rights of Persons with Disabilities; 2022 (<https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>, accessed 31 May 2023).
207. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), Article 12: Equal recognition before the law; para. 36 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>, accessed 31 May 2023).
208. Convention on the Rights of the Child. General comment n°14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1); para. 31 (CRC/C/GC/14); 14 January–1 February 2013. Geneva: Committee on the Rights of the Child; 2013 (<https://undocs.org/CRC/C/GC/14>, accessed 31 May 2023).
209. Convention on the Rights of the Child. General comment n°15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24); para. 21 (CRC/C/GC/15); 14 January–1 February 2013. Geneva: Committee on the Rights of the Child; 2013 (<https://undocs.org/CRC/C/GC/15>, accessed 31 May 2023).
210. Convention on the Rights of the Child. General comment n°15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24); para. 31 (CRC/C/GC/15); 14 January–1 February 2013. Geneva: Committee on the Rights of the Child; 2013 (<https://undocs.org/CRC/C/GC/15>, accessed 31 May 2023).
211. Convention on the Rights of the Child. General comment n°20 (2016) on the implementation of the rights of the child during adolescence; para. 39 (CRC/C/GC/20). Geneva: Committee on the Rights of the Child; 2016 (<https://undocs.org/CRC/C/GC/20>, accessed 31 May 2023).
212. Freedom from coercion, violence and abuse. WHO QualityRights core training: mental health and social services. Course guide; p. 24. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329582>, accessed 31 May 2023).
213. Implementing alternatives to coercion: a key component of improving mental health care. Geneva: World Psychiatric Association; 2020 (https://www.wpanet.org/_files/ugd/e172f3_635a89af889c471683c29fcd981db0aa.pdf, accessed 31 May 2023).
214. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, 10 April 2018, para. 25 (A/HRC/38/36). Geneva: United Nations, Human Rights Council; 2018 (<https://undocs.org/en/A/HRC/38/36>, accessed 31 May 2023).
215. Convention on the Rights of Persons with Disabilities (A/RES/61/106). Article 25(d): Health. New York: United Nations, General Assembly; 2006 (<https://undocs.org/en/A/RES/61/106>, accessed 31 May 2023).
216. Lin YK, Liu KT, Chen CW, al. e. How to effectively obtain informed consent in trauma patients: a systematic review. BMC Med Ethics. 2019;20:8. doi: 10.1186/s12910-019-0347-0.
217. Warren JB. The trouble with antidepressants: why the evidence overplays benefits and underplays risks – an essay by John B Warren. BMJ. 2020;370:m3200. doi: 10.1136/bmj.m3200.
218. Murray RM. Mistakes I have made in my research career. Schizophr Bull. 2017;43:253-6. doi: 10.1093/schbul/sbw165.
219. Read J, Cunliffe S, Jauhar S, McLoughlin DM. Should we stop using electroconvulsive therapy? BMJ. 2019;9:k5233. doi: 10.1136/bmj.k5233.
220. Breggin PR. Electroshock: scientific, ethical, and political issues. Int J Risk Saf Med. 1998;11:5. (http://www.ectresources.org/ECTscience/Breggin_1998_ECT__Overview.pdf, accessed 31 May 2023).
221. Read J, Harrop C, Geekie J, Renton J, Cunliffe S. A second independent audit of electroconvulsive therapy in England, 2019: usage, demographics, consent, and adherence to guidelines and legislation. Psychol Psychother Theory Res Pract. 2021;94:603–19. doi: 10.1111/papt.12335.

222. Gazdag G, Takács R, Ungvari GS, Sienaert P. The practice of consenting to electroconvulsive therapy in the European Union. *J ECT*. 2012;28:4–6. doi: [10.1097/YCT.0b013e318223c63c](https://doi.org/10.1097/YCT.0b013e318223c63c).
223. Sackeim H, Prudic J, Fuller R, Keilp J, Lavori PW, Olfson M. The cognitive effects of electroconvulsive therapy in community settings. *Neuropsychopharmacol*. 2007;32:244–54. doi: [10.1038/sj.npp.1301180](https://doi.org/10.1038/sj.npp.1301180).
224. Regulatory update to thymatron system IV instruction manual. Somatics; 2018 (http://www.thymatron.com/downloads/System_IV_Regulatory_Update.pdf, accessed 31 May 2023).
225. Faria MA. Violence, mental illness, and the brain – a brief history of psychosurgery: part 1 – from trephination to lobotomy. *Surg Neurol Int*. 2013;4:49. doi: [10.4103/2152-7806.110146](https://doi.org/10.4103/2152-7806.110146).
226. Chandler JA, Cabrera LY, Doshi P, Fecteau S, Fins JJ, Guinjoan S et al. International legal approaches to neurosurgery for psychiatric disorders. *Front Hum Neurosci*. 2021;14:588458. doi: [10.3389/fnhum.2020.588458](https://doi.org/10.3389/fnhum.2020.588458).
227. International Covenant on Civil and Political Rights. General comment n°20: Article 7 (prohibition of torture, or other cruel, inhuman or degrading treatment or punishment); para. 3. Geneva: Human Rights Committee; 1992 (<https://www.refworld.org/docid/453883fb0.html>, accessed 31 May 2023).
228. International Covenant on Economic, Social and Cultural Rights. General comment n°14 (2000). The right to the highest attainable standard of health (art. 12); para. 8 (E/C.12/2000/4); 25 April–12 May 2000. Geneva: Committee on Economic, Social and Cultural Rights; 2000 (<https://digitalibrary.un.org/record/425041?ln=en>, accessed 31 May 2023).
229. German Civil Code (Federal Law Gazette [Bundesgesetzblatt] I page 42, 2909; 2003 I page 738), amended 2021; section 1901a. Berlin: Federal Republic of Germany; 2002 (https://www.gesetze-im-internet.de/englisch_bgb/englisch_bgb.html, accessed 31 May 2023).
230. Standing H, Lawlor R. Ulysses contracts in psychiatric care: helping patients to protect themselves from spiralling. *J Med Ethics*. 2019;45:693–9. doi: [10.1136/medethics-2019-105511](https://doi.org/10.1136/medethics-2019-105511).
231. Gergel T, Das P, Owen G, Stephenson L. Reasons for endorsing or rejecting self-binding directives in bipolar disorder: a qualitative study of survey responses from UK service users. *Lancet Psychiatry*. 2016;8:599–609. doi: [10.1016/S2215-0366\(21\)00115-2](https://doi.org/10.1016/S2215-0366(21)00115-2).
232. Roennfeldt H, Wyder M, Byrne L, Hill N, Randall R, Hamilton B. Subjective experiences of mental health crisis care in emergency departments: a narrative review of the qualitative literature. *Int J Environ Res Public Health*. 2021;18:9650. doi: [10.3390/ijerph18189650](https://doi.org/10.3390/ijerph18189650).
233. Harris B, Beurmann R, Fagien S, Shattell MM. Patients’ experiences of psychiatric care in emergency departments: a secondary analysis. *Int Emerg Nurs*. 2016;26:14–9. doi: [10.1016/j.ienj.2015.09.004](https://doi.org/10.1016/j.ienj.2015.09.004).
234. Stastny P, Lovell AM, Hannah J, Goulart D, Vasquez A, O’Callaghan S et al. Crisis response as a human rights flashpoint: critical elements of community support for individuals experiencing significant emotional distress. *Health Hum Rights*. 2020;22:105–19. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348421/>, accessed 31 May 2023).
235. Minkowitz T. Reimagining crisis support: matrix, roadmap and policy. New York: Lilith’s Warrior Press; 2021.
236. Ennis E, Walker E. Experiences of a community crisis intervention service. *Issues Ment Health Nurs*. 2022;43:96–102. doi: [10.1080/01612840.2021.1953650](https://doi.org/10.1080/01612840.2021.1953650).
237. Gooding P, McSherry B, Roper C. Preventing and reducing “coercion” in mental health services: an international scoping review of English language studies. *Acta Psychiatr Scand*. 2020;142:27–39. doi: [10.1111/acps.13152](https://doi.org/10.1111/acps.13152).
238. Szmukler G, Daw R, Callard F. Mental health law and the UN Convention on the Rights of Persons with Disabilities. *Int J Law Psychiatry*. 2014;37:245–52. doi: [10.1016/j.ijlp.2013.11.024](https://doi.org/10.1016/j.ijlp.2013.11.024).
239. Zinkler M, Von Peter S. End coercion in mental health services – toward a system based on support only. *Laws*. 2019;8:19. doi: [10.3390/laws8030019](https://doi.org/10.3390/laws8030019).
240. Simon J, Mayer S, Łaszewska A, Rugkåsa J, Yeeles K, Burns T et al. Cost and quality-of-life impacts of community treatment orders (CTOs) for patients with psychosis: economic evaluation of the OCTET trial. *Soc Psychiatry Psychiatr Epidemiol*. 2021;56:85–95. doi: [10.1007/s00127-020-01919-4](https://doi.org/10.1007/s00127-020-01919-4).

241. Barbui C, Purgato M, Abdulmalik J, Caldas-de-Almeida J, Eaton J, Gureje O et al. Efficacy of interventions to reduce coercive treatment in mental health services: Umbrella review of randomised evidence. *Br J Psychiatry*. 2020;1–11. doi: [10.1192/bjp.2020.144](https://doi.org/10.1192/bjp.2020.144).
242. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar. Visit to France; 8 January 2019; para. 65 (A/HRC/40/54/add.1). Geneva: United Nations, Human Rights Council; 2019 (<https://undocs.org/A/HRC/40/54/ADD.1>, accessed 31 May 2023).
243. Moritz S, Gawęda Ł, Heinz A, Gallinat J. Four reasons why early detection centers for psychosis should be renamed and their treatment targets reconsidered: we should not catastrophize a future we can neither reliably predict nor change. *Psychol Med*. 2019;49:2134–40. doi: [10.1017/S0033291719001740](https://doi.org/10.1017/S0033291719001740).
244. Parker I, Schnackenberg J, Hopfenbeck M. The practical handbook of hearing voices: therapeutic and creative approaches. Monmouth: PCCS Books; 2021.
245. Implementing alternatives to coercion in mental health care. Discussion paper from the WPA Taskforce. Geneva: World Psychiatric Association; 2020 (https://3ba346de-fde6-473f-b1da-536498661f9c.filesusr.com/ugd/e172f3_3702b1a4202c458b85451e6d74075cbc.pdf, accessed 31 May 2023).
246. Strategies to end seclusion and restraint. WHO QualityRights specialized training. Course guide. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329605>, accessed 31 May 2023).
247. Newton-Howes G, Savage M, Arnold R, Hasegawa T, Staggs V, Kisely S. The use of mechanical restraint in Pacific Rim countries: an international epidemiological study. *Epidemiol Psychiatr Sci*. 2020;29:e190. doi: [10.1017/S2045796020001031](https://doi.org/10.1017/S2045796020001031).
248. Rose D, Perry E, Rae S, Good N. Service user perspectives on coercion and restraint in mental health. *BJPsych Int*. 2017;14:59–61. doi: [10.1192/s2056474000001914](https://doi.org/10.1192/s2056474000001914).
249. The Mental Healthcare Act, 2017. Law no 10 of 2017, 7 April 2017; provision 95(d). New Delhi: Ministry of Law and Justice; 2017 (<https://www.indiacode.nic.in/bitstream/123456789/2249/1/A2017-10.pdf>, accessed 31 May 2023).
250. Undang-undang Republik Indonesia, nomor 18 Tahun 2014, tentang, Kesehatan Jiwa [act (bill) of the Republic of Indonesia, no 18, 2014, regarding mental health], Article 86. Jakarta: President of the Republic of Indonesia; 2014 (<https://peraturan.bpk.go.id/Home/Details/38646/uu-no-18-tahun-2014>, accessed 31 May 2023).
251. Live life: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021 (License: CC BY-NC-SA 3.0 IGO; <https://apps.who.int/iris/handle/10665/329643>, accessed 31 May 2023).
252. International Covenant on Civil and Political Rights. General comment n°36, Article 6: Right to life, para. 9 (CCPR/C/GC/36); 3 September 2019. Geneva: Human Rights Committee; 2019 (<https://undocs.org/CCPR/C/GC/36>, accessed 31 May 2023).
253. Major changes to suicide prevention needed, with rights-based approach to make life “more liveable” – UN expert. In: Office of the High Commissioner for Human Rights [website]. Geneva: Office of the High Commissioner for Human Rights; 2019 (<https://www.ohchr.org/en/press-releases/2019/10/major-changes-suicide-prevention-needed-rights-based-approach-make-life-more>, accessed 31 May 2023).
254. Preventing suicide: a global imperative; p. 51. Geneva: World Health Organization; 2014 (<https://apps.who.int/iris/handle/10665/131056>, accessed 31 May 2023).
255. Decriminalising suicide: saving lives, reducing stigma. London: United for Global Mental Health; 2021 (<https://unitedgmh.org/knowledge-hub/decriminalising-suicide-saving-lives-reducing-stigma-latest-report/#:~:text=WHY%20DOES%20DECRIMINALISING%20SUICIDE%20MATTER,suicide%2C%20such%20as%20pesticide%20control>, accessed 31 May 2023).
256. Wu KC-C, Cai Z, Chang Q, al e. Criminalisation of suicide and suicide rates: an ecological study of 171 countries in the world. *BMJ Open*. 2022;12:e049425. doi: [10.1136/bmjopen-2021-049425](https://doi.org/10.1136/bmjopen-2021-049425).
257. Mental health: achieving ‘parity of esteem’. In: UK Parliament, House of Commons Library [website]. London: UK Parliament, House of Commons Library; 2020 (<https://commonslibrary.parliament.uk/mental-health-achieving-parity-of-esteem/>, accessed 31 May 2023).

258. Mental health parity. In: NAMI, National Alliance on Mental Illness [website]. Arlington: NAMI, National Alliance on Mental Illness; n.d. (<https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Parity>, accessed 31 May 2023).
259. Ley Nacional de Salud Mental (2010). Ley n° 26.657 y su decreto reglamentario n° 603/13; Article 32. In: Buenos Aires. Ministerio de Salud; 2010 (<https://bancos.salud.gob.ar/recurso/ley-nacional-de-salud-mental-ndeg26657-y-decreto-reglamentario-6032013>, accessed 31 May 2023).
260. Ley de Protección de la Salud Mental. Ley n.° 314, Article 21. Panama City: National Assembly of Panama; 2021 (<https://alamocpanama2016.bravesites.com/ley-314-conceptos>, accessed 31 May 2023).
261. Mental health act. Act no 846; 31 May 2012, Article 88. Accra: Republic of Ghana; 2012 (<https://www.moh.gov.gh/wp-content/uploads/2016/02/Mental-Health-Act-846-2012.pdf>, accessed 31 May 2023).
262. Clarke D, Rajan D, Schmets G. Creating a supportive legal environment for universal health coverage. *Bull World Health Organ.* 2016;94:482. doi: 10.2471/BLT.16.173591.
263. Judd F, Armstrong S, Kulkarni J. Gender-sensitive mental health care. *Australas Psychiatry.* 2009;17:105–11. doi: 10.1080/10398560802596108.
264. Chalmers KJ, Bond KS, Jorm AF, Kelly CM, Kitchener BA, Williams-Tchen A. Providing culturally appropriate mental health first aid to an Aboriginal or Torres Strait Islander adolescent: development of expert consensus guidelines. *Int J Ment Health Syst.* 2014;8:6. doi: 10.1186/1752-4458-8-6.
265. United Nations Declaration on the Rights of Indigenous Peoples (Resolution A/RES/61/295); 2 October 2007. New York: United Nations, General Assembly; 2007 (<https://www.refworld.org/docid/471355a82.html>, accessed 31 May 2023).
266. International Covenant on Economic, Social and Cultural Rights. General comment n°14 (2000). The right to the highest attainable standard of health (art. 12); para. 27 (E/C.12/2000/4); 25 April–12 May 2000. Geneva: Committee on Economic, Social and Cultural Rights; 2000 (<https://digitalibrary.un.org/record/425041?ln=en>, accessed 31 May 2023).
267. Maree Kopua D, Kopua MA, Bracken PJ. Mahi a Atua: a Māori approach to mental health. *Transcult Psychiatry.* 2020;57:375–83. doi: 10.1177/1363461519851606.
268. Maura J, Weisman de Mamani A. Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: a review. *J Clin Psychol Med Settings.* 2017;24:187–210. doi: 10.1007/s10880-017-9510-2.
269. McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Aff (Millwood).* 2008;27:393–403. doi: 10.1377/hlthaff.27.2.393.
270. Londono Tobon A, Flores JM, Taylor JH. Racial implicit associations in psychiatric diagnosis, treatment, and compliance expectations. *Acad Psychiatry.* 2021;45:23–33. doi: 10.1007/s40596-020-01370-2.
271. Swanson J, Swartz M, Van Dorn RA, Monahan J, McGuire TG, Steadman HJ et al. Racial disparities in involuntary outpatient commitment: are they real? *Health Affairs.* 2009;28:816–26. doi: 10.1377/hlthaff.28.3.816.
272. Barnett P, Mackay E, Matthews H, Gate R, Greenwood H, Ariyo K et al. Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *Lancet Psychiatry.* 2019;6:305–17. doi: 10.1016/S2215-0366(19)30027-6.
273. Cénat JM. How to provide anti-racist mental health care. *Lancet Psychiatry.* 2020;7:929–31. doi: 10.1016/S2215-0366(20)30309-6.
274. WHO QualityRights e-training on mental health [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qe-training>, accessed 31 May 2023).
275. Funk M, Saraceno B, Drew N, Faydi E. Integrating mental health into primary healthcare. *Ment Health Fam Med* 2008;5:5–8. doi: 10.1002/wps.20600.

276. Integrating mental health into primary care: a global perspective; pp 39–40. Geneva: World Health Organization and World Organization of Family Doctors; 2008.
277. Jenkins R, Lancashire S, McDaid D, Samyshkin Y, Green S, Watkins J et al. Mental health reform in the Russian Federation: an integrated approach to achieve social inclusion and recovery. *Bull World Health Organ.* 2007;85:858–66. doi: 10.2471/blt.06.039156.
278. World Health Organization. (2016). mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP), version 2.0. World Health Organization; (<https://apps.who.int/iris/handle/10665/250239>) accessed 31 May 2023).
279. Peer support groups by and for people with lived experience: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/329594/9789241516778-eng.pdf>, accessed 31 May 2023).
280. One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module: module slides. Geneva: World Health Organization; 2019 (License: CC BY-NC-SA 3.0 IGO; <https://apps.who.int/iris/handle/10665/329643>, accessed 31 May 2023).
281. Kohrt BA, Asher L, Bhardwaj A, Fazel M, Jordans JD, Mutamba BB et al. The role of communities in mental health care in low- and middle-income countries: a meta-review of components and competencies. *Int J Environ Res Public Health.* 2018;15:1279. doi: 10.3390/ijerph15061279.
282. Jorm AF. Mental health literacy: empowering the community to take action for better mental health. 2012. 2012;67:231–43. doi: 10.1037/a0025957.
283. Gask L, Coventry P. Person-centred mental health care: the challenge of implementation. *Epidemiol Psychiatr Sci.* 2012;21:139–44. doi: 10.1017/S2045796012000078.
284. Tellez JJ, Kidd J. Peer support workers: an untapped resource in primary mental health care. *J Prim Health Care.* 2015;7:84–7. (<https://pubmed.ncbi.nlm.nih.gov/25770722/>, accessed 31 May 2023).
285. Guidelines on deinstitutionalization, including in emergencies (2022) (CRPD/C/5). Geneva: United Nations, Committee on the Rights of Persons with Disabilities; 2022 (<https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd-c5-guidelines-deinstitutionalization-including>, accessed 31 May 2023).
286. Ley Nacional de Salud Mental (2010). Ley n° 26.657 y su decreto reglamentario n° 603/13; Article 27. In: Buenos Aires. Ministerio de Salud; 2010 (<https://bancos.salud.gob.ar/recurso/ley-nacional-de-salud-mental-ndeg26657-y-decreto-reglamentario-6032013>, accessed 31 May 2023).
287. Salud Mental, Ley N° 19.529, Article 38. Montevideo: Asamblea General de Uruguay; 2017 (<https://www.gub.uy/ministerio-salud-publica/sites/ministerio-salud-publica/files/2022-01/Res%201165%202021.pdf>, accessed 31 May 2023).
288. Guidelines on deinstitutionalization, including in emergencies (2022) (CRPD/C/5); para. 67. Geneva: United Nations, Committee on the Rights of Persons with Disabilities; 2022 (<https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd-c5-guidelines-deinstitutionalization-including>, accessed 31 May 2023).
289. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar; 11 January 2019; para. 67 (A/HRC/40/54). Geneva: United Nations, Human Rights Council; 2019 (<https://undocs.org/en/A/HRC/40/54>, accessed 31 May 2023).
290. Guidelines on deinstitutionalization, including in emergencies (2022) (CRPD/C/5); paras. 115–123. Geneva: United Nations, Committee on the Rights of Persons with Disabilities; 2022 (<https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd-c5-guidelines-deinstitutionalization-including>, accessed 31 May 2023).
291. Linking disaster risk reduction (DRR) and mental health and psychosocial support (MHPSS): practical tools, approaches and case studies. Geneva: Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings; 2021 (<https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/technical-note-linking-disaster-risk-reduction-drr-and-mental-health-and-psychosocial-support-mhpss>, accessed 31 May 2023).

292. Santegoeds J. Mind the gap 1/4. Facing a human rights emergency. COVID19 vaccination in institutions is not enough. In: European Disability Forum [website]. Brussels: European Disability Forum; 2020 (<https://www.edf-feph.org/blog/mind-the-gap-1-4-facing-a-human-rights-emergency-covid19-vaccination-in-institutions-is-not-enough/>, accessed 31 May 2023).
293. Mental Health and COVID-19: Early evidence of the pandemic's impact: Scientific brief, 2 March 2022. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/352189>, accessed 31 May 2023).
294. Technical note: linking disaster risk reduction (DRR) and mental health and psychosocial support (MHPSS). Practical tools, approaches and case studies. Geneva: Inter-Agency Standing Committee; 2021 (<https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/technical-note-linking-disaster-risk-reduction-drr-and-mental-health-and-psychosocial-support-mhpss>, accessed 23 May 2023).
295. Guidelines on deinstitutionalization, including in emergencies (2022) (CRPD/C/5); paras. 107–114. Geneva: United Nations, Committee on the Rights of Persons with Disabilities; 2022 (<https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>, accessed 31 May 2023).
296. Promoting mental health preparedness and response for public health emergencies. Geneva: World Health Organization; 2021 ([https://apps.who.int/gb/ebwha/pdf_files/EB148/B148\(3\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/EB148/B148(3)-en.pdf), accessed 31 May 2023).
297. Security Council Resolution 2668 (2022). New York: United Nations, Security Council; 2022 ([https://undocs.org/S/RES/2668\(2022\)](https://undocs.org/S/RES/2668(2022)), accessed 31 May 2023).
298. Convention on the Rights of Persons with Disabilities. General comment n°7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention; para. 13 (CRPD/C/GC/7); 27 August–21 September 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/7>, accessed 31 May 2023).
299. Convention on the Rights of Persons with Disabilities. General comment n°7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention; para. 48 (CRPD/C/GC/7); 27 August–21 September 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/7>, accessed 31 May 2023).
300. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar, 20 July 2020; para. 72 (A/75/186). Geneva: United Nations, Human Rights Council; 2020 (<https://undocs.org/en/A/75/186>, accessed 31 May 2023).
301. International Covenant on Civil and Political Rights. General comment n°34. Article 19: Freedoms of opinion and expression (CCPR/C/GC/34); 11–29 July 2011. Geneva: Human Rights Committee; 2011 (<https://undocs.org/CCPR/C/GC/34>, accessed 31 May 2023).
302. SDG-CRPD Resource Package. In: United Nations High Commissioner for Human Rights [website]. Geneva: United Nations High Commissioner for Human Rights; n.d. (<https://www.ohchr.org/EN/Issues/Disability/Pages/SDG-CRPD-Resource.aspx>, accessed 31 May 2023).
303. International principles and guidelines on access to justice for persons with disabilities. Principle 8. Geneva: United Nations, Human Rights Special Procedures; 2020 (<https://www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/GoodPracticesEffectiveAccessJusticePersonsDisabilities.aspx>, accessed 31 May 2023).
304. Resolution A/RES/60/147. Basic principles and guidelines on the right to a remedy and reparation for victims of gross violations of international human rights law and serious violations of international humanitarian law, adopted and proclaimed by the General Assembly on 16 December 2005. New York: United Nations, General Assembly; 2006 (<https://undocs.org/en/A/RES/60/147>, accessed 31 May 2023).
305. Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P et al. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry*. 2018;5:357–69. doi: 10.1016/S2215-0366(18)30060-9.
306. Supported living services for mental health: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341645>, accessed 31 May 2023).

307. Comprehensive mental health service networks: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341646>, accessed 31 May 2023).
308. Report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, 20 December 2016, para. 20 (A/HRC/34/58). Geneva: United Nations, Human Rights Council; 2016 (<https://undocs.org/en/A/HRC/34/58>, accessed 31 May 2023).
309. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar; 11 January 2019; para. 20 (A/HRC/40/54). Geneva: United Nations, Human Rights Council; 2019 (<https://undocs.org/en/A/HRC/40/54>, accessed 31 May 2023).
310. Schlanger M. Prisoners with disabilities. In: Luna E, editor. Reforming criminal justice: punishment, incarceration, and release. Phoenix: Academy for Justice; 2017:295–323.
311. “I needed help, instead I was punished”: abuse and neglect of prisoners with disabilities in Australia [website]. New York: Human Rights Watch; 2018 (<https://www.hrw.org/report/2018/02/06/i-needed-help-instead-i-was-punished/abuse-and-neglect-prisoners-disabilities> accessed 31 May 2023).
312. Bignall T, Jeraj S, Helsby E, Butt J. Racial disparities in mental health: Literature and evidence review. London: VCSE & Race Equality Foundation; 2019 (<https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/mental-health-report-v5-2.pdf> accessed 31 May 2023).
313. International principles and guidelines on access to justice for persons with disabilities; p. 9. Geneva: United Nations, Human Rights Special Procedures; 2020 (<https://www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/GoodPracticesEffectiveAccessJusticePersonsDisabilities.aspx>, accessed 31 May 2023).
314. International principles and guidelines on access to justice for persons with disabilities. Guideline 1.2(j). Geneva: United Nations, Human Rights Special Procedures; 2020 (<https://www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/GoodPracticesEffectiveAccessJusticePersonsDisabilities.aspx>, accessed 31 May 2023).
315. International principles and guidelines on access to justice for persons with disabilities. Principle 6.1. Geneva: United Nations, Human Rights Special Procedures; 2020 (<https://www.ohchr.org/EN/Issues/Disability/SRDisabilities/Pages/GoodPracticesEffectiveAccessJusticePersonsDisabilities.aspx>, accessed 31 May 2023).
316. Sirotych F. The criminal justice outcomes of jail diversion programs for persons with mental illness: a review of the evidence. *J Am Acad Psychiatry Law*. 2009;37:461–72. (<http://jaapl.org/content/37/4/461.long>, accessed 31 May 2023).
317. Lange S, Rehm J, Popova S. The effectiveness of criminal justice diversion initiatives in North America: a systematic literature review. *Int J Forensic Ment Health*. 2011;10:3, 200–14. doi: 10.1080/14999013.2011.598218.
318. Dewa CS, Loong D, Trujillo A, Bonato S. Evidence for the effectiveness of police-based pre-booking diversion programs in decriminalizing mental illness: a systematic literature review. *PLoS One*. 2018;13:e0199368. doi: 10.1371/journal.pone.0199368.
319. Steele L. Disability, criminal justice and law: reconsidering court diversion. London: Routledge; 2020.
320. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar; 11 January 2019; para. 33 (A/HRC/40/54). Geneva: United Nations, Human Rights Council; 2019 (<https://undocs.org/en/A/HRC/40/54>, accessed 31 May 2023).
321. Expert meeting on deprivation of liberty of persons with disabilities. Conclusions and recommendations. Geneva: Office of the United Nations High Commissioner for Human Rights; 2015 (<https://www.ohchr.org/Documents/Issues/Disability/DeprivationLiberty/Conclusions.doc>, accessed 31 May 2023).
322. Dhanda A, Gombos G. Questions of criminal culpability and persons with disabilities. In: Flynn E, Arstein-Kerslake A, de Bhailís C, Serra ML, editors. Global perspectives on legal capacity reform; our voices, our stories. London and New York: Routledge; 2019.
323. Convention on the Rights of Persons with Disabilities. Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities. The right to liberty and security of persons with disabilities; para. 20. Geneva: Committee on the Rights of Persons with Disabilities; 2015 (www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc, accessed 31 May 2023).

324. Convention on the Rights of Persons with Disabilities. Views adopted by the Committee under Article 5 of the Optional Protocol, concerning communication no. 32/2015 (CRPD/C/22/D/32/2015); 15 October 2019. Geneva: Committee on the Rights of Persons with Disabilities; 2019 (https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2F22%2FD%2F32%2F2015&Lang=en, accessed 31 May 2023).
325. Convention on the Rights of Persons with Disabilities. Concluding observations on the initial report of Kenya (CRPD/C/KEN/CO/1); 30 September 2015; para. 28. Geneva: Committee on the Rights of Persons with Disabilities; 2015 (<https://undocs.org/CRPD/C/KEN/CO/1>, accessed 31 May 2023).
326. Convention on the Rights of Persons with Disabilities. Concluding observations on the initial report of the Plurinational State of Bolivia (CRPD/C/BOL/CO/1); 4 November 2016; para. 36. Geneva: Committee on the Rights of Persons with Disabilities; 2016 (<https://undocs.org/CRPD/C/BOL/CO/1>, accessed 31 May 2023).
327. Minkowitz T, Fleischner RD, Curiae A. Observations regarding the relevance to this case of the Convention on the Rights of Persons with Disabilities ICC-02/04-01/15-1930; 21 December 2021. The Prosecutor v. Dominic Ongwen. The Hague: International Criminal Court; 2021 (https://www.icc-cpi.int/sites/default/files/CourtRecords/CR2021_11888.PDF, accessed 31 May 2023).
328. McSherry B, Sullivan D. An analysis of arguments for the retention of the defence of mental impairment. *Psychiatr Psychol Law*. 2023;30:96–105. doi: 10.1080/13218719.2022.2112102.
329. United Nations standard minimum rules for the treatment of prisoners (the Nelson Mandela Rules), adopted by General Assembly resolution 70/175 on 17 December 2015, rule 24(1). New York: United Nations, General Assembly; 2016 (<https://undocs.org/A/RES/70/175>, accessed 31 May 2023).
330. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), adopted by General Assembly resolution 70/175 on 17 December 2015, rule 27(1). New York: United Nations, General Assembly; 2016 (<https://undocs.org/A/RES/70/175>, accessed 31 May 2023).
331. Increasingly consulted, but not yet participating. IDA global survey on participation of organisations of persons with disabilities in development programmes and policies. New York: International Disability Alliance; 2020 (https://www.internationaldisabilityalliance.org/sites/default/files/ida_global_survey_complete_report_final.pdf, accessed 31 May 2023).
332. Convention on the Rights of Persons with Disabilities. General comment n°7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention (CRPD/C/GC/7); 27 August–21 September 2018. Geneva: Committee on the Rights of Persons with Disabilities; 2018 (<https://undocs.org/CRPD/C/GC/7>, accessed 31 May 2023).
333. United Nations Disability Inclusion Strategy. Guidelines on consulting persons with disabilities. Indicator 5. Geneva: United Nations; 2021 (https://www.un.org/sites/un2.un.org/files/un_disability-inclusive_consultation_guidelines.pdf, accessed 31 May 2023).
334. Guidance on community mental health services: promoting person-centred and rights-based approaches; pp. 215–217. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341648>, accessed 31 May 2023).
335. From exclusion to equality: realizing the rights of persons with disabilities. Handbook for parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol; p. 73. Geneva: United Nations, Office of the High Commissioner for Human Rights, Inter-Parliamentary Union; 2007. (<https://www.ohchr.org/en/publications/policy-and-methodological-publications/exclusion-equality-realizing-rights-persons>, accessed 31 May 2023).
336. Disability laws and acts by country/area. In: UN Department of Economic and Social Affairs [website]. New York: UN Department of Economic and Social Affairs; n.d. (<https://www.un.org/development/desa/disabilities/disability-laws-and-acts-by-country-area.html>, accessed 31 May 2023).
337. van Aeken K. From vision to reality: ex post evaluation of legislation. *Legisprudence*. 2011;5:41–68. doi: 10.5235/175214611796404859.
338. The Mental Healthcare Act, 2017. Law no 10 of 2017, 7 April 2017; provision 125(1). New Delhi: Ministry of Law and Justice; 2017 (<https://www.indiacode.nic.in/bitstream/123456789/2249/1/A2017-10.pdf>, accessed 31 May 2023).

World Health Organization
Avenue Appia 20
1211 Geneva 27
Switzerland
Website: <https://www.who.int/>

**Office of the United Nations High Commissioner
for Human Rights (OHCHR)**
Palais des Nations
1211 Geneva 10
Switzerland
Website: www.ohchr.org

