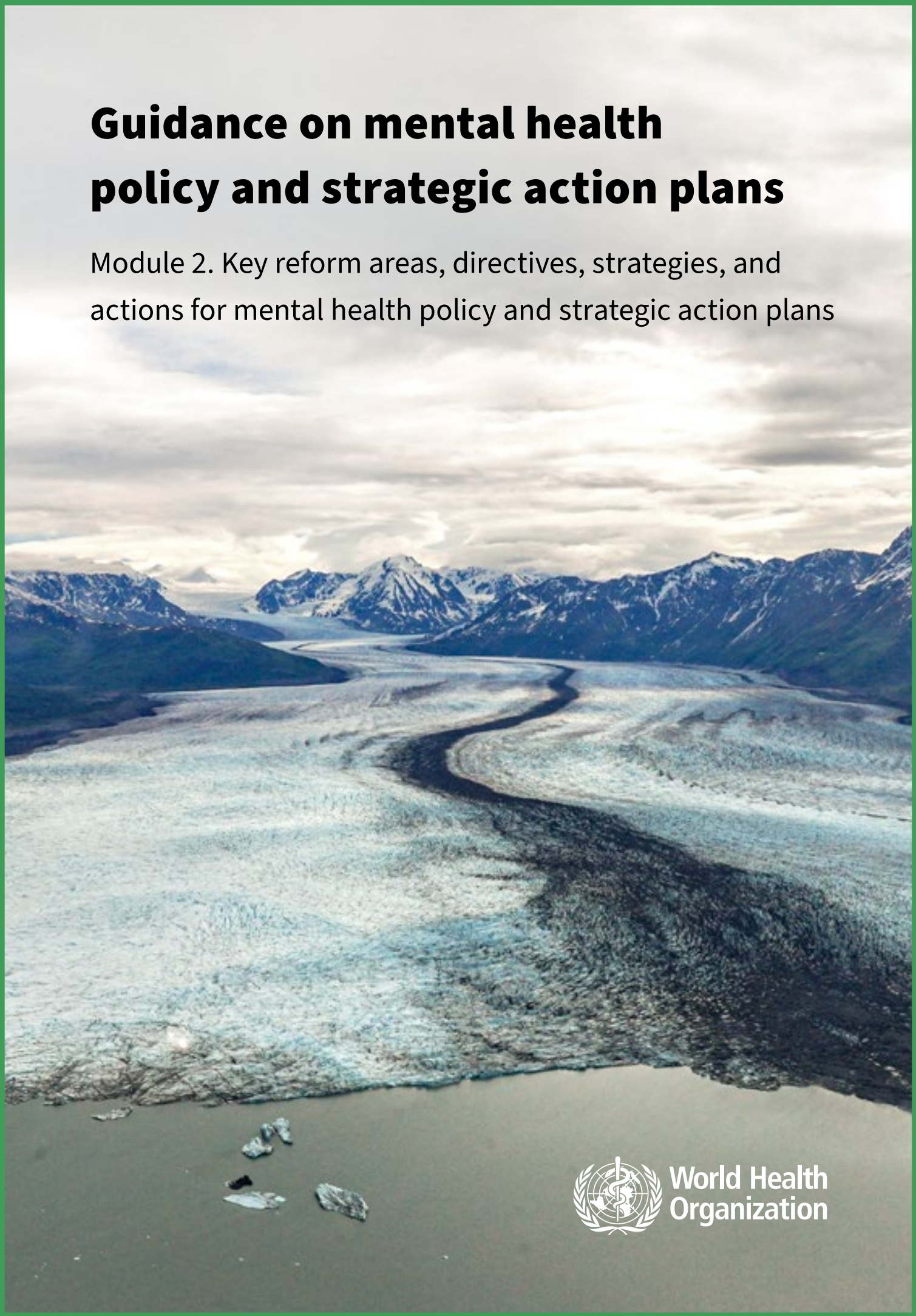
Guidance on mental health policy and strategic action plans

Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans



World Health Organization

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Guidance on mental health policy and strategic action plans. Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans

(Guidance on mental health policy and strategic action plans. Module 1. Introduction, purpose and use of the guidance – Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans – Module 3. Process for developing, implementing, and evaluating mental health policy and strategic action plans – Module 4. Country case scenarios – Module 5. Comprehensive directory of policy areas, directives, strategies and actions for mental health)

ISBN 978-92-4-010681-9 (electronic version)
ISBN 978-92-4-010682-6 (print version)

Suggested citation. Guidance on mental health policy and strategic action plans. Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans. Geneva: World Health Organization; 2025 (Guidance on mental health policy and strategic action plans). Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at https://iris.who.int/.

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Design and layout: Jennifer Rose Fivefold Studio
Cover photo: Mountain range in Alaska. ©Tobias Funk

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Foreword

This Guidance on mental health policy and strategic action plans provides countries with a comprehensive pathway to mental health policy reform. This is in line with an increasing consensus on the importance of embracing rights-based, person-centered, and recovery-oriented approaches that emphasize autonomy and dignity, while also engaging people with lived experience in planning and decision-making.

Our collective vision is for a world where mental health is integrated into primary health care, and where services are accessible, respectful, and empowering. Mental health planning should also take into account the social and structural factors such as poverty, housing, education, and employment, as well as the negative impact of stigma, discrimination, and other systemic barriers. Addressing these interconnected issues is fundamental to achieving holistic and sustainable outcomes. Collaboration across sectors is essential to implement equitable and effective community-based services.

This publication is a testament to the invaluable contributions of people with lived experience, whose voices and insights are central to this transformative agenda. It is their stories, resilience, and advocacy that underpin the urgency of this work and inspire us towards a more inclusive and compassionate world. This Guidance is a vital resource for policymakers, practitioners, and advocates alike, providing practical and actionable strategies to accelerate progress, while helping to protect the rights and dignity of those seeking care.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

Acknowledgements

The development and coordination of this guidance was led by **Michelle Funk**, with the support of **Dévora Kestel**, of the Department of Mental Health, Brain Health and Substance Use of the World Health Organization (WHO).

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WHO would also like to acknowledge the coordinated input received from the **Australian Government Department of Health and Aged Care**, to this publication.

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Financial support

WHO gratefully acknowledges generous financial support towards this publication. **The Government of the Republic of Korea** provided much of the funding, alongside an additional contribution from the **Government of Portugal**.

Glossary

Biomedical model

The biomedical model views mental health conditions as primarily caused by neurobiological factors *(1, 2)*. With this approach the main focus of care is on diagnosis, medication, and symptom reduction, often overlooking the social and structural factors affecting mental health and individuals' needs and rights for inclusion, social protection, among others *(3)*.

Community mental health care

Community-based mental health care, including both specialized and non-specialized care, allows people to live and to receive care within their own communities, rather than in institutional settings (such as psychiatric hospitals or social care facilities), promoting equality and inclusion within society. Community mental health care involves a network of interconnected services, including: mental health services integrated into general health care; community mental health centres; outreach, providing care at home or in public spaces; and access to key social and other support services. While there is no universal model for organizing these services, every country can take steps to restructure and expand community mental health care to uphold the right to live and be included in the community *(3)*.

Deinstitutionalization

Deinstitutionalization involves relocating individuals from institutional settings back into their communities and closing institutional beds to prevent further admissions. Successful deinstitutionalization requires comprehensive community-based services, sufficient financial and structural investment, and a shift in mindsets and practices to value people's rights to community inclusion, liberty, and autonomy *(3)*.

Disability

According to the United Nations Convention on the Rights of Persons with Disabilities (CRPD), disability results from the interaction between individuals with impairments or health conditions and societal barriers that limit their full and equal participation. Article 1 of the CRPD defines "persons with disabilities" as those with long-term physical, mental, intellectual, or sensory impairments that, when combined with barriers, hinder their full and effective participation in society. This reflects the social model of disability, which highlights the role of societal barriers that give rise to disability, and the human rights model, which asserts that people with disabilities have the right to demand the removal of these barriers to ensure equality and non-discrimination *(4)*.

Groups that face discrimination

This refers to groups of people within a given culture, context and history, who face, or are at risk of, discrimination and exclusion due to unequal power relationships. These groups may face discrimination based on age, gender, sexual orientation, disability, migrant and refugee status, race and ethnicity, indigeneity, houselessness status, language, religion, political or other opinions, education or income, living in various localities, or any other status *(5)*. Discrimination on any such ground is prohibited in international human rights law.

Human rights-based approach

This is an approach grounded in international human rights law, aimed at promoting and protecting human rights. In mental health, it involves adopting legal and policy frameworks that comply with State obligations under international law. It equips both State and non-State actors to identify, analyze, and address inequalities and discrimination, and to reach those who are marginalized. It also provides avenues for redress and accountability when necessary *(6)*.

Legal capacity
The CRPD defines legal capacity as "…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" *(7)*. Legal capacity is an inherent and inalienable right, distinct from 'mental capacity' (which refers to people's decision-making abilities) since, regardless of a person's perceived abilities to make decisions, under the CRPD they nevertheless retain their right to exercise their legal capacity on an equal basis with others.

LGBTIQ+
LGBTIQ+ is an acronym for lesbian, gay, bisexual, transgender, intersex and queer/questioning people. The plus sign represents people of diverse sexual orientation, gender identity, gender expression and sex characteristics who identify with other terms. This acronym, adopted from a Western (predominantly Anglophone) context, has become a term of convenience in the realm of public health and health research, including for some normative statements on human rights by WHO and other UN entities *(8)*. While the acronym LGBTIQ+ (or a derivation of it, such as LGB or LGBT) is widely used globally and in UN publications, it does not encompass the full diversity of terms used to describe sexual orientation, gender identity and expression, and sex characteristics.

Lived experience
This can refer to personal experience with mental health services, mental health conditions, or specific living conditions like poverty. It describes how someone has experienced and understands a particular situation, challenge, or health issue.

Mental health and psychosocial support (MHPSS)
This is a composite term for any local or external support aimed at protecting or promoting psychosocial well-being or preventing and treating mental health conditions *(9)*.

Procedural accommodation
This refers to necessary modifications and adjustments in the context of access to justice, ensuring equal participation for persons with disabilities and other groups. Unlike reasonable accommodations, procedural accommodations are not limited by the concept of disproportionate or undue burden *(10)*.

Person-centred care
This focuses on aligning care with individuals' preferences, needs, values, and strengths, and with people's unique circumstances and goals in life. It requires that people actively participate in decisions about their treatment and care, aiming to foster trusting partnerships, dignity, respect, and autonomy, while also addressing social and structural factors affecting mental health in order to provide holistic care *(11)*.

Psychiatric and social care institutions
Institutions are living environments where residents are separated from the broader community, are often isolated, and lack control over their lives and decisions affecting them. Such settings also often prioritize institutional over individuals' needs *(12)*. Institutions may include standalone psychiatric hospitals, social care homes, and other facilities where people experience these restrictions. Even small, community-based facilities can be considered institutional if they impose rigid routines, restrict autonomy, and fail to promote genuine community inclusion. This definition does not include psychiatric units or services located in the community and integrated within general hospitals, and within the broader general healthcare system, provided that autonomy and rights are respected.

Psychosocial disability

This guidance adopts the definition of disability set out in the CRPD — see above. In this context, psychosocial disability refers to the barriers (for example discrimination, stigma and exclusion) that arise from the interaction between individuals with mental health difficulties and attitudinal and environmental factors that hinder people's full and equal participation in society. This term emphasizes a social rather than a medical approach to mental and emotional experiences. While the CRPD uses the term "impairment", this Guidance avoids this term in order to respect the diverse perspectives of people with lived experience of psychosocial disability, and the dynamic nature of mental and emotional states *(3, 13, 14)*.

Reasonable accommodation

The CRPD defines reasonable accommodation as necessary and appropriate modifications that do not impose a disproportionate or undue burden, ensuring that persons with disabilities and other groups can enjoy and exercise all human rights and fundamental freedoms on an equal basis with others *(15)*.

Recovery

The recovery approach in mental health focuses on supporting people to regain or maintain control over their lives. Recovery is personal and different for each person, and can include finding meaning and purpose, living a self-directed life, strengthening self-worth, healing from trauma, and having hope for the future. Each person defines what recovery means for them and decides which areas of life to focus on as part of their recovery journey. Recovery views the person and their context as a whole, rather than aiming for the absence of symptoms or a so-called cure *(16)*.

Substitute decision-making

This refers to regimes where a person's legal capacity is removed, and a substitute decision-maker is appointed to make decisions on their behalf, often based on what is perceived as the person's best interests, rather than their own will and preferences *(17)*.

Supported decision-making

The CRPD describes supported decision-making as regimes that provide various support options enabling a person to exercise legal capacity and make decisions with support *(18)*. Supported decision-making can take many forms but does not remove or restrict legal capacity. A supporter cannot be appointed by a third party without the person's consent, and support must align with the individual's will and preferences *(19)*.

Executive summary

Mental health policy reform is urgent

Mental health has become a global priority, recognized as influencing every aspect of life — from emotional and social well-being to physical health, relationships, and community involvement. It is a vital asset that should be protected and nurtured for individuals and societies to thrive. To achieve this, governments need to establish robust policies and approaches to address the mental health needs of their populations, while continually acting to protect and promote mental well-being.

In response there is growing momentum for policies to adopt a rights-based, person-centred, and recovery-oriented approach, in line with international human rights commitments, such as the Convention on the Rights of Persons with Disabilities and the WHO *Comprehensive mental health action plan 2013–2030* *(20, 21)*. These approaches emphasize addressing stigma and discrimination and ensuring people's autonomy, dignity, and rights are respected. They also stress that mental health should be integrated as a core component of Universal Health Coverage (UHC) and the universal need for equitable access to comprehensive, quality mental health services, regardless of people's socioeconomic status or geographical location.

Despite these global commitments, many countries still lack mental health policies and plans that fully align with international human rights standards or address the broader societal factors affecting mental health. All countries having endorsed WHO's *Comprehensive mental health action plan 2013–2030* are committed to developing, updating, and implementing national policies and strategies, with a global target for 80% of countries to achieve this alignment by 2030.

A comprehensive framework for reform

This Guidance on mental health policy and strategic action plans was created to support countries in reforming their mental health policies and updating strategic action plans, placing human rights and the social and structural determinants of mental health at the core of all policy reform efforts. Grounded in international human rights frameworks, particularly the UN Convention on the Rights of Persons with Disabilities (CRPD), the Guidance calls for mental health systems that promote legal capacity, non-coercive practices, participation, and community inclusion. It aims to ensure that all people are treated with dignity, respect, and on an equal basis with others. By addressing broader social and structural determinants – such as poverty, housing insecurity, unemployment, and discrimination – and emphasizing multi-sectoral collaboration, the guidance promotes a holistic approach to mental health reform, advancing equity and social justice.

This Guidance serves as a valuable resource not only for policy-makers and planners but also for a wide range of stakeholders, including individuals and organizations involved in mental health advocacy and reform. It can help these stakeholders gain a better understanding of mental health systems, policy reform processes and key issues to be addressed in the development and implementation of rights-based mental health policy and strategic actions.

Structure of the Guidance

The Guidance discusses important policy areas for reform and outlines key steps that countries should work through in developing, implementing, evaluating and monitoring their mental health policy and strategic action plan. The Guidance is divided into five modules published as separate documents.

Module 1. Introduction, purpose and use of the guidance

This module discusses the challenges related to mental health policy and the need for reform in line with the international human rights framework, highlighting essential considerations and new directions.

Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans (this document)

This module details five key policy areas for reform together with associated directives, strategies and actions that can be prioritized and adapted by policy-makers and planners according to each country's specific contexts.

Key policy areas for reform

Within each policy area, a menu of policy directives, strategies, and actions guides reform efforts, helping policy-makers and planners prioritize and tailor policies to their specific context, in line with their available resources or organizational structures. At the end of each policy area, the Guidance highlights key issues requiring special considerations for diverse groups: children and adolescents, older adults, women, men and gender-diverse persons, the LGBTIQ+ community, persons with disabilities, migrants and refugees, persons from minoritized racial and ethnic groups, Indigenous Peoples, and persons who are houseless or with unstable housing. Due to unique characteristics, life circumstances, or unmet needs, these groups may require specific support and attention beyond that of the general population.

Policy area 1. Leadership, governance, and other enablers

Policy area 1 discusses strengthening leadership and governance structures to ensure the sustainability, accountability, and effective implementation of mental policy reforms.

Policy directives

- coordination, leadership and accountability;
- financing and budget;
- information systems and research;
- people with lived experience, civil society, and communities;
- rights-based law reform.

Policy area 2. Service organization and development

Policy area 2 discusses development and implementation of comprehensive community-based mental health services and support that are rights-based, person-centred and recovery-oriented; and reorganization of mental health systems to transition from institutionalized care to services in the community.

Policy directives

- coordinated rights-based community mental health services and support at all levels of care;
- integrated mechanisms that respond to social and structural factors and take rights-based approaches in mental health;
- partnerships for community inclusion, socioeconomic development, and for protecting and promoting rights;
- deinstitutionalization.

Policy area 3. Human resource and workforce development

Policy area 3 discusses building a diverse, competent and resilient workforce capable of delivering person-centred, rights-based, and recovery-oriented mental health services and support.

Policy directives

- a multidisciplinary workforce with task sharing, training and support;
- recruitment, retention and staff well-being;
- competency based curricula for mental health.

Policy area 4. Person-centred, recovery-oriented and rights-based assessment, interventions and support

Policy area 4 discusses providing assessment, interventions and support that is comprehensive, offers choice, is responsive to individual support needs and is rights-based, person-centred and recovery-oriented.

Policy directives

- assessment of mental health and support needs by multidisciplinary teams;
- physical health and lifestyle, psychological, social and economic interventions;
- psychotropic drug interventions.

Policy area 5. Mental health sector contributions to addressing social and structural determinants and society-wide issues impacting mental health and well-being

Policy area 5 discusses expanding the mental health sector's role to address the social and structural determinants that shape mental health outcomes, promoting equity, human rights and inclusiveness.

Policy directives

- improved literacy and transformed mindsets to promote mental health and well-being and combat stigma, discrimination, and exclusion;
- joint actions on social and structural determinants and society-wide issues.

Module 3. Process for developing, implementing, and evaluating mental health policy and strategic action plans

This module outlines key principles and nine discrete and non-linear steps.

1. **Conduct high-level policy dialogue**. Bring together high-level stakeholders from key sectors and civil society to establish commitment and engagement for mental health reform.

2. **Establish a multistakeholder advisory committee**. This committee is important to oversee development and implementation of the policy and strategic action plan with input from all relevant sectors and stakeholders, including people with lived experience.

3. **Build understanding and new mindsets**. It is key to address stigma and discrimination and resistance to rights-based approaches from the outset of policy development.

4. **Review international human rights obligations and commitments**. Understanding key international human rights frameworks, including the UN Convention on the Rights of Persons with Disabilities (CRPD) is essential to inform policy development.

5. **Undertake situational analysis**. Assess the current mental health context, identifying gaps, priorities, and challenges to inform policy and strategic action plan development.

6. **Draft the mental health policy**. Develop the mental health policy, including key areas for action and policy directives based on a situational analysis, incorporating input from all relevant stakeholders.

7. **Draft the mental health strategic action plan**. Develop a strategic action plan with defined strategies including timeframes, targets, indicators, specific actions, outputs, and costs to effectively implement the policy.

8. **Implement the policy and strategic action plan**. Well-planned and sustainable implementation requires awareness-raising, dissemination, and communication; incremental and scaled up implementation processes; fundraising; and a realistic programme of work.

9. **Monitor and evaluate**. Set up mechanisms to continuously track progress, identify challenges, and adjust for successful implementation.

Checklists are also included to help planners assess and evaluate both pre-existing and newly drafted policies and strategic action plans.

Module 4. Country case scenarios

This module provides three country case scenarios to illustrate the varied approaches countries can take when reforming their mental health policy, including how policy directives, strategies, and actions can be tailored to fit specific local contexts.

Module 5. Comprehensive directory of policy areas, directives, strategies and actions for mental health

This module provides a quick access directory to material discussed in Module 2, enabling easy navigation.

A pathway to action

This Guidance offers a comprehensive blueprint and framework for developing national mental health policies and strategic action plans and aligning them with international human rights standards. It outlines key policy areas for reform, including policy directives, associated strategies and actions that are adaptable and can be selected and prioritized in line with country-specific contexts. It also advocates a rights-based, person-centred, and recovery-oriented approach while addressing the social and structural determinants of mental health. By promoting multi-sectoral collaboration, the guidance provides a pathway to building equitable, inclusive mental health systems that respect autonomy and dignity.

Countries are urged to implement this guidance to reform their mental health policies, so that these deliver lasting, evidence-based and rights-driven solutions for all.

Introduction

This module outlines five key policy areas often in need of reform:

- leadership, governance and other enablers;
- service organization and development;
- human resource and workforce development;
- person-centred, recovery-oriented and rights-based assessment, interventions and support;
- mental health sector contributions to addressing social and structural determinants and society-wide issues affecting mental health and well-being.

The first policy area, *Leadership, governance, and other enablers*, is cross-cutting, influencing each of the other policy areas and fostering important interrelationships among them. Additionally, there are frequent cross-references between these areas, reflecting their close interconnections.

For each of these policy areas, the module offers a menu of policy directives, strategies, and associated actions to guide reform efforts and address human rights challenges and social determinants of mental ill-health (see Box 1). Each policy area begins with an overview of key challenges, followed by policy directives that provide contextual information and illustrative text examples. Strategies and actions are then organized under each directive, offering clear guidance on the necessary steps to implement the policy effectively.

Box 1. Example social and structural determinants of mental health

Social and structural determinants include (but are not limited to):

- stigma, discrimination and racism based on individuals' status or identity;
- poverty;
- gender (for example, inequality and harmful gender norms);
- lack of, lower levels of or interrupted education;
- unemployment, job insecurity or income inequality;
- houselessness or unstable housing;
- food insecurity (in terms of availability and type of food);
- public health emergencies (for example, COVID-19);
- climate change, natural hazards, pollution and industrial disasters;
- humanitarian crises (such as war, armed conflict, forced displacement, natural disasters, human-caused disasters, and other complex emergencies) and forced displacement and migration;
- violence and abuse; and
- loneliness and social isolation.

At the end of each policy area, the Guidance highlights key issues requiring special considerations for diverse groups. Due to unique characteristics, life circumstances, or unmet needs, these groups may require additional support beyond that of the general population. Figure 1 presents a schematic representation of the policy areas, directives, themes, and groups requiring special consideration covered in this module.

All five policy areas emphasize: a person-centered, recovery-oriented and rights-based approach, in collaboration with diverse government sectors (see Box 2); the meaningful participation of people with lived experience; eliminating stigma and discrimination; and fostering positive changes in attitudes, mindsets and culture within mental health.

Box 2. Government sectors with influence over mental health

This non-exhaustive list highlights sectors that can play a role in protecting and promoting mental health:

- culture, art, and sports;
- defence and veterans' services;
- education;
- employment;
- environment, conservation and climate protection;
- financing and treasury;
- health;
- interior;
- justice;
- social protection; and
- urban and rural development.

The policy directives, strategies, and actions outlined in this module show how key challenges in mental health can be addressed. Countries are encouraged to prioritize and select options based on their specific needs, tailoring policies, and strategic actions to fit their unique local contexts, circumstances and resources. It is not expected that countries will adopt every policy directive, strategy, or action listed in the Guidance. Some may choose only a limited number of areas to focus on, while others may select a broader set. Prioritization should be a collaborative, bottom-up process engaging diverse stakeholders (See Box 3). Module 3 provides a comprehensive discussion of the development and implementation process, along with checklists to assist policymakers and managers. Module 4 provides illustrative case study scenarios and Module 5 offers a quick access directory of policy areas, directives strategies and actions.

Box 3. Key actors and groups/organizations to engage

Key actors

- people with lived experience of mental health conditions and psychosocial disabilities;
- policy-makers and managers from health and social sectors;
- politicians (for example, ministers, city and town mayors);
- representatives from groups that face discrimination;
- community leaders and gatekeepers, such as local chiefs or village leaders, traditional and faith-based healers or leaders;
- mental health and general health practitioners as well as other relevant and allied professionals at all levels of health care;
- families and other caregivers;
- legal and human rights experts and professionals;
- academics and researchers; and
- philanthropists.

Key groups and organizations

- government sectors/departments (see Box 2);
- organizations of people with disabilities;
- organizations of people with lived experience;
- other organizations of groups that face discrimination;
- local civil society groups;
- nongovernmental organizations (NGOs);
- charity and voluntary organizations;
- faith-based organizations;
- organizations representing mental health practitioners, general health practitioners, and other multidisciplinary practitioners;
- organizations representing families and caregivers;
- academic and research institutions; and
- legal aid and human rights organizations.

Furthermore, each policy directive, strategy, or action outlined in this module can be modified or adapted to meet a country's unique needs, reflecting its specific history, organizational structures, and stage of mental health system development. The examples provided are intended to guide, not prescribe, offering a flexible model for how policies and strategic action plans might be drafted. Final texts should reflect each country's context, clearly outlining the purpose, scope, and commitments of its policy. Additionally, countries are encouraged to introduce new directives, strategies, and actions that may not be covered in this Guidance.

The annex gathers practical resources from wide-ranging sources that may help policy-makers and implementers. These tools and references are grouped by the policy directive they can help implement.

Fig. 1. Overview of policy areas, directives, themes and groups needing special consideration

Integrated themes for policy areas 1–5
Person-centred, recovery-oriented and human rights-based approach; meaningful participation of people with lived experience; eliminating stigma and discrimination; changing attitudes, mindsets and culture in mental health; and addressing the social and structural determinants of mental health

Policy area 1. Leadership, governance and other enablers

Policy directives

- **1.1** Coordination, leadership and accountability
- **1.2** Financing and budget
- **1.3** Information systems and research
- **1.4** People with lived experience, civil society, and communities
- **1.5** Rights-based law reform

Diverse groups that need special considerations for policy areas 1–5
Children and adolescents; older persons; women, men and gender diverse persons; persons belonging to the LGBTIQ+ community; persons with disabilities; migrants and refugees; persons from minoritized racial and ethnic groups; Indigenous Peoples; persons who are houseless or with unstable housing

Policy area 2. Service organization and development

Policy directives

- **2.1** Coordinated rights-based community mental health services and support at all levels of care
- **2.2** Integrated mechanisms that respond to social and structural factors and take rights-based approaches in mental health
- **2.3** Partnerships for community inclusion, socioeconomic development, and for protecting and promoting rights
- **2.4** Deinstitutionalization

Policy area 3. Human resource and workforce development

Policy directives

- **3.1** A multidisciplinary workforce with task sharing, training and support
- **3.2** Recruitment, retention and staff well-being
- **3.3** Competency-based curricula for mental health

Policy area 4. Person-centred, recovery-oriented and rights-based assessment, interventions and support

Policy directives

- **4.1** Assessment of mental health and support needs by multidisciplinary teams
- **4.2** Physical health and lifestyle, psychological, social and economic interventions
- **4.3** Psychotropic drug interventions

Policy area 5. Mental health sector contributions to addressing social and structural determinants and society-wide issues impacting mental health and well-being

Policy directives

- **5.1** Improved literacy and transformed mindsets to promote mental health and well-being and combat stigma, discrimination and exclusion
- **5.2** Joint actions on social and structural determinants and society-wide issues

1

Policy Area 1: Leadership, governance and other enablers

Key challenges

The government plays a crucial role as the ultimate guardian of a population's mental health. It is responsible for establishing and coordinating governance mechanisms, including institutional, legal, and financial frameworks, to meet mental health needs and promote overall well-being. These mechanisms need to be supported by strong leadership and held accountable to people with lived experience and the broader community, using the best available data and evidence. To eliminate discriminatory practices and ensure equal human rights for people with mental health conditions and psychosocial disabilities, countries should also adopt mental health legislation aligned with the CRPD and other international human rights standards *(22)*. The key challenges outlined below highlight some of the barriers and gaps that effective governance should address.

Inefficient coordination

Efficient coordination within the mental health sector and between other government sectors is often lacking. This results in fragmented and insufficient responses to mental health needs, wasting precious human and financial resources. In addition, poor coordination arises from procedural and administrative gaps, such as misaligned policies and ineffective communication between national and local government levels and mental health services *(3, 23–25)*. Mental health spans multiple sectors, requiring strong collaboration between sectors as well as inclusive processes for developing and implementing strategies that address the social and structural determinants of people's mental health (see Box 1). Effective coordination mechanisms are crucial for integrating services at both national and local levels and between sectors, ensuring the development of person-centred, recovery-oriented, and human rights-based mental health systems and services.

Lack of rights-based skills and mechanisms for leadership

Leadership often fails to promote a rights-based approach to mental health, which requires overturning decades of entrenched policy and practice. Many mental health systems remain focused on diagnosis, drug treatment, and symptom reduction — an emphasis embedded in academic curricula, service practices, and community campaigns — while often neglecting essential social and human rights dimensions necessary for comprehensive care. Strong leadership and a commitment to rights-based approaches are essential to advancing a broader vision for mental health, guiding a shift toward inclusive, rights-focused policies and practices.

Insufficient mental health data

Health information systems and research frequently lack comprehensive, valid, and reliable mental health data, particularly at the population level. Even when data are collected, national systems often focus on limited indicators, such as medication usage and hospital admissions *(23)*. Furthermore, mental health research has been disproportionately focused on neuroscience, genetics, and psychopharmacology, with insufficient attention

given to non-pharmacological approaches, community-based service delivery, and broader recovery-focused interventions that address social and structural determinants *(26–29)*. Yet informing countries about performance, identifying gaps, sharing best practices, monitoring outcomes and redirecting research efforts can be crucial to improve care quality and protect rights at individual, service, and population levels.

Lack of independent monitoring, evaluation and accountability

There is a critical absence of systematized, independent monitoring, evaluation and accountability mechanisms to address human rights violations in mental health services, including inadequate sanitation and food, overcrowding, outdated or harmful treatments such as unmodified electroconvulsive therapy, overmedication, violence, abuse and coercive practices like forced admission and treatment and seclusion and restraint *(30–37)*. Establishing independent monitoring and evaluation systems is essential to assess and improve the quality of care and protect human rights within mental health services, and can help to promote change and accountability.

Inadequate or misallocated resources

Many countries do not adequately invest in mental health, and this leads to limited access to services and poor quality of care *(3)*. Even when adequate resources are invested, they are often allocated to psychiatric hospitals or reimbursement for hospital services rather than rights- and community-based services and evidence-based interventions *(38)*. Stand-alone interventions (such as medications) are often used rather than more complex interventions that might benefit person-centred, recovery-oriented, human rights-based services in the community *(39)*.

Lack of civil society engagement, especially from those with lived experience

Mental health services often fail to involve civil society, particularly organizations of persons with lived experience. Historically, individuals with mental health conditions and psychosocial disabilities have been excluded from decision-making processes and their concerns overlooked *(40, 41)*. Those facing multiple forms of discrimination are further marginalized in political structures, leading to many of the issues, challenges, and barriers they face being ignored in the area of mental health. Participation is instrumental to self-determination — an essential element for fulfilling human potential and promoting each person's mental health *(42, 43)*. Participation should be encouraged in mental health settings and through collaboration with other government services. A strong civil society, especially organizations of people with lived experience, can help develop more effective and accountable mental health policies, laws, and services that align with international human rights standards.

Discriminatory legal frameworks

Legal frameworks in many parts of the world continue to authorize and regulate — and thereby legitimize — coercive practices in mental health settings, such as involuntary admission and treatment, seclusion, and restraint. These laws often restrict and regulate people's legal capacity, allowing health practitioners, family members, or court-appointed guardians to make decisions on their behalf *(44–46)*. Additionally, legislation frequently limits key rights for people with mental health conditions and psychosocial disabilities, such as the right to own property, marry, or vote *(47–49)*. Reforming these legal frameworks is crucial to eliminating discriminatory practices and ensuring that people with mental health conditions and psychosocial disabilities enjoy their rights on an equal basis with others.

1.1 Policy directive 1.1 Coordination, leadership and accountability

A mental health system requires coordinated services, interventions, and actions that reinforce a common vision. Without alignment to this vision through a harmonized coordination mechanism, fragmentation, inconsistency, and conflicts can arise, making policies and strategies less effective. These coordination challenges are not unique to the mental health sector and will need collaboration and joint action with other sectors, civil society, and the private sector to achieve healthier populations and successful societies.

Illustrative example text

This policy directive will strengthen coordination mechanisms across all levels of the mental health system — national, regional, district, and community — in collaboration with other sectors. It will focus on building and sustaining person-centred, recovery-oriented, human rights-based mental health systems and services. Additionally, it will invest in strong leadership skills to support this vision.

Strategy 1.1.1

Establish coordination structures and mechanisms within the mental health sector and across sectors to strengthen leadership and governance for mental health.

Actions

- **Create a mental health department or smaller unit within the ministry and/or clarify responsibilities and authority, while improving communication channels through to community-level mental health staff**. A mental health department or organizational unit should be well staffed and have significant agency within the health sector, for example, through an independent reporting line to the health minister. This central mental health department plays a crucial role in coordinating with regional, district and municipal units and focal people working in communities. Mental health experts (including people with mental health conditions or psychosocial disabilities, and people from groups that face discrimination) can be recruited to work with the central mental health department or unit.

- **Establish a national advisory board for mental health and convene working groups to advise on policy, legislative, strategic and evaluation issues**. Key directions for mental health should respond to the needs of diverse stakeholder groups. Engaging these groups brings valuable insights and fosters commitment to policy changes. Stakeholders can be represented on high-level advisory boards and working groups, with clear terms of reference and specified term of tenure, to guide discussions and decision-making. Representation should be broad, including key government sectors and other groups (See Box 3 for examples). All members should receive leadership training, including on rights-based approaches (see actions for Strategy 1.1.2 on strengthening leadership). Crucially, several representatives of people with mental health conditions and psychosocial disabilities should be included to ensure they feel confident, safe, and supported in expressing views that may challenge established norms. If a ministerial-level council or similar body exists to coordinate mental health sector responses, integrating the national advisory board's work into these discussions is vital.

- **Hold regular coordination meetings along the chain of responsibility linking the national mental health department and regional, district, and community-level units or focal staff**. These will proactively solve challenges, share best practices, and continuously improve coordination. Issues to cover include: needs and priorities; analysis of successes and failures; bottle necks; referral mechanisms; problems in coordination; service gaps and solutions. Other stakeholders, for example, organizations of persons with lived experience, NGOs, and community leaders (see Box 3), can be brought in as required.

- **Establish a regular forum to gather stakeholder views. An annual forum can be held, with options for more frequent meetings as needed**. It is essential to ensure that people with lived experience of mental health conditions, including service users, and those from groups facing multiple forms of discrimination, have a voice. This forum will broaden understanding of priorities and challenges and help generate potential policy responses.

- **Create an accessible information source for navigating services, support and treatments**. A user-friendly website can offer stakeholders and the general public clear information on available community services, support, and treatment options. The site should be accessible to everyone, including individuals with disabilities, and should prominently feature services for groups facing discrimination.

Strategy 1.1.2

Strengthen mental health sector leadership aligned with the rights-based, recovery-oriented and person-centred approach.

Actions

- **Provide leadership training for managers and members of advisory boards and committees**. Develop a leadership programme or facilitate access to existing national, regional, and global programmes. Training should cover change management, training on policy and strategic action planning, culture change, rights-based approaches, transformation strategies, communication styles, conflict resolution, inspiring and empowering others, performance assessments, feedback techniques, and team development strategies.

- **Celebrate successes and reward good leadership towards transformative change**. Recognize and celebrate achievements, both large and small, as they occur and through specially created events. Celebrations remind managers, staff, and stakeholders of progress made, helping to keep them motivated and engaged. Rewards and incentives, such as monetary bonuses, official recognition, increased visibility, or additional leave days, are effective strategies for empowering and motivating managers.

- **Create a coaching and mentoring system that supports aspiring managers and stakeholders**. For example, a peer mentoring programme could pair new leaders with mentors who have successfully navigated similar challenges, providing practical guidance and support. This system helps improve knowledge, skills, and work performance through regular discussions with experienced professionals about leadership and managerial challenges.

Strategy 1.1.3

Monitor service quality and rights protection, including via an independent monitoring committee and complaints mechanism.

Actions

- **Identify or create an independent committee or mechanism for monitoring service quality and human rights protections**. Existing mechanisms, such as national prevention mechanisms or health commissions, may lack experience in monitoring according to international human rights standards. Additionally, their members may not reflect the diversity of stakeholder groups or possess expertise in mental health, human rights, disability, social determinants, and lived experience. Bringing in external experts may be necessary to assess services, provide recommendations, and train committee members. If appropriate committees do not exist, new ones can be established, and a pool of trained assessors can be developed.

- **Establish a service monitoring framework with a centralized reporting mechanism linked to the appropriate accrediting organization**. The framework should specify (i) the assessment tools to be used, (ii) the schedule of (re)assessments, reporting, and co-production of recommendations, and (iii) the approach to quality improvement or transformation. The WHO QualityRights assessment toolkit and transformation guidance *(50)* provide detailed information on setting up such a process and can be used individually or in combination with other tools and guides. Linking the monitoring mechanism to accreditation from the relevant national or regional body will help ensure high standards and, in turn, improve the community's confidence in services.

- **Define and implement an independent complaints mechanism**. This should cover all mental health services, allowing individuals concerned, staff and others to escalate complaints directly to the independent monitoring body if unresolved at the service level, and access the justice system for criminal allegations *(18)*. To ensure efficiency and accessibility, complaint processes and forms should be clear, easily understandable, available, and accessible to all individuals. The mechanism should regularly report all complaints to the monitoring committee, which can act on them and influence accreditation decisions (see also Strategy 1.5.2 on mental health legislation reform). A dedicated website for reporting violations, tracking responses, and sharing lessons can enhance service accountability and public trust.

For practical resources related to Policy directive 1.1 Coordination, leadership and accountability see the relevant section of the annex.

1.2 Policy directive 1.2 Financing and budget

Many countries underinvest in mental health, leading to limited access, poor quality services, and inadequate prevention and promotion efforts. Mental health is often either excluded or minimally covered by the package of services provided through public health systems or health insurance schemes. Despite evidence that hospitalization costs often exceed the costs of equivalent treatment, care and support in the community, psychiatric hospitals continue to receive the largest share of mental health funding *(51)*.

Illustrative example text

This policy directive commits to increasing mental health funding by 10% of the total government health budget over five years,[1] with additional allocations to address mental health in education, social protection, employment, interior, culture, arts, sports, and justice sectors. These budgetary changes will accrue benefits and savings for the sectors involved and improve the mental health and well-being of the general population. Incentives and disincentives for shifting towards person-centred, rights-based community services will be analyzed and disincentives will be addressed in order to overcome resistance to change.

KEY POINT: limited mental health funding must be used strategically. In many countries, minimal mental health funding necessitates prioritizing key initiatives; integrating mental health interventions into existing services for other health issues or into other sector actions; and leveraging community mobilization to support implementation.

Strategy 1.2.1

Build a sustainable funding base for mental health, including within universal health coverage.

Actions

- **Analyse, formulate and report the budget and multi-year expenditure plan for mental health**. Mental health and financing experts, health economists, and representatives of people with mental health conditions, psychosocial disabilities, and marginalized groups should be involved. The task force should calculate the total and annual mental health budget for the duration of the strategic action plan, including funds required for implementation, and identify funding sources and gaps. Funds for both operational (new human resources and activities) and capital (long-term infrastructure) expenditures should be outlined (see Module 3, Step 7.6). To ensure long-term sustainability, the budget should be adjusted for inflation. For countries with strong cross-sector collaboration, the mental health budget analysis should include both direct sector funding and allocations from other sectors for mental health-related issues (as detailed in Policy directive 5.2 Joint actions for social and structural determinants, to ensure a holistic approach for meaningful transformation.

1 Please note this figure is included for illustrative purposes only. Each country will need to determine the percentage increase appropriate to their particular context.

- **Make the investment case for mental health, highlighting both short- and long-term returns to the sector and wider society**. It is important to show how addressing mental health reduces societal costs (for example, unemployment related costs) and yields economic benefits *(52)*. Specific interventions can be modelled to illustrate potential costs and gains. The obligation to respect human rights should be emphasized in the funding case, ensuring that all proposed strategies and interventions align with a human rights-based approach. The funding case should also use an appropriate time horizon to capture the impact of interventions that require short as well as medium and long time periods.

- **Explore all opportunities to secure the funding base for mental health**. Domestic resource mobilization, along with external funding options, should be examined. Examples of domestic resource mobilization include treasury funds; tax-based national health insurance schemes; community fundraising activities; excise taxes on tobacco, alcohol and sugar-sweetened drinks; reallocation of under-used funds in the health or other sectors; linking mental health programmes to other funded priority programmes such as maternal health; and strengthening public-private partnerships. External funds could potentially be mobilized from multinational or bilateral donors, foundations, philanthropists, lottery funds, or pay-for-success mechanisms like social impact bonds *(53)*.

- **Create budget lines for mental health interventions and support within the health sector**. Budget lines for mental health can be created within other health service areas (for example, maternal health, child and adolescent health) and health system areas (for example, universal health coverage, health emergency protection). However, these budget lines should balance accountability and flexibility. It is important to recognize that tracking mental health expenditures can be challenging when services are fully integrated within broader health systems.

REFLECTION on innovation funds. Could creating a mental health innovation fund help inform mental healthcare delivery? Innovative projects in neglected service areas might evaluate and demonstrate new and successful ways to deliver services and initiatives, offering a rationale for future investment.

Strategy 1.2.2

Reorient funding and insurance schemes towards person-centred recovery-oriented and rights-based services and initiatives for mental health.

Actions

- **Negotiate with government financing authorities to fund mental health services through publicly financed health protection schemes**. There are three broad financing/purchasing models between governments/private funders and providers: reimbursement models (providers are paid after services are supplied); contract models (payers and providers agree on costs and services, for example, NGO-delivered recovery-based services funded through health insurance); and integrated models (a single agency funds and provides care, as seen in government-financed public health systems). Each model offers different incentives, allowing governments and other purchasers to choose the most appropriate mechanism. Regardless of the mechanism, rights, equity, and effectiveness should be protected and promoted. This should include timely and consistent payment of the mental health workforce to improve recruitment and retention of staff and support stable, effective mental health service delivery.

- **Explicitly include mental health distress and conditions, as well as treatments, support, and services, in essential care packages and financial protection schemes, and remove discriminatory practices that limit access**. Discrimination can take many forms. For instance, health insurance schemes may exclude mental health interventions, cover only drug interventions but not psychological therapies, or deprioritize people with mental health conditions for treatment, as seen during the COVID-19 pandemic. Additionally, people with psychosocial disabilities may be denied health insurance based on their disability status. This should be prohibited. Regulations can ensure that insurance plans and premiums are fair and reasonable *(54)*. Such protections should also cover people with complex or costly needs (for example, people with disabilities, older adults with complex health needs, migrants, and refugees requiring translation services or culturally adapted care). Moreover, health insurance should cover long-term care and support, not just acute admissions.

- **Review financial incentives and disincentives to providing, using, and paying for rights-based and evidence-based community mental health services and interventions**. Perverse incentives may maintain the status quo, hindering the development of person-centred, rights-based, and recovery-oriented services. Disincentives often exist at the service level, such as public health finances or insurance schemes that offer higher payments for inpatient care, discouraging community-based services. Additionally, health insurance or national health system reimbursement schemes may favour interventions that do not align with human-rights and evidence-based approaches, such as restraints or polypharmacy. The need for a diagnosis in insurance claims can also limit treatment options, favouring traditional interventions such as medications over more complex, holistic approaches like lifestyle, psychological, social, and economic interventions. This limits treatment options and choice. The review should capture how these incentives and disincentives affect individuals, requiring input from stakeholders like service users, peer supporters, family members, caregivers, volunteers, and those from groups facing discrimination. For instance, individuals might face the disincentive of co-payments for comprehensive rights-based treatment while medications are free. Or they might encounter additional barriers to attending psychological interventions compared with the convenience of drug treatments. Conversely, incentives might include insurance coverage for rights-based interventions and support, or being able to access online services (see WHO *Guidance on community mental health services: promoting person-centred and rights-based approaches (55)* and Policy area 2 Service organization and development for more information).

- **Negotiate and adjust financial incentives and disincentives in order to promote and prioritize access to rights-based community mental health services**. Key stakeholders include policy-makers, insurance agencies, and managers of independent hospitals. The following options can be considered.

    - Remove financial incentives that sustain psychiatric hospitals and social care institutions, and instead incentivize their systematic downsizing and eventual closure with careful planning for residents' transition to community-based supported living.
    - Adjust financial incentives to encourage referrals from hospitals to more cost-effective community-based services.
    - Reallocate cost savings obtained through the shift to community services to expand these services, other activities, and staffing to reach more people.
    - Use financial incentives, including insurance reimbursements, to implement a comprehensive range of treatments that avoid coercion and support holistic, evidence-based, person-centred recovery.
    - Introduce budget flexibility to allow reallocation of costs between hospital and community-based settings.
    - Ring-fence funding for community services to protect resources from being redirected.
    - Use financial incentives to encourage collaboration between the health sector and other key sectors.

KEY POINT: deinstitutionalization needs overlapping funding. Sufficient temporary overlapping funding (potentially double) is needed when developing community services before downsizing and eventually closing institutions (see Strategy 2.4.1 on establishing the foundation and enabling environment for successful deinstitutionalization). A well-planned and adequately funded budget will minimize the risk of disorganized institutional closures and ensure that former residents have access to the comprehensive community-based services and supports they need to live independently and be fully included in the community.

Strategy 1.2.3

Allocate sectoral budgets and financing to protect and promote mental health according to both joint and sector-specific responsibilities.

Actions

- **Make sector-specific cases for investing in rights-based mental health interventions, estimating costs of inaction and potential benefits**. The cost of inaction, as well as the potential benefits, should be estimated. For example, within the employment sector, employers can be provided with data on the costs of poor mental health, such as workdays lost, and reduced productivity. Some groups could be prioritized for interventions, such as young employees, or groups that face discrimination. Decision-makers will need to understand expected outcomes in terms of mental well-being and productivity in relation to their sector, as well as the overall economic and social return of investing in mental health interventions. It is important to differentiate benefits to the sector being considered, other sectors, and wider society, both in the short and long term. Guidance on how to make an investment case for mental health can be found in WHO publications *Investing in mental health: evidence for action (56, 57)* and in *Mental health investment case: a guidance note (56, 57)*.

- **Talk with government sectors at local, regional, and national levels to discuss budget allocations for mental health, and advocate for more resources**. Joint initiatives between sectors can be co-financed. For example, mental health and housing sectors could collaborate to fund supportive housing with ongoing mental health care for people with psychosocial disabilities. Each sector might also finance initiatives related to their specific responsibilities. For instance, the social protection sector could extend benefit schemes to include people with mental health conditions and other at-risk groups. This might involve creating disability benefits, transport concessions, tax breaks, or personalized care budgets. Budgets can be based on a plan with a care provider to help individuals achieve their life goals. Cash transfers could support people with psychosocial disabilities in fully exercising their rights to housing, employment, education, and social inclusion *(58)*.

- **Establish intersectoral funding mechanisms, including joint budgets, to facilitate collaboration**. Some services, projects, and initiatives require joint or complementary actions between sectors. For example, in France, the Un chez soi d'abord initiative, adapted from the Housing First model used in New York in the 1990s, provides people in precarious situations and with challenging mental health conditions direct access to stable and supported housing, leading to overall cost savings compared to traditional care. The initiative is supported through collaboration and joint financing from various French government sectors, including health, housing, and territorial cohesion (l'agence régionale de santé, la direction régionale et interdépartementale de l'hébergement et du logement, et les collectivités territoriales) *(59–61)*.

KEY POINT: mental health is a human right with cross-sectoral benefits. Mental health is a human right and not solely the responsibility of the health sector. Governments have obligations to protect and promote mental health across all sectors, regardless of immediate or long-term payoffs or whether investments benefit other sectors. Addressing mental health in areas like employment can lead to broader benefits, such as fewer sick days, improved productivity, and reduced workforce turnover. These actions also benefit other sectors, such as by reducing healthcare pressure, lowering disability payments, minimizing family conflict, and enhancing children's well-being and learning. Although these impacts may take time to manifest and can be complex to measure, cumulative cross-sectoral action can yield substantial benefits.

For practical resources related to Policy directive 1.2 Financing and budget see the relevant section of the annex.

1.3 Policy directive 1.3 Information systems and research

Data are essential for understanding and guiding mental health responses, and helping to build a responsive system that evolves over time according to population needs. Evaluations of policy, services, and interventions, along with new data generated from research, are key to guiding investments. Given the impact of social determinants and the importance of human rights in providing good care and support, data, indicators, evaluation, and research are needed not only in the health sector but also in education, employment, justice, social protection and other sectors.

Illustrative example text

This policy directive aims to strengthen the information system both in the health and other government sectors to better understand population needs and monitor system changes over time. It also establishes evaluation and research frameworks to improve policy, services, and interventions related to mental health, while generating new information in areas with significant gaps.

Strategy 1.3.1

Establish indicators and information systems to track progress for mental health and well-being.

Actions

- **Identify and rank indicators that can track progress**. There are many potential indicators and associated data requirements. Groups of indicators should be ranked (at individual, service and population levels, see Box 4) according to their importance, validity, reliability, cost, relevance, specificity, sensitivity, balance and the feasibility of collecting them. These indicators can be incorporated into population-level information systems, surveys and other tools to track trends, inform policy decisions, and support data-driven interventions. Cohort and longitudinal studies can also be valuable for monitoring mental health progress among specific populations and risk groups. While these data sources can help guide proactive policies, it is essential to avoid data overload or inefficient data use, as this can detract from the effective delivery of services and interventions.

- **Identify appropriate information systems to store and manage data**. Data can be stored and managed through general health information systems, mental health information systems, or other sectoral systems. Decisions should be made about which systems to use. All suicides should be recorded in a death certificate and be registered in a national Civil Registration and Vital Statistics (CRVS) system. All cases of self-harm presenting to health facilities should be registered in a hospital-based self-harm surveillance system.

- **Identify which data will be collected as well as where and how**. The data collected will depend on the selected indicators and should be detailed enough for disaggregation by service type, gender, age, sexual orientation, race/ethnicity, disability, and other relevant variables. Such sensitive data should be used solely to promote health and well-being. Mental health data handling requires strict confidentiality, with careful consideration of data security, including anonymization for aggregated data. Data can be collected routinely through the chosen information system or via one-off or regular surveys, such as national population-based surveys, census surveys, specific epidemiological studies, or rapid assessments.

- **Improve mental health data collection with walk-through analyses, reviews, and revised procedures**. Walk-through analyses can track how key data are collected and flow through information systems *(62)*. A systematic analysis of the entire process should map how data are collected, processed, analyzed, disseminated, and used, identifying problems and areas for improvement. Gaps can be addressed by updating instruction and procedural manuals as needed.

- **Transform manual information systems into electronic systems where feasible**. This change improves data collection and processing. Using electronic records and unique service user identifiers can facilitate the integration of data across service providers, enhancing continuity and quality of care. This advancement strengthens information systems, allowing seamless integration with other databases and supporting more comprehensive, coordinated care *(23)*. Before digitalizing information, data protection guidelines need to be established and the necessary technology should be consistently available throughout a region or country. Proper training for all users is essential for effective system management.

- **Collate, routinely report and use mental health data to improve outcomes**. Data should be disaggregated as appropriate by sex, age, gender, race, ethnicity, disability, or other variables to identify population trends in mental health and well-being. These can then inform mental health service development and delivery, and promotion and prevention strategies. Data are key to understanding: (i) morbidity and mortality caused by treatments and interventions (or by exclusion from treatments and services); (ii) the needs and challenges for groups that face discrimination; (iii) demographic subsets that disproportionately experience human rights violations and coercive practices; (iv) quality of care delivered in services in terms of accessibility, appropriateness, continuity of care, equity and safety; (v) cost-effectiveness of interventions, services and approaches; and (vi) policy impacts. Data are also crucial to inform the community about the treatment quality, human rights protections and outcomes linked to their mental health services. Data and reports need to be readily available to all, including discriminated-against groups, and should include accessible formats.

SPOTLIGHT on avoiding pitfalls when developing a sustainable information system.

Lack of clarity and training. If service providers and staff don't understand why data is being collected or how it will be used, data collection is likely to be poor, especially when staff are overburdened. This issue can be mitigated through proper training *(63)*.

Local use of data. Even when data is efficiently collected, it often bypasses local analysis and goes directly to national systems. Information systems should be designed to serve both senior managers and local staff, ensuring that data is useful at all levels *(64)*.

Unanalysed data. A significant amount of collected data often remains unanalysed, suggesting that the data isn't perceived as useful or that there are insufficient resources for analysis. Managers should be trained to use indicators and generate relevant questions for the system. Additionally, the health sector should enhance information sharing between services and across sectors *(64)*.

Centralization and staffing. Information systems are often over-centralized and understaffed, leading to inefficiencies. It is essential to avoid wasting limited resources on inappropriate systems by ensuring the right balance between centralization and local needs *(390)*.

Box 4. Examples of indicators, and their constituent data at population, service and individual levels

Population level indicators include:

- the proportion of the mental health budget allocated to community-based services and support, compared with the budget allocated to psychiatric hospitals and beds;
- the budget allocated to forms of treatment, such as psychotropic drugs, psychosocial interventions and psychological therapies;
- prevalence rates for mental health conditions;
- the number and proportion of people receiving psychological and psychosocial interventions;
- rates of poverty, income level, employment, educational attainment, secure housing status, social protection requirements, and disability support among people with psychosocial disability, other disabilities, and among the general population;
- mortality rates by mental health condition and cause, particularly the number of people who have died in mental health institutions;
- numbers and rates of completed suicides and suicide attempts in the population;
- the number and proportion of homeless people with mental health conditions or psychosocial disabilities;
- morbidity and mortality rates associated with treatments, interventions, comorbidities, lack of access to health care, and inequalities in care;
- prescription rates and costs for psychotropic drugs;
- the number and proportion of people under guardianship or other substitute decision-making mechanisms;
- the number and proportion of people receiving support for decision-making; and
- the number and proportion of people with legally enforceable advance plans or directives.

Service level indicators and data include:

- the number of institutions and number of residents per institution;
- the number of secure/forensic units and the number of people in these units;
- the number and proportion of inpatient services using seclusion, and how frequently seclusion is used within each service;
- the number and proportion of inpatient services using physical, mechanical or chemical restraints, and how often these are used within each service;
- the number and proportions of voluntary and involuntary admissions per service, and the length of voluntary and involuntary stays for each service;
- the number and proportion of inpatient services administering forced interventions (for example, medication, ECT, psychosurgery, sterilization) without informed consent, and the frequency of these interventions within each service;
- the number of services, and the number of people per 100,000 accessing various services, including: (i) community-based mental health centres (ii) crisis services (iii) hospital-based services (iv) outreach services (v) supported living and home support services and (vi) peer support services;
- the number and proportion of services meeting quality and human rights standards (the QualityRights assessment tool kit can be used to measure this);
- the number and proportion of service staff (health, psychiatric, mental health, social care and supported living service, and institutional staff) trained on the rights of people with disabilities;
- the number and proportion of services using legally enforceable advance plans, and how frequently they are used within each service;
- the number and proportion of services using recovery plans and the proportion of service users using these within each service; and
- mortality rates per service.

Individual level data include:

- the incidence of discrimination, violence, abuse or neglect;
- the incidence of coercive practices including forced treatment (for example, medication, seclusion, physical, mechanical, or chemical restraint), and any subjective perceptions of coercion.
- whether the person has had support to develop an advance directive;
- whether existing advance directives expressing will and preference have been upheld;
- whether the person has had support to develop, revise, and implement a recovery plan;
- whether the recovery plan addresses community inclusion and social connection;
- whether the person has access to complaint mechanisms;
- how many complaints the person has made, and the services these relate to;
- whether peer support has been offered within or outside the service; and
- the person's level of satisfaction with the service.

Strategy 1.3.2

Set a prioritized research and evaluation agenda in collaboration with stakeholder groups.

Actions

- **Establish a research and evaluation agenda that is grounded in the human rights-based approach to mental health**. Studies on rights-based approaches to policy, law, services, treatment, interventions and support should be prioritized (see Box 5). Key focus areas to consider for research). This is crucial because most countries have ratified the CRPD and have committed to taking such measures as part of their obligations under the convention. The research agenda should be developed and implemented with inputs from stakeholders, especially people with lived experience of mental health conditions and psychosocial disabilities, and people belonging to groups that face or are at risk of discrimination amongst others. A variety of research and evaluation methods can be used, for example quantitative, qualitative, and mixed-methods research and evaluations. It is useful to bring all stakeholders together in a forum to discuss the research and evaluation agenda.

- **Establish commitment and consensus to include human rights criteria in research projects**. Government funding bodies, foundations and other donors and independent research organizations can commit to upholding human rights in all research projects. Key standards include non-coercive approaches, respect for legal capacity, participation, community inclusion, and adopting a recovery approach. Upholding these standards should be a prerequisite for individuals, researchers, and institutions seeking research funding (see *Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors (58)*).

- **Create centres of research excellence that employ and engage a multidisciplinary workforce using participatory approaches**. Centres of excellence should have the capacity to assess needs and evaluate the effectiveness, implementation, and scale-up of services and programmes, including those focused on human rights and recovery approaches. A centre's workforce can include people with mental health conditions and psychosocial disabilities, including those from groups facing discrimination.

- **Strengthen collaboration around research and evaluation**. Collaboration between universities, research institutes, centres of excellence, health, mental health, and social services, other relevant sectors, and community actors should be strengthened. Joint research projects and funding mechanisms can foster co-development and co-production. Establishing direct links with services and service users helps ensure that research is relevant and addresses the real and priority needs of the community. Such research should lead directly to improved services and support and inform curricula for mental health.

SPOTLIGHT on how to enrich the research agenda by engaging people with lived experience.

Engage people with lived experience on ethics committees. They provide crucial perspectives on ethical issues in research, treatment, and care, and can help ensure that human rights standards are maintained.

Increase representation of lived experience through investment in diversity scholarships and awards, and ensure these researchers lead research design and implementation.

Redefine what constitutes expertise in mental health to include lived experience, for example, survivor-scholars, peer researchers, or user researchers.

Box 5. Key focus areas to consider for research

Focus areas include:

- rights-based services and support within mental health and social care systems;
- policies, laws, services, and training to end coercion, respect legal capacity and autonomy, and reduce over-reliance on medication;
- interventions targeting social and structural determinants of mental health at both individual and population levels;
- bringing lived experience into ethical decision-making, research design, the research team itself, and how research is interpreted and used;
- approaches, services, and interventions that meet the needs of groups facing discrimination;
- local beliefs about, and responses to, distress and mental health conditions, including harmful responses (chaining, use of toxic substances), protective factors (for example, social support, traditional customs), as well as local help-seeking behaviours (such as seeking support from traditional and faith-based healers or leaders);
- general health, lifestyle, psychological, social, and economic interventions, including for groups facing discrimination, (where research is scarce);
- redefining research outcomes to include participation, community inclusion, and recovery dimensions, rather than focusing solely on clinical outcomes and symptom-based categories;
- understanding intersectional effects on mental health;
- the social and economic benefits of mental health investment, which are vital for policy change and multisectoral investment, requiring collaboration between health economists and other researchers;
- how to use digital technologies to promote mental health (for example, using video calls to deliver psychological therapies, and online interventions); and
- implementation approaches to accelerate uptake of research findings and translation into policy.

For practical resources related to Policy directive 1.3 Information systems and research see the relevant section of the annex.

1.4 Policy directive 1.4 People with lived experience, civil society, and communities

International human rights standards require countries to nurture an active civil society. People with mental health conditions, psychosocial disabilities, and their organizations should play a key role in policy-making and decision-making at political, social and community levels. Their involvement helps define problems and generate solutions that are acceptable to local people and communities. Organizations of persons with lived experience, including (ex-)mental health service users and groups facing multiple forms of discrimination, provide crucial perspectives to ensure that the mental health system meets their needs and respects their rights. These groups have an important role as advisors to the government on mental health related policy and laws, on reforming mental health and social services and on measures to protect human rights. However, they often face barriers to participation due to limited funding, resources, and support *(55, 65)*.

Illustrative example text

This policy directive recognizes that improving mental health requires creating inclusive societies where diversity is accepted, and human rights of all people are respected. Strengthening health and social systems alone is insufficient. People with mental health conditions and psychosocial disabilities, and their organizations, will play key roles such as: (i) conducting advocacy campaigns to change attitudes and practices, including engaging with international human rights systems to hold governments accountable; (ii) providing education and training on mental health, disability, and human rights; and (iii) directly providing services like crisis support, peer support, livelihood initiatives, and personal assistance.

SPOTLIGHT on how to engage and involve people with lived experience.

Dignity and respect. Participation is a human right. People's lived experience should be valued as expertise, equal to traditional evidence in global public health policy and practice.

Power and equity. Participatory approaches should remove systemic and structural barriers, address power imbalances, and eliminate stigmatization and discrimination.

Inclusivity and intersectionality. Engagement should account for intersecting identities, ensuring inclusivity and accessibility.

Accommodations for participation. Information must be available in accessible formats. Meetings must offer flexibility in times and methods of input, and creating safe spaces for discussion, particularly before joining larger groups.

Commitment and transparency. Engagement should be consistent and transparent at every stage, with clear communication on who will be involved, how, and when.

Embedding engagement. Engagement should be formally integrated into organizational practices and culture to ensure it is meaningful and sustainable *(399)*.

Strategy 1.4.1

Build and invest in a network of people with lived experience, and representatives from other stakeholder groups, to contribute to high-level decision-making as part of advisory boards and working groups on policy, law, strategy and evaluation.

Actions

- **Employ people with lived experience in the government department responsible for mental health**. This should include individuals with lived experience of mental health conditions and psychosocial disabilities, (ex-) mental health service users, and those from groups facing multiple intersecting forms of discrimination. Whenever possible, it is beneficial to recruit individuals who also possess knowledge, experience, and expertise in policy, legal, and service areas. Providing reasonable accommodations is essential for ensuring meaningful participation.

- **Engage people with lived experience, and other stakeholder groups, on the main government-led advisory board and working groups and build their capacity to participate**. Sufficient funds should be allocated to involve people with lived experience, including where possible those representing organizations of persons with mental health conditions and psychosocial disabilities, alongside other stakeholder groups, on government-led advisory boards and working groups. Funds should cover fair compensation for their work, transport costs, and provision of reasonable accommodations to ensure equal participation. Capacity building is crucial for meaningful involvement and may include training on rights-based approaches, mental health systems, policy-making, and other relevant factors influencing the system.

- **Establish mechanism(s) to maintain the independence and autonomy of organizations of people with lived experience**. Organizations of people with lived experience are scarce or nonexistent in many countries, despite their crucial role in decision-making. Governments can provide financial support to establish and scale up these organizations, but it is vital they retain autonomy to prevent government co-opting. Transparent funding agreements with clear terms, expectations, and conflict of interest statements are needed to safeguard against political interference. Multi-year funding should be prioritized for sustainability and long-term planning. Governments can also help civil society organizations diversify funding sources by forming partnerships with foundations, philanthropic organizations, development bodies, academic institutions, and other donors, reducing reliance on a single source *(66, 67)*.

Strategy 1.4.2

Implement standards so that people with lived experience can participate meaningfully in policy, law, service delivery, training and research.

Actions

- **Draft standards collaboratively with organizations and individuals with lived experience to broaden their representation and participation**. These standards will foster meaningful involvement of people with lived experience in all aspects of mental health policy, services, training, and research. Standards for developing policy could include ensuring people with lived experience are in leadership roles, are involved in selecting and overseeing priority directives, in monitoring and evaluation processes, and in strategic decision-making at managerial and operational levels. Standards for services could involve people with lived experience as regular staff members, as peer workers in support programmes, and in strategic decision-making roles. Standards for training initiatives could ensure that all training programmes are co-developed and co-delivered with people who have lived experience. Standards for research initiatives could involve people with lived experience in developing research themes, selecting projects, and co-developing or leading funded research projects. Standards for capacity building could require that staff at mental health services, training facilities, and research institutions receive training on valuing contributions from people with lived experience, establishing cooperative environments that reduce power imbalances, and incorporating accommodations for broader participation.

- **Incentivize increased representation of people with lived experience within policy development, service delivery, training initiatives, and research**. Incentives could include financial compensation (payment or reimbursed expenses) on an equal basis with others involved, opportunities for professional development and progression based on newly acquired skills and knowledge, leadership positions in training and research for people with lived experience, and public recognition of their participation and contributions, including authorship and acknowledgements in publications, articles, media, and public meetings.

Strategy 1.4.3

Conduct national and local advocacy campaigns led by and featuring people with lived experience of mental health conditions and psychosocial disabilities.

Actions

- **Prepare campaigns and advocacy efforts focused on pressing mental health issues**. Key topics could include raising awareness about the need for mental health investment, advocating for person-centred, rights-based services, and challenging stigma and discrimination. More focused efforts might promote mental health law reforms or community housing support for people with psychosocial disabilities. Campaigns should actively involve those connected to the theme. Campaigns can be aligned with significant dates like World Mental Health Day (10 October), World Suicide Prevention Day (10 September), International Day of Persons with Disabilities (3 December), and Human Rights Day (10 December) to amplify messages and enhance stakeholder engagement.

- **Work with traditional and social media to promote responsible coverage of mental health issues and actively educate against stereotypes and human rights violations**. This collaboration should be led by people with lived experience. Excessive focus on risk, harm, danger, suicide and crimes can link mental health conditions with danger in the public consciousness *(68)*. This is often compounded by stigmatizing language and labels (69). Journalists have an important role in promoting a human rights and recovery agenda by focusing on recovery success stories and respect for human rights *(70)*. Social media is increasingly the forum through which mental health issues are explored, and offers people with mental health conditions and psychosocial disabilities from all demographics a space to express themselves and to make connections *(71)*. It has substantial potential for education and for promoting human rights and recovery, as well for delivering supportive interventions *(72)*.

SPOTLIGHT on responsible reporting of mental health and suicide.

Guidelines for reporting on mental health should emphasize using sensitive, non-sensational, and accurate language. Avoid stigmatizing terms like mentally ill, mental disorders, schizophrenic, psychotic, and committed suicide.

Promote positive recovery narratives and best practices for interviewing people with lived experience.

Provide journalists and social media influencers who might cover mental health and suicide-related stories with links to crisis hotlines, support services, and contact information for experts, including those with lived experience *(73)*.

For practical resources related to Policy directive 1.4 People with lived experience, civil society, and communities see the relevant section of the annex.

1.5 Policy directive 1.5 Rights-based law reform

National mental health legislation, along with associated rules, regulations, and operational mechanisms for implementation, should be developed or updated in line with international human rights standards, including the CRPD. This will protect and promote the rights of people with mental health conditions, codify rights-based principles, and support the aims of mental health policies and strategies. Aligning legislation with these standards can help change ingrained attitudes, reduce stigma and discrimination, and foster rights-based mindsets. Conversely, outdated laws reinforce stigma, discrimination and violations, hindering the development of person-centred, rights-based mental health systems and services.

Illustrative example text

This policy directive will initiate a law review process to identify legislation to be abolished, modified or adapted to align with international human rights standards. Reforms will target both stand-alone mental health laws and discriminatory provisions in laws related to education, employment, social welfare, housing, health, justice, family rights, and participation in public and political life. The mental health sector will collaborate with legislative bodies (for example, Attorney General's offices, other offices with the same function, or parliamentarians) to repeal guardianship and substitute decision-making laws and replace them with law that recognizes legal capacity and promotes supported decision-making, including the use of advance plans.

Strategy 1.5.1

Conduct training for wide-reaching mindset change and advocacy for law reform.

Actions

- **Implement widescale capacity building with key stakeholders and the community to change mindsets, reduce stigma and discrimination, and promote a rights-based approach in mental health**. A priority is to provide stakeholders who will be engaged in the law reform, including the drafting committee, alongside the broader community (also see Strategy 1.5.2 on reforming legislation) with information and training on country obligations under international human rights law, including the CRPD, and on applying these standards in the mental health sector. Progress in law reform requires a significant mindset shift to avoid superficiality. New laws risk being minor improvements or failing in implementation if interpreted through outdated perspectives. To change attitudes among stakeholders, training programmes should go beyond imparting knowledge and engage participants emotionally through debates, discussions, and case studies (see also Strategy 5.1.1 on awareness strategies).

- **Hold dialogues with the key stakeholder groups to discuss the need for, and implications of, legislative reform towards a rights-based approach**. These dialogues should explain the main components of the new legislation and its impact on various sectors. Engaging members of the executive branch and legislature from all political parties early on is crucial to inform them about the challenges and gaps in existing legislation; the implications for rights enjoyment; the background of the proposed law and the concerns of people with mental health conditions and psychosocial disabilities; and the human rights obligations and political commitments under the international human rights and sustainable development framework. People with lived experience should play an active role in these discussions and activities *(22)*.

- **Implement awareness campaigns with the media, highlighting the need for change**. Stigma, myths, and misconceptions about mental health conditions and psychosocial disabilities make it harder to implement rights-based legislation. It is crucial to start changing attitudes and mindsets before developing new laws. Awareness efforts should explain the importance of a human rights-based approach in law, and why it applies to everyone. The media can play a key role in emphasizing the importance of respecting human rights and educating the public about new approaches to mental healthcare, particularly the value of community-based approaches.

REFLECTION on driving change. Changing the law can take years. But people can start change within existing laws. For example, even if the law gives guardians decision-making power, they can still act in the spirit of the CRPD, supporting individuals to make their own choices, and respecting these. A culture shift and legal reform should work together.

Strategy 1.5.2

Reform legislation related to mental health to align it with human rights standards, including the CRPD.

Actions

- **Undertake a rights-based analysis of current laws, policies, and services related to mental health to understand alignment with international human rights standards**. Initially, it is important to identify which United Nations and regional human rights treaties have been ratified by the country. A thorough review of these international instruments is crucial for understanding the legal obligations imposed on the government and ensuring they are reflected in national legislation. Human rights standards from conventions not ratified by the country should also be considered, as they provide valuable guidance. The analysis should also examine domestic mental health laws and other related laws — such as those covering general health, social care, anti-discrimination, patients' rights, capacity, employment, disability, and access to justice — to determine whether they promote or hinder human rights. Laws that directly violate human rights, such as those criminalizing suicide and self-harm, should be identified as barriers to care and support and repealed *(409)*. Additionally, policies, services, and other aspects of the mental health system should be reviewed to identify potential obstacles to rights-based law reforms (see Step 4, on reviewing international human rights obligations, in Module 3, Process for developing, implementing, and evaluating mental health policy and strategic action plans).

- **Repeal, amend and draft laws for alignment with human rights standards using multidisciplinary expertise and inputs from consultations**. The analysis and technical work should be conducted by a drafting committee made up of experts with collective experience in human rights, legal and clinical issues, and lived experience of mental health conditions (see Box 3 above). This approach can ensure that legislation aligns with CRPD human rights standards. Stakeholders, including people with mental health conditions and psychosocial disabilities, should inform the drafting process through ongoing consultation and negotiation and have the opportunity to review and provide feedback on draft versions of the bill to ensure their views are accurately captured and reflected.

- **Facilitate the legislative process during debate and adoption phases**. The multidisciplinary committee should address queries and clarify technical issues, including the impacts and costs of proposed amendments. Mobilizing public opinion is also crucial (see Strategy 1.5.1 on training and capacity building). Advocacy efforts are essential for building and demonstrating support. These efforts might include aligned coalitions of advocates, newspaper articles, radio and television broadcasts, meetings with key parliamentarians and decision-makers, or letters to influential figures. It may help to identify champions for the reform, such as senior officials within the Ministry of Health, parliamentarians, journalists, or well-known national personalities.

KEY POINT: mental health legislation can be separate from, or integrated into other existing laws. Mental health provisions can be established as stand-alone laws. However, they can also be integrated into existing law, such as law on health, disability, discrimination, welfare, education, employment, housing, or the judiciary. Prioritizing integration into mainstream law can better ensure equal rights, reduce stigma, discrimination, and marginalization. Some countries will combine the approaches. Whichever is chosen, the focus should remain on protecting human rights, ensuring individuals with mental health conditions enjoy equal rights with others.

Strategy 1.5.3

Set up implementation mechanisms and actions including training.

Actions

- **Establish an oversight agency and bodies for monitoring and implementing the law**. Establish an oversight agency and monitoring bodies to implement and enforce the law, including review bodies, courts, and similar mechanisms. Legislation should define the mandate and composition of these bodies, determining whether they operate nationally or at local, district, or regional levels. The functions of independent monitoring mechanisms (see Box 6) may vary by country and can complement the court's role. A key responsibility of the oversight body is to eliminate involuntary admission and treatment. It should have a set timetable for implementing reforms, measurable targets, and sufficient administrative and financial authority. Complaints procedures in the reformed legislation should be designed to be both speedy and effective.

- **Draft and adopt regulations and codes of practices**. After reforms become law, regulations for implementation need to be developed, finalized, and published in the official gazette by relevant ministries or agencies. Public consultations are often required before finalizing these regulations. Codes of practice should accompany regulations, offering practical advice for professionals on complying with legal obligations, including best practices and relevant case law. All regulations, guidance, and codes should align with the law's text.

- **Raise public awareness of the law**. Ongoing efforts to raise public awareness of mental health and human rights, reduce stigma and discrimination, and overcome resistance to change are crucial, especially with new legislation. The public, professionals, advocacy groups, and people with lived experience often lack information about new laws and some of these groups may resist changes, particularly when the legislation requires significant shifts in customary mental health practices.

- **Train stakeholders on rights and the law**. Stakeholders in the mental health and social care system, as well as other sectors and the broader community, should receive training on relevant laws and rights. This training should be provided to diverse groups, including individuals with mental health conditions, families, health and social workers, traditional and faith-based healers or leaders, lawyers, civil society organizations, and magistrates. The training should cover each provision of the legislation in detail, ensuring a thorough understanding of people's rights and the obligations of stakeholders to uphold them. Additionally, it should include capacity building on international human rights standards and conventions (see Box 4 Resources for understanding human rights in mental health, in Module 3. Process for developing, implementing, and evaluating mental health policy and strategic action plans).

- **Evaluate whether implementation meets the new legislation's objectives and requirements**. A comprehensive evaluation should assess: the law's impact; relevance to people's needs; effectiveness in achieving its objectives; cost-efficiency; coherence with other actions; effectiveness in addressing inequalities and improving equity; and should identify any harmful effects of the law. This ensures the law is implemented as intended and meets its goals.

Box 6. Important roles and functions for oversight agencies and bodies

Roles and functions for agencies and bodies tasked with monitoring and implementing the law include:

- conducting regular and unannounced inspections of mental health settings or services;
- guiding efforts to eliminate coercion, and monitoring progress;
- collecting and reviewing data and statistics relating to service provision (for example duration of hospitalizations, use of specific treatments, suicides, natural or accidental deaths);
- monitoring deinstitutionalization plans and community-based support services;
- ensuring that major, invasive or irreversible interventions (for example, psychosurgery, electroconvulsive therapy) are not practiced, or are only permitted with free and informed consent;
- maintaining registers of mental health settings and enforcing quality and human rights standards;
- proposing penalties for legislative breaches including accreditation withdrawal;
- directly reporting to government minister(s) with responsibility for mental health services;
- recommending legislative improvements;
- raising awareness and supporting training for the human rights-based approach to mental health; and
- publishing findings regularly and reporting to regional and international human rights bodies.

For practical resources related to Policy directive 1.5 Rights-based law reform see the relevant section of the annex.

Special considerations for diverse groups
Policy area 1. Leadership, governance and other enablers

Coordination, leadership and accountability

Participation of diverse groups

- Ensure diverse groups are properly represented: within leadership, coordination, and accountability functions, including government departments, advisory groups, monitoring committees, and complaints mechanisms.

Financing and budgets

Children and adolescents

- Allocate funds to provide accessible age-appropriate psychological support services within schools and community settings for children and adolescents exposed to bullying and peer violence.
- Support evidence-based social skills training programmes for children and adolescents with autism and other disabilities.
- Include provisions for caregiver training to support the social, emotional, and cognitive development of these individuals.

Older adults

- Support companionship schemes to maintain social connections and maintain or initiate an active life.
- Establish support schemes to help develop advance directives for future care and support preferences.

Women, men and gender diverse persons

- Fund psychological support for survivors of gender-based violence and those undergoing gender-affirming treatments.
- Support programmes to assist persons transitioning gender, their family members or caregivers.
- Allocate resources for suicide prevention initiatives that consider and target the unique risk factors faced by different groups, including men, women, and gender-diverse persons, such as gender-based violence, poverty, social discrimination, employment insecurity, social isolation, and pressures from traditional gender roles.

Persons belonging to the LGBTIQ+ community

- Provide psychological support to individuals questioning their sexual orientation and those facing homophobia, transphobia or other forms of discrimination based on sexual orientation.

Persons with disabilities

- Finance schemes for reasonable accommodations, such as communication devices and those that facilitate access to mental health services (such as access ramps, non-fixed examination tables, and improved signage within mental health facilities).
- Provide personal budgets for a range of supportive services including training and education opportunities, essential accessible equipment, and technology that supports independence

Migrants and refugees

- Allocate funds to create culturally appropriate environments in mental health services for example by providing interpretation services and ensuring access to culturally appropriate food.

Persons from minoritized racial and ethnic groups

- Support psychological and psychosocial interventions addressing collective trauma and other culturally specific needs (for example, genocides or racist crimes affecting entire societies).

Indigenous Peoples

- Support culturally safe mental health practices, (for example, ceremonies, spiritual cleansing, healing circles).

Persons who are houseless or with unstable housing

- Provide support for basic needs such as food, clothing, and hygiene for houseless individuals

Information systems and research

Children and adolescents

- Track the impact of global challenges such as conflict, climate crisis, social withdrawal, isolation, polarization, and economic downturn on children's mental health and well-being.
- Research how social media and digital technologies affect the development and well-being of children and adolescents.
- Examine both the positive and negative impacts of screen time, considering not only the duration but also the content and context of use.

Older adults

- Address the risks of overmedication and oversedation on people's health in care homes and general hospitals
- Consider the complexities of physical comorbidities when supporting older adults with mental health conditions, as medication interactions can complicate their care.

Women, men and gender diverse persons

- Understand and respond to the higher rates of psychotropic drug prescriptions among women.
- Understand the extent, impact and causes of domestic violence on women.
- Focus on (over-)admissions and harmful treatment practices, focusing on instances of misdiagnosis and ineffective treatments, such as conversion therapy.
- Incorporate non-binary and diverse gender categories into monitoring and evaluation tools to achieve comprehensive and accurate data collection and analysis.

Persons belonging to the LGBTIQ+ community

- Design data collection tools that avoid heteronormative assumptions and that use inclusive language.
- Include indicators to assess how homophobia and discrimination based on sexual orientation impacts mental health outcomes.

Persons with disabilities

- Design research instruments that address not only health conditions/impairments but also the functional limitations and barriers faced by people with disabilities.
- Conduct research on effective reasonable accommodations in mental health services for people with disabilities.

Migrants and refugees

- Address barriers that prevent undocumented migrants, immigrants with unclear status, and refugees from accessing mental health care.
- Develop culturally appropriate research tools and indicators, presented in the languages used by migrants and refugees, to ensure meaningful data collection and analysis for these populations.

Persons from minoritized racial and ethnic groups

- Focus on the racial disparities in incarceration rates and the use of involuntary treatment and coercive practices among individuals with mental health conditions and psychosocial disabilities *(74–76)*.

Indigenous Peoples

- Include Indigenous Peoples' values and healing practices in mental health research.

Persons who are houseless or with unstable housing

- Investigate the effects of chronic and temporary housing instability on mental and physical health.
- Focus on the challenges houseless individuals face in accessing basic needs, such as food, clothing, and hygiene, and explore effective support mechanisms.

People with lived experience, civil society, and communities

Representation of diverse groups

- Include representation from all groups facing discrimination in high-level decision-making.
- Incorporate diverse experiences and perspectives to build a comprehensive mental health system that accommodates a diverse range of needs.

Rights-based law reform

Children and adolescents

- Incorporate provisions in legislation to make sure children and adolescents are involved in healthcare-related decisions consistent with their evolving capacities, and to provide them with age-appropriate supported decision-making, if they wish.
- Establish clear legal frameworks that protect children and adolescents from harmful practices.
- Prohibit harmful practices in mental health care, such as electroconvulsive therapy in childhood and adolescence.

Older adults

- Include safeguarding mechanisms to prevent abuse of older adults.

Women, men and gender diverse persons

- Repeal legislation that allows (i) female genital mutilation (ii) conversion therapies (iii) involuntary admission based on non-binary identity.

Persons belonging to the LGBTIQ+ community

- Reform laws to ensure sexual and reproductive health rights are respected and to prohibit conversion therapies and involuntary admission based on sexual orientation.

Persons with disabilities

- Introduce accommodations for expressing will and preferences in health-related and other matters.

Migrants and refugees

- Establish provisions to ensure that migrants, asylum-seekers, refugees, and stateless persons, regardless of documentation status, have access to the same mental health services, supports, and treatments as nationals.

Persons from minoritized racial and ethnic groups

- Prohibit discrimination in healthcare access and promote active participation of minoritized racial and ethnic groups in developing mental health programmes.

Indigenous Peoples

- Repeal colonial mental health laws and integrate provisions that acknowledge mental health and well-being within its cultural context.
- Respect and incorporate indigenous approaches and traditional healing practices that align with human rights.

Persons who are houseless or with unstable housing

- Repeal laws criminalizing houselessness and ensure people are not penalized for resting, sleeping, and eating in public spaces.

2

Policy Area 2: Service organization and development

Key challenges

Many countries have limited or no access to basic mental healthcare *(77–79)* and where access exists, care is often poor quality and violates people's human rights, including in high income countries. To ensure the right to health for all, governments should address the following key challenges.

- **Limited access to quality community-based mental health services**. Many people are prevented from receiving the appropriate care they want because services are unavailable, inaccessible, unaffordable, or of poor quality *(80, 81)*. In most countries, mental healthcare is concentrated in major cities. Large psychiatric hospitals and institutions are often the main providers *(82)*. WHO's 2020 Mental Health Atlas reports that 41% of countries allocate more than 60% of their mental health budget to mental hospitals *(51)*. When care is provided through large psychiatric hospitals or institutions, less money is available for community care options, which are more accessible, acceptable, and generally higher quality. Hospitals and institutions are places where people are often forced to live for long periods, without control over their daily lives or decision-making. People are confined to rigid routines that prioritize institutional needs over individual ones, leading to isolation and segregation from the community. Institutions have a track record of poor-quality care, poor health outcomes, and widespread human rights violations *(12, 83–85)*.

- **Human rights violations, including coercive practices, denial of legal capacity, and institutionalization**. Human rights violations are widespread in mental health services across the globe, occurring in high-, middle-, and low-income countries, and cannot be attributed solely to a lack of resources *(86)*. Violations include poor quality care, the denial of legal capacity, lack of informed consent, and coercive practices, such as involuntary admission and treatment, seclusion, and restraint. While such violations can occur in any setting, some of the worst abuses are found in large institutions, where issues such as inadequate infrastructure, overcrowding, poor sanitation, and inadequate food are common. In addition to coercion, these institutions often perpetuate physical, sexual, and emotional abuse and neglect, *(30, 31, 87, 88)*. Smaller community services can also replicate these violations, acting as mini-institutions. Therefore, deinstitutionalization efforts require services to develop or transform towards a human rights approach, comprehensively eliminating institutional mindsets and practices.

- **Over-reliance on the biomedical approach and psychotropic drugs**. Many mental health services rely significantly on a biomedical model that focuses predominantly on diagnosis, medication, and symptom reduction. Even when the biopsychosocial model is referenced, it often prioritizes the 'bio' component over other factors. This approach often neglects holistic treatments that support recovery by addressing broader aspects of a person's life, such as relationships, meaning, and living conditions *(1, 89)*.

- **Failure to address social and structural determinants of mental health**. Social and structural determinants are crucial factors influencing populations' and individuals' mental health but are often overlooked in mental health discourse and practice *(90, 91)*. As a result, mental health professionals are often ill-equipped to address these issues, leading to over-medicalization of human distress including over-reliance on medication. Broader psychological, social, and economic interventions are under-used, even though, when implemented collaboratively with communities and non-health sectors, these can address the root causes of mental ill health *(92–95)*.

- **Poor coordination between mental and physical health services**. People with mental health conditions and psychosocial disabilities are at higher risk of developing physical health problems, such as diabetes, cardiovascular disease, cancer and HIV/AIDS, due to factors like the effects of psychotropic drugs, lifestyle factors (for example, high rates of smoking), living conditions, and discrimination *(96–98)*. Poor coordination between mental and physical health services leads to worse physical and mental health outcomes. *(25, 80, 99)*. People with mental health conditions have an excess mortality rate two to three times higher than the general population (they are more likely to die, of any cause, than the overall population) *(98, 100)*. Of these deaths, 60% are linked to physical health conditions, reflecting how people with mental health conditions have often had their physical health neglected for decades *(101–103)*.

- **Insufficient financial resources**. Countries underfund mental health services, resulting in insufficient staffing, inadequate training, and limited support for quality improvement efforts *(50)*. This lack of resources significantly contributes to lower-quality care.

When addressing these challenges and selecting policy options, it is helpful to consider what an integrated service model might look like within a policy framework. Fig. 2 highlights key considerations for building this model. While not every element needs to be included, policy-makers can adapt these and other relevant factors to suit their specific contexts. These elements, spanning service types, functions, settings, partnerships, financing, interventions, and operational structures, provide a robust foundation for developing policy that establishes adaptable and inclusive mental health services. Such a model builds upon and complements the framework outlined in the *World mental health report: transforming mental health for all (104)*. The model maintains alignment with the Report while offering additional depth and operational guidance. Each of these components is further explored in this and subsequent sections.

Fig. 2 A framework to help countries build their service policy model

Organizational aspects

What service types?

- Mental health services in general hospitals
- Crisis response services
- Community mental health centres
- Community outreach mental health services
- Mental health services in primary care
- Mental health peer support services
- Mental health specialized services

Which functions?

- Crisis support
- Ongoing treatment & care
- Community living & inclusion
- Prevention and promotion

Which locations?

- National
- Regional
- District
- Village

Which settings?

- Health services
- Community centers
- Schools
- Workplaces
- Refugee, Internally displaced persons camps
- Places of detention
- Faith-based settings, including churches & mosques
- Homes
- Other meeting places

Which sector/provider will provide the service?

- State health sector
- State social sector
- Private
- NGO
- OPD
- Faith-based

Which financing source?

- State health sector
- State social sector
- Health insurance
- Donor
- Individual/Out of pocket

Which sector partnerships & collaborations?

- Health sector
- Social protection
- Education
- Interior
- Justice
- Employment
- Culture, arts & sports
- Environment, conservation & climate protection
- Defence & Veterans
- Research, innovation & implementation
- Urban & rural development
- Finance & Treasury

Which community partnerships & collaborations?

- NGO/OPD
- Caregivers, families, friends & supporters
- Teachers & employers
- Mayors & leaders of cities, towns & villages
- Faith-based healers & traditional healers

Fig. 2 A framework to help countries build their service policy model *continued*

Operational aspects

Which interventions & supports?

- Physical health & lifestyle interventions
- Psychological interventions
- Social interventions
- Economic interventions
- Drug interventions

Training & supervision requirements: content and approach

- Clinical
- Recovery
- Human rights
- Social determinants
- Public mental health
- Leadership & management
- Participatory approaches
- Culturally sensitive approaches

Which core values & principles?

- Evidence-based
- Human rights
- Person-centred
- Trauma-informed
- Life course
- Respect for legal capacity
- Non-coercive practices
- Participation
- Community inclusion

Budget & financing

- Premises/building/infrastructure
- Training & supervision
- Salaries
- Intervention costs
- other

Which human resources?

- Psychiatrists
- Nurses
- Medical doctors
- Psychologists
- Peer supporters & workers
- Social workers
- Community health workers
- Occupational therapists
- Counsellors
- Clinical staff
- Community volunteers
- Other multidisciplinary resources: nutritionists, physiotherapists & dentists; neurologists; pharmacists; employment & education specialists; physical activity trainers & sports coaches; art & music therapists; speech therapists, legal advisers, traditional and faith-based healers or leaders, families & other caregivers

Other operational aspects

- Availability: 24 hours a day, seven days a week?
- Modes of delivery: in-person, online, phone-based, digital, hybrid
- Population served: will the service be available for all; will anyone be excluded; how will the service be accessed?

2.1 Policy directive 2.1 Coordinated rights-based community mental health services and support at all levels of care

The right to health requires governments to provide communities with access to quality mental health care services that respect people's rights and dignity, and that continue for as long as people need care. Decades of research show that coordinated community-based services enhance acceptability, accessibility, and quality of care, leading to better health and social outcomes. However, not all countries can implement every type of service outlined in this Guidance. Appropriate service provision depends on each country's specific context, including whether they operate in low or high-resource settings. The mental health services presented here are not a rigid model for universal adoption. Instead, they are a flexible menu of options, allowing countries to select and scale up services that align with their specific economic and policy frameworks, while still promoting human rights and recovery.

Illustrative example text

This policy directive aims to establish a network of community-based, person-centred, and human rights-focused mental health services. These include services in general hospitals, crisis response, community mental health centres, outreach programmes, peer support, primary care, integrated health services, and specialist mental health care *(55)*.

The network will operate across various settings, interfacing with social and other sectors to provide crisis support, ongoing treatment, and community inclusion. Developed within a human rights framework, the services will emphasize non-coercive care, meaningful participation, and community integration, addressing social and structural factors that undermine mental health. The network will meet health needs alongside social, economic, housing, employment, and social protection needs, ensuring coordination and continuity of care across mental health and social services.

This integrated approach offers a spectrum of care throughout a person's life, ensuring access to comprehensive services tailored to individual needs. It also recognizes the crucial role of families as primary caregivers, providing them with necessary support to be active participants in the care journey of those with mental health conditions or psychosocial disabilities.

A diverse group of stakeholders will be involved in developing and delivering this network, including individuals with lived experience, policy-makers, politicians, representatives of marginalized groups, community leaders, health practitioners, families and caregivers, legal experts, academics, and philanthropists (See Box 3).

In building this community mental health network, service providers will also focus on creating healthy, environmentally sustainable services, acknowledging the country's climate commitments and emerging evidence that engaging with nature improves well-being and is cost-effective *(105, 106)*.

KEY POINT: sustainable workforce and service planning is essential. Long-term workforce planning can ensure there are enough trained staff to run new services and implement the required interventions. If financial and human resources are limited, begin with a small-scale service that could expand over time and eventually be scaled up across districts and regions. This is relevant to all the strategies discussed under this policy directive.

Strategy 2.1.1

Create and expand rights-based, short-term inpatient units, outpatient, and community outreach services in general hospitals.

Actions

- **Consult with hospital authorities and stakeholders on creating short-term inpatient unit(s) or beds, outpatient units and community outreach services**. To facilitate informed decision-making, hospital authorities should understand the scope, functions, and challenges of integrating mental health services, along with the health and social benefits. They may need to tackle stigma and discrimination, accessibility issues (for example for people with disabilities) and financial barriers. Securing commitment from hospital authorities and selecting suitable general hospitals in accessible locations for the local community may take time. It is crucial that new hospital units do not replicate the coercive practices and neglect that is common in many existing psychiatric units (see Policy directive 2.1 on deinstitutionalization).

- **Identify appropriate space and designs for inpatient and outpatient unit(s) in hospitals**. Inpatient units should be small, with bed numbers limited to prevent overcrowding and institutional approaches. They should remain unlocked to ensure a voluntary, recovery-oriented atmosphere. Stays should be brief, focused on recovery, with community living options explored if returning home isn't possible. Both inpatient and outpatient units should provide a welcoming, comfortable, and stimulating environment that fosters active participation among users, staff, and visitors. Sleeping, bathroom and toilet areas, should be separate for women and men, uphold high standards of sanitation and maintain privacy (See *WHO QualityRights assessment toolkit (50)*).

- **Establish operational protocols for the mental health services within the hospital**. This should include protocols for rights-based assessment, treatment and support (see Policy area 3) as well as for service quality. Functions may vary based on service type (inpatient, outpatient, liaison services within the hospital and community outreach), requiring clear protocols for collaboration within the hospital. Operational protocols will need to specify roles and responsibilities for staff, including for those carrying out ongoing supervision and education (See Policy area 3 on human resource and workforce development). Standards need to be specified and should be backed by anonymous feedback and complaint mechanisms, to ensure ongoing evaluation and improvement (see Strategies 2.2.2 on upholding rights, eliminating coercion and promoting recovery and Strategy 1.1.3 on monitoring service quality and rights protections).

- **Establish the range of specialized mental health services to be provided in general hospitals, based on the local context**. Specialized services should address the specific needs of the populations the hospital serves. These may include services for dementia, eating disorders, neurodiversity (such as autism), suicide risk and attempts, alcohol and other psychoactive substance use, and support for groups facing discrimination, such as those experiencing gender-based violence, seeking gender-affirmative care, or involved with the justice system. Establishing these services may require introducing specific functions, investing in specialized equipment, and recruiting or training staff with the necessary expertise.

- **Recruit and/or deploy trained multidisciplinary staff in hospital mental health services**. Implementing a person-centred, recovery-oriented, rights-based approach across inpatient, outpatient, and community outreach services requires staff with diverse skills. Recruitment should prioritize engaging multidisciplinary teams, whenever possible, including individuals who can provide peer support. Potential staff should be identified early to ensure efficient operation of mental health services. Training new staff and re-deploying existing ones requires time. It is also important to increase the number of university and college students training for required professions (see Policy area 3 on human resource and workforce development).

- **Train and supervise other hospital staff on rights-based care and support for mental health**. All staff in general health services should receive basic training in rights-based mental health and psychosocial support. Those employed in the newly established services will be well-positioned to deliver this training.

Strategy 2.1.2

Create and expand rights-based crisis response services.

Actions

- **Establish mental health-friendly environments and rights-based responses in accident and emergency units**. Emergency departments in general hospitals, or in other acute care centres, are places that people use when experiencing acute distress. It is important that staff, including first responders, are trained to support people experiencing an emotional crisis or severe distress, without coercion, and that they can call on additional expertise to respond to a crisis. Incorporating peer support roles within emergency departments can offer valuable, empathetic assistance to individuals in crisis, drawing on lived experience to provide understanding and comfort. Additionally, creating a calm, comfortable space where individuals can wait while being supported is crucial, as the typical noise and activity of a busy emergency department can intensify distress and emotional crises.

- **Establish crisis telephone line(s) with rights-based operational protocols**. Implementing crisis telephone lines with rights-based protocols is crucial for mental health emergencies. Warmlines are preferable to traditional hotlines, as they avoid police involvement and involuntary detention, offering support during crises, reducing isolation, and connecting individuals to resources. Importantly, they respect autonomy, allowing individuals to seek help without fear of unwanted interventions. Effective crisis lines, available 24/7 and staffed by skilled workers, including peers, require strong communication, empathy, and mental health understanding. They should allow anonymity and ensure continuous support in emergencies until a mobile crisis team arrives, without imposing unwanted assistance.

- **Establish mobile crisis team(s), their functions and rights-based operational protocols**. This enables a rapid in-person response to someone who is experiencing extreme distress. A mobile crisis team should prioritize a person's expressed immediate needs and offer support in an unobtrusive, non-coercive and non-threatening manner. The mobile team needs to be skilled and experienced in engaging people. Staff should implement collaborative problem-solving to help the person to cope more effectively with their immediate stresses and to de-escalate the situation, making it safer for the distressed person and their community. The team can also link the person to other services and support and resources for longer term follow-up.

- **Establish crisis accommodation, its functions and rights-based operational protocols**. Crisis accommodation, should include gender-specific options and provide a home-like healing environment where people can work through an emotional crisis at their own pace and in their own way. Crisis housing should accept people on a voluntary basis only. Staff should be available to stay with a person going through a crisis day or night and provide counselling, peer support, help to develop wellness plans and advance plans, a supportive communal living environment and access to community resources, all without resorting to coercion.

SPOTLIGHT on responding to people in crisis

Mental health crisis and suicide risk and attempts. In mental health crises, where suicide risk and attempts may be present, coercive practices like involuntary admission and treatment are often imposed. However, prioritizing de-escalation, offering care options, and developing a support plan to connect individuals with community resources fosters trust and encourages future support-seeking *(22)*.

Prioritizing care over policing in crises *(107)*. Police-only crisis responses often fail to meet the needs of individuals during mental health crises and can increase the risks of distress, harm, arrests, and fatalities, particularly among marginalized groups. Establishing crisis response teams that combine mental health expertise with lived experience can help address these challenges and reduce the need for police involvement.

Crisis support during humanitarian emergencies. In humanitarian emergencies and refugee contexts, crisis response services, such as emergency units, crisis teams, and telephone hotlines, should address the specific needs of affected populations. This includes having staff who speak relevant languages, respecting cultural preferences, and ensuring accessibility without stigma. Collaboration among mental health services, government departments (for example, telecommunications, social protection, health ministries), and NGOs is essential to establish and maintain these crisis lines, including referral pathways for those in crisis. It is also vital that refugees and people displaced to other countries have access to these services.

Strategy 2.1.3

Create and expand rights-based community mental health centres and outreach services.

Actions

- **Establish functions and operational protocols for community mental health centres**. It is important to define and detail the core functions of assessment, recovery/treatment planning and follow-up, crisis support, prevention and promotion, coordination and linking to community resources.

- **Establish functions and operational protocols for community outreach mental health teams**. Outreach teams can plan and deliver assessments, rights-based recovery and treatment planning, follow-ups, crisis support, and coordination with community resources to individuals at home or living on the street. They are ideally positioned to operate from community mental health centres or other mental health services and should be available around the clock.

- **Establish the range of specialized services that community mental health centres and outreach services will provide**. Specialized services should meet the specific needs of the population being served. They may include specialized services for dementia; eating disorders; neurodiversity including autism; suicide risk and attempts; alcohol and other psychoactive substance use. Community beds may be needed for people who require specialized support after a mental health crisis. Services may be needed for people from groups that face discrimination, for example people experiencing gender-based violence, people seeking gender-affirmative care, trauma-informed services for refugees or services for people coming into contact with the justice system. Establishing specialized services may require mapping of, and collaboration with, other services in the community (see also Strategy 2.3.2 on strengthening partnerships). Investment in specialized equipment may be needed alongside recruitment and retention of staff with specific competences, or training for existing staff on specialized care and treatment.

- **Recruit and/or deploy trained multidisciplinary staff to work in rights-based community mental health centre(s) and outreach service(s)**. Establishing and scaling up community mental health centres and outreach teams depends on having sufficient human resources available and trained (new recruitment, staff deployed from other services etc.). As far as possible, community mental health teams should be both multidisciplinary and reflect local community diversity, including groups facing discrimination.

REFLECTION on crises. Humanitarian crises, such as conflict or health emergencies, can quickly disrupt or overwhelm general hospitals and other health and mental health services. At such times, outreach teams can be crucial in reaching out to individuals, including displaced persons, and providing support directly in the community.

Strategy 2.1.4

Create and expand rights-based peer support services.

Actions

- **Create or expand one-to-one peer support**. Mental health services can employ people with lived experience of mental health conditions or psychosocial disability to support service users. Alternatively, independent peers (potentially from peer-run organizations) can provide voluntary or paid support within services and within the community. Service users can also provide mutual unpaid peer support. It is also important to ensure that peer supporters receive adequate support for their own well-being in these roles, aligning with a duty of care approach that safeguards their mental health as they support others.

- **Create or expand group peer support**. Support groups can operate within mental health services, in the community, or both. Group peer support offers companionship, helps people understand their mental health and experiences, supports decision-making, and creates and strengthens social networks. Group support can lead to social change and can foster inclusion for people with mental health conditions and psychosocial disabilities at community and national levels.

- **Create or expand peer support for family members and caregivers**. Rights-based one-to-one and/or group support services can help people who support relatives/others with lived experience of mental health issues. Families and other caregivers develop valuable knowledge, experience, and perspectives and can share this through peer support. For example, peer support can help a family member when their relative is receiving treatment and care, or transitioning from inpatient care to their family home or community residence. Families affected by a suicide, or a suicide attempt, may need immediate or ongoing support, particularly when they are the primary support for the distressed person.

SPOTLIGHT on peer support

Aims of peer support. Peer support plays a crucial role by offering emotional support, helping individuals understand and share information, resources, and experiences. It also supports decision-making, promotes autonomy, fosters social inclusion and advocacy, and helps people access social benefits *(108)*. Peer support can be tailored to specific conditions, such as depression, issues like bereavement, or broader issues like emotional distress, or voice hearing. Another key role is to provide information on human rights and access to justice, supporting people to navigate these systems and advocate for themselves. Peer support can also help people obtain official identification and ensure their personal information, such as name and age, is properly documented, which is important for human rights protection, access to social benefits, and other services.

Integrating peer support into mental health care. Peer support, embodying values of mutuality, equality, self-determination, empathy, and a person-centred, recovery- and rights-oriented approach, should be integral to mental health referral pathways and networks. Peer supporters, particularly in official roles, should also be competent in core helping skills, which may require formal or informal training. Fostering a culture that values peer support is crucial to overcoming staff resistance and deepening their understanding of the peer role *(109)*.

Employment and independence. Ideally, peer supporters working within health or social services should be employed through independent peer organizations to preserve their independence. Direct employment by the service may pressure peer supporters to assume a staff role rather than maintaining their peer identity. However, it is important to recognize that some peer supporters may prefer the security, stability, and respect that come from being part of a funded health team. There are benefits to facilitating naturally developing relationships between peers, but peers who are filling a part of a mental health service should always be compensated at the same rate and scale as other expert staff.

Strategy 2.1.5

Integrate rights-based mental health approaches into primary care and other health services.

Actions

- **Identify and integrate mental health functions and operational protocols into primary care**. Primary care centres, clinics and dispensaries, and community health centres can provide assessment, recovery and treatment planning and follow-up, crisis support and prevention and mental health promotion while also addressing physical health needs. Primary care settings provide an opportunity to implement a collaborative care model, where primary care staff collaborate with mental health and other relevant professionals to address people's care and support needs. This holistic approach improves accessibility, affordability, and health outcomes, reducing the costs associated with specialized mental health services. Primary care services should coordinate with secondary care and other community resources. Where possible, additional professional and support staff should be recruited.

- **Identify and integrate mental health functions into specialized health services**. People using specialized health services may be experiencing emotional distress or mental health conditions, sometimes due to a general health condition or a side effect of its treatment (see also Strategy 2.1.1 on services in general hospitals). Specialized health services include (but are not limited to): accident and emergency services; child and maternal health care; older adult care; noncommunicable disease care (such as for cancer, cardiovascular, respiratory, and autoimmune diseases); palliative care; sexual and reproductive health care; communicable diseases care (such as for HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases), and services addressing alcohol and other psychoactive substance use.

- **Define tasks, roles and training of staff at primary care and at specialized health services so they can provide rights-based mental health interventions**. Services should carefully define the mental health responsibilities and tasks of primary care and specialist staff, taking local contexts into account. Targeted efforts are essential to reduce stigma and discriminatory attitudes among health workers and to provide relevant training, equipping staff to support people experiencing mental health issues and to offer treatment and assistance within a recovery-oriented approach. In addition, primary care staff should be specifically trained to support individuals experiencing suicidal thoughts, ensuring timely referrals to appropriate specialized services when needed. Furthermore, it is essential for staff to be knowledgeable about community resources in order to connect individuals with additional physical health, lifestyle, psychological, social, and economic interventions that may fall outside the scope of primary care.

Strategy 2.1.6

Implement an integrated, comprehensive and sustainable approach in and across services.

Actions

- **Provide wide access to assessments, interventions and support for service users and caregivers**. Mental health services should provide comprehensive assessments of individuals' support needs and offer a wide range of rights- and evidence-based interventions as part of recovery and treatment plans. A key priority is supporting families and caregivers, helping them navigate and access appropriate services. Staff should be trained and supervised to effectively deliver these interventions and support, which may include physical health and lifestyle changes, psychological, social, economic, and pharmacological interventions. Service users should be offered a variety of support and interventions, with their will and preferences respected. Even when a full range of options is not immediately available, maintaining choice remains crucial. For further guidance, refer to Policy area 3 on person-centred, recovery-oriented, and rights-based assessment, interventions, and support, as well as other parts of Policy area 2 on human resource and workforce development.

- **Put in place a system and protocols to provide consistent access to psychotropic treatments**. A proactive monitoring system (including reliable ordering and supply chain mechanisms) is key to ensuring psychotropic drugs in the national formulary are available, and remain in date, at all levels of the health system, from specialized care through to community and primary care. Supply chain difficulties and shortages of psychotropic drugs in pharmacies can worsen outcomes for people. Abruptly stopping medication is often unsafe and can lead to avoidable mental health crises, withdrawal symptoms and reduced trust in services. Ensuring timely delivery from central stores to services and pharmacies avoids shortfalls in availability, and the knock-on effects this can have.

- **Continue liaison with government authorities and health insurance agencies, even once services are established, in order to secure long-term funding**. Even where there has been initial government commitment for new services, ongoing dialogue, and reflection on, or adjustment of, insurance schemes is essential for sustainable success.

- **Develop high-quality and secure digital infrastructure for delivering online mental health interventions and support**. Psychotherapy, counselling, crisis response and other services can sometimes be successfully delivered online. However, services should establish safe and secure channels that ensure confidentiality and privacy *(110)*. Online services should also be accessible, aligned with global standards around the accessibility of digital health (see *Web content accessibility guidelines (111)* or *WHO-ITU global standard on accessibility of telehealth services (112)*). Video and teleconferencing, websites, and apps being used to deliver interventions and support, should offer strong data protection and their interventions should be evidence-based. Services need to avoid digital exclusion, and instead provide all groups and communities with widespread access to interventions. This should include underserved areas, such as rural and peri-urban areas, as well as people with physical, sensory, or other disabilities. Where people cannot use a digital intervention, it should be offered in a non-digital format such as phone-based interventions. It is important to note that digital services should complement, not replace, in-person support, as face-to-face interactions remain vital for social engagement and community integration, particularly for those at risk of isolation (see also Strategy 2.3.1 on improving people's meaningful connections).

- **Implement referral, back referral and other coordination mechanisms**. Collaboration, coordination and continuity of care within and between mental health services, general health services and other sector services (such as housing, social services, employment, education etc.) is important to ensure people can access a full range of support. For example, link workers may be needed to help people, or their caregivers, navigate complex and at times fragmented services across sectors. Services can develop partnerships and collaboration agreements and can designate focal points or coordination teams at district, regional and national levels.

- **Continually monitor and evaluate services and publish the findings**. Evaluation can identify areas for improvement and can also provide government policy-makers and health insurance agencies with data that convince them to continue and perhaps scale up funding for services. Broad outcome measures should be considered, including: user satisfaction; quality of life; community inclusion (such as employment, education, income levels, housing status, and social benefits); recovery and symptom reduction rates; physical health indicators; and the frequency of coercive practices like involuntary treatment and mechanical, chemical, and physical restraints. It is important to track both the number and duration of these events per year, as well as the number of individuals affected. Periodic assessments are necessary to ensure services meet core quality and human rights standards. Tools like the WHO QualityRights assessment toolkit and transformation guidance are valuable for identifying gaps in quality, rights, and service provision, and for developing strategies to address these issues *(50)*. Additionally, collecting data disaggregated by age, gender, disability and any relevant marginalized groups (for example, refugees and migrants, people from minoritized racial or ethnic groups or LGBTIQ+ individuals) is essential for assessing discrimination and addressing disparities in how individuals experience care.

- **Advocate and promote the service with all stakeholders, and establish ongoing dialogue**. Public forums, hearings, and meetings are effective platforms for people to express their views on mental health services, share ideas, and address concerns. Depending on the local context, key groups to involve might include individuals with lived experience, those facing discrimination, families, politicians, health insurance agencies, OPDs, NGOs, traditional and faith-based healers and leaders, village leaders, and city and town mayors (or additional stakeholders, refer to Box 3). Advocacy and promotion efforts should involve active outreach through both traditional and social media. Publicly highlighting the services' successes is an effective way to engage and bring more people on board.

KEY POINT: sustainable care is essential during emergencies. In humanitarian emergencies, action to ensure continuity of care is critical, for example relocating services, integrating mental health into general healthcare, establishing remote support, and making services accessible for refugees and displaced persons. Examples of measures to improve accessibility include covering cost, providing services in appropriate language, and ensuring cultural relevance *(113)*.

For practical resources related to Policy directive 2.1 Coordinated rights-based community mental health services and support at all levels of care see the relevant section of the annex.

2.2 Policy directive 2.2 Integrated mechanisms that respond to social and structural factors and incorporate rights-based approaches in mental health

Over the past decade, policy has increasingly emphasized promoting and respecting human rights within mental health services. Despite this, people continue to experience poor care, inadequate living conditions, violence, abuse, and neglect, all of which damage their mental and physical health. Services should strive to eliminate coercive practices and fully respect individuals' will and preferences. Furthermore, services frequently focus on diagnosis, drug treatment, and symptom reduction rather than adopting a holistic, person-centred, recovery-oriented approach. While diagnosis, symptom reduction, and medical treatment are beneficial for some individuals in certain situations, a more comprehensive approach is needed: one that addresses the root causes of distress, often rooted in social and structural factors.

Illustrative example text

This policy directive marks a paradigm shift: moving from a focus on diagnosis and symptom management to considering the individual in the context of their entire life. A broader range of interventions will address physical health, lifestyle, psychological, social, and economic factors. Central to this approach are informed consent and respect for people's will, preferences, and choices, with the goal of eliminating coercion. New service-level policies will be implemented through evidence-based actions, with an emphasis on building staff capacity and collaborating with community organizations. Guided by the principle 'Nothing about us without us', services will ensure that those with lived experience co-develop, implement, and evaluate services. Mental health services will also address climate-related mental health issues, recognizing their significant impact.

Strategy 2.2.1

Operationalize mechanisms within services to address the social and structural determinants of mental health.

Actions

- **Delineate ways to address social and structural determinants of mental health in service policy**. Service policies should be firmly rooted in a thorough understanding of the local community's needs and assets, particularly focusing on the social and structural determinants that impact mental health. This requires a comprehensive assessment of these determinants within each community. Engaging in ongoing dialogue with community members is crucial for gaining insights into social dynamics and prevalent issues, allowing services to effectively tailor their actions to address the underlying factors contributing to or exacerbating mental health conditions. It is crucial for services to assess and respond to these determinants without pathologizing normal responses to adversity. Rather, they should adopt strategies that directly address issues like discrimination and marginalization.

- **Educate and train staff of all services on addressing the social and structural determinants of mental health**. This action should span staff in general hospitals, crisis response teams, community mental health centres, those working in peer support efforts, and those in primary care and in other health settings. Education and training should help staff recognize how social and structural determinants affect the ways

mental health services are conceptualized and delivered (for example, the roles of implicit biases, past histories of institutional racism, privilege). Education and training should also explore how social and structural determinants affect the way people receive mental health services (for example, the roles of internalized racism, ableism, and self-stigma). Furthermore, education should consider the best approaches for mental health professionals to continuously improve their knowledge, competence and confidence in recognizing and responding to these issues.

- **Ensure that assessment, treatment and support in services directly address individuals' experiences of social and structural determinants**. For example, assessments should record individuals' experiences of social and structural determinants. Treatment should be informed by this knowledge. Support should include access to services and resources, such as those for housing, education, employment and income generation, legal support/aid, and organizations combatting discrimination and domestic violence.

- **Task staff of services with supporting individuals to access social and economic interventions, including disability and social protection benefits**. Making staff responsible for informing people of their rights and entitlements, and for supporting people to access these, is crucial. Helping people to navigate the often complex and confusing process of applying for opportunities and benefits can directly improve their mental health and overall quality of life (also see Policy directive 2.3 on partnerships for community inclusion, socio-economic empowerment and for protecting and promoting rights).

- **Create safe spaces in services for discussing how social and structural factors influence mental health**. Services should make it easy for service users, families, concerned stakeholders and staff to share distress and concerns about social and structural determinants, and to explore ideas on tackling these. This requires a mechanism for talking openly in a non-judgemental atmosphere where feelings are met with validation and support.

- **Maintain good knowledge of, and collaboration with, local community and support services**. Mapping the availability and location of other sector services can facilitate access to housing, education, employment, and social protection. It can also help service users access support groups and specialized services addressing specific challenges such as violence, racism, loneliness, and the need for connection. Mapping is not a one-off activity, as local community assets change regularly. Maintaining this knowledge requires continuous monitoring and updating in collaboration with the external services (See also Strategy 2.3.2 on strengthening partnerships and Strategy 2.3.5 on engaging with families and informal care providers).

- **Build environmentally friendly and sustainable services that help mitigate climate change and address climate hazards**. Service design and operations should follow practices that help address global climate change, such as saving energy, using clean energy, ensuring safe water and sanitation, reducing waste, recycling, and serving sustainable food. Additionally, services should provide proper cooling, heating, and ventilation to address the impacts of climate change. Services can also educate staff, service users, and visitors on environmental issues and promote lower-carbon, healthier transportation options, such as walking and cycling, where appropriate. Services can foster social connections and support employment inclusion by partnering with environmental organizations, cooperatives, and volunteer groups to engage staff and users in environmental activities. See *Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors (58).*

- **Include nature-based interventions in service delivery**. This is sometimes called green care and involves improving access to nature for service users and staff, perhaps by creating green spaces within services. Where possible, services should educate service users and staff on the environmental exposures harming their lives, and how to avoid these, and on the benefits of more sustainable choices in improving mental health and well-being. Peer support meetings, team consultations, and group activities in green spaces can foster connection and collaboration. Activities such as hiking, sports, and teaching relaxation techniques in natural environments like parks can be promoted in order to help people relax and connect. Again, see *Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors (58).*

Strategy 2.2.2

Uphold human rights, eliminate coercion, and promote recovery while continuously improving service quality.

Actions

- **Introduce policy guidelines and protocols for improving quality and embedding respect for human rights into the service**. Service-level policies should define values, principles, and practices that promote quality rights-based services and enhance well-being. Policies should eliminate forced admission, treatment, and coercive practices such as physical, mechanical, and chemical restraints, as well as seclusion and address the higher rates of coercion among individuals from discriminated groups. Community treatment orders that compel compliance with treatment lack evidence, violate human rights, and should be discontinued *(114)*. Key areas to address in service-level policy include:

  - preventing and eliminating coercion (instead using de-escalation techniques, comfort rooms and other strategies);
  - protocols for informed consent, supported decision-making, and advance planning and access to information, privacy and confidentiality;
  - ensuring individuals have official identification and records that document basic demographic data and interventions received;
  - establishing complaints mechanisms; and
  - developing recovery plans *(22, 50, 106)*.

  See WHO QualityRights face to face training tools for additional information *(115)*.

- **Train service staff on understanding human rights, disability and recovery in mental health**. Training should extend to all health and auxiliary staff in hospitals, crisis teams, community mental health centres, peer support services, primary care, and other health services. Training should cover: informed consent and respect for legal capacity; the rights of people with mental health conditions and psychosocial disabilities; recovery principles and planning; human rights approaches to crisis interventions; zero coercion strategies (including using de-escalation and communication techniques); trauma-informed approaches; addressing power dynamics and unconscious bias; and intersectional and life-course approaches *(22, 116–20)*. Useful tools are *WHO QualityRights e-training on mental health, recovery and community inclusion (121)* and the *QualityRights face to face training tools (115)*

- **Involve people with lived experience in developing, delivering and managing the service, as well as making peer support an integral component**. Meaningful participation of people with lived experience at all service levels is essential for upholding rights, ensuring quality care, and meeting people's needs. Services can employ individuals with lived experience as staff across all hierarchical levels. Additionally, peer support workers can be hired to provide one-to-one peer support or to lead peer support groups *(122)*. Formal structures should also be established to systematically collect and use service user feedback for continuous improvement and planning *(55, 108, 109)*. See also Strategy 1.3.1 on indicators and information systems.

- **Introduce holistic recovery plans for people using services**. A recovery plan outlines personal goals, wellness strategies, crisis management and post crisis actions. Mental health services should support service users in creating these plans, ensuring plans reflect individual treatment and life goals. Recovery plans also identify additional support and community resources, promoting a personalized and integrated approach to recovery. See *Person-centred recovery planning for mental health and well-being: self-help tool: WHO QualityRights* for further guidance *(123)*.

- **Set up protocols that integrate supported-decision-making into the service and train all staff to understand and follow these**. Supported decision-making helps individuals assert their right to legal capacity within mental health services. A supporter is chosen by the person who wishes to receive support, and helps them make their own decisions, including about treatment and care. Their role includes gathering information, discussing options for support, treatment and care with the service user, helping the person communicate with health staff, providing emotional support, advocating for their choices, and ensuring respect for those choices. People can specify their supporter in their advance directives (see the action on advance directives below). See *Supported decision-making and advance planning. WHO QualityRights Specialized training: course guide* for further guidance *(124)*.

- **Introduce advance directives/plans to promote the right to legal capacity within the service**. Advance plans, also known as living wills or advance directives, allow people to record their future preferences if they later cannot communicate their wishes. Supporters and health care workers can refer to the advance plans to ensure decisions align with the person's directives. Advance plans are especially useful for individuals who may experience distress, psychosis, or dementia, or who wish to specify their preferences in advance. Typically written, advance plans can also be in audio or video formats. Services should adopt protocols for using advance plans, provide training to support their development, and include additional protocols to uphold legal capacity (see Box 7). See *Supported decision-making and advance planning. WHO QualityRights Specialized training: course guide* for further guidance *(124)*.

- **Set-up comfort and calming spaces within the service**. Comfort and calming spaces are designated areas specifically designed to promote relaxation, reduce stress, and offer a sense of calm. They serve as retreats from potentially stressful, escalating, or overwhelming situations. Staff and service users should collaborate to plan these spaces, drawing on people's lived experiences. Key considerations include purpose, usage, furnishings, decor and the overall desired environment. Safety is also key, for example removing potential hazards like glass, flammable objects, or harmful fixtures. See *Strategies to end seclusion and restraint. WHO QualityRights Specialized training: course guide* for further guidance *(120)*.

- **Train staff on communication and de-escalation procedures**. This training can equip staff with the knowledge, tools, and skills to clearly convey information, resolve conflicts, navigate challenges with empathy, and build positive relationships. It should extend beyond health staff to include allied staff, such as security, administrators, porters, cleaners, and maintenance, who also need de-escalation skills (see *Strategies to end seclusion and restraint. WHO QualityRights Specialized training: course guide* for further guidance *(120)*).

- **Set up response teams that can address difficult and conflictual situations**. The team should include members from diverse backgrounds, including those with lived experience, and should be skilled in communication, de-escalation, problem-solving, and leadership. A comprehensive response plan should outline roles, responsibilities, and procedures for intervening in a variety of crisis situations. Additionally, procedures for documenting incidents and outcomes are essential for continuous learning and improvement (see *Strategies to end seclusion and restraint. WHO QualityRights Specialized training: course guide* for further guidance *(120)*).

- **Put in place comprehensive service assessments, monitoring, improvement/transformation plans and reporting to assess quality and human rights conditions in services**. It is essential to establish comprehensive monitoring and reporting systems through an ongoing cycle of assessment, feedback, action planning, and continuous monitoring. While service self-assessments are encouraged, it is also important that these are periodically complemented by objective external evaluations from independent teams trained in human rights and relevant standards *(50)*. An improvement or transformation action plan should cover key areas such as service culture, power dynamics, and addressing specific gaps and priorities identified during the assessments. All assessments, feedback, improvement plans, and ongoing monitoring should be carried out by multidisciplinary teams *(50, 117)* that include service users, families and caregivers, and professionals such as psychiatrists, nurses, social workers, and lawyers (see Box 3 and also Strategy 1.1.3 on monitoring service quality and rights protection). The *QualityRights assessment toolkit (50)* and *WHO transformation guidance tools (117)* can be used.

- **Develop an anonymous complaints mechanism that feeds into improvement/transformation plans**. Complaint mechanisms should be accessible to all, with information available in multiple languages and formats, such as Braille or Easy Read. Complaints should be accepted in writing, orally, or via a support person or advocate. An independent central mechanism should be available for unresolved cases *(116)*. Both service-level and central complaint mechanism should inform service improvement plans and be linked to safeguarding systems to address and monitor safety and well-being concerns (see also Policy directive 1.1 above and *Freedom from coercion, violence and abuse. WHO QualityRights Core training: mental health and social services. Course guide* for further guidance *(116))*.

Box 7. Legal capacity and informed consent

Informed consent, a fundamental aspect of legal capacity, means that a person has consented after receiving and understanding all available information concerning a treatment and care. Information should include benefits and risks of the treatment, and any alternatives. A requirement for informed consent also means that people have the right to refuse treatment. Mental health services should:

- plan how informed consent will be achieved and recorded for all treatment decisions;
- provide service users with full information about medication, including its efficacy and any potential negative effects;
- consider how to support people to make informed decisions and choices about treatment and care options;
- plan how to provide supported decision-making and how to establish and use supporters to help people make their will and preferences known;
- establish mechanisms to support advance plans;
- support people to make a complaint if they need to; and
- facilitate access to legal advice and representation (for example, refer people for pro bono legal representation) if service users need this.

For practical resources related to Policy directive 2.2 Integrated mechanisms that respond to social and structural factors and incorporate rights-based approaches in mental health see the relevant section of the annex.

2.3 Policy directive 2.3 Partnerships for community inclusion, socioeconomic development, and for protecting and promoting rights

Mental health services are crucial for fostering community inclusion, but they cannot meet all the needs of those they serve. Many people with mental health conditions and psychosocial disabilities have limited social networks, living in isolation and experiencing loneliness, which can contribute to poor mental health and increase the risk of suicide *(125–129)*. Enhancing community inclusion and social connections is key to helping individuals build meaningful lives. To achieve this, many also require employment, housing, income, education, and social protection. Practical collaboration with social and other related sectors (including civil society organizations and local, national and international NGOs) is essential. The strategies and actions under this directive interlink with Policy directive 5.2 on joint actions addressing social and structural determinants.

Illustrative example text

This policy directive will guide services in helping people with mental health conditions and psychosocial disabilities build strong social and peer networks while addressing their social, economic, housing, employment, and protection needs. The strategies aim to reduce isolation and loneliness, which are key risk factors for mental health conditions. Actions under these strategies will foster an enabling and inclusive environment, bringing new meaning to people's lives. Additionally, success stories, achievements, positive impacts, and challenges will be documented and shared to raise community awareness about available opportunities, resources, and social groups.

Strategy 2.3.1

Improve meaningful social connection for people using mental health services

Actions

- **Map and connect with local opportunities for engagement and participation**. Mental health services should identify and map opportunities, activities, and organizations in the local community that may benefit service users. For example, staff could connect with sports and social clubs, cultural societies, and local charities to discuss ways to engage and facilitate participation. It may be possible to create programmes that encourage long-term involvement for people with mental health conditions and psychosocial disabilities. These programmes could include mentoring, where individuals already involved in a social activity welcome newcomers, helping them integrate and build friendships. In undertaking these efforts, mental health services should consider the specific needs of diverse groups who experience marginalization and exclusion (for example, based on gender, age, disability, minority, or ethnic status) and identify appropriate opportunities to enable them to (re)gain meaningful social connection and inclusion.

- **Create or utilize support groups and social communities (both face to face and online) to combat loneliness and reinforce social connectedness**. Whenever possible, it is beneficial to work with existing groups or communities, encouraging them to welcome and include people with mental health conditions and psychosocial disabilities, as creating new groups can be challenging and often requires additional financial resources. Where these do not already exist, services can establish a coordinating team, including individuals with lived experience of mental health conditions, to collaboratively create support groups or social communities

(130). This team should discuss and determine the purpose of the groups or communities, their goals, whether meetings will be in person or online, or a mixture of both, and the scheduling and locations for gatherings. These groups or communities can be promoted within health and mental health services, as well as through local organizations, cultural and sports centers, community centres, and partnerships with other services or organizations, such as mental health NGOs and OPDs. Also, see *Peer support groups by and for people with lived experience. WHO QualityRights guidance module: module slides* *(109)* and Strategy 2.1.4 for additional guidance around peer support and 2.1.6 for additional guidance for ensuring secure online platforms.

- **Mobilize community-based workers or volunteers to assist people at risk of isolation, or who lack support networks**. Community-based workers or volunteers play a crucial role in identifying and supporting individuals or groups at high risk of isolation by facilitating connections to existing support networks or creating new ones *(130)*. Whenever possible, workers or volunteers should come from the same background as the people they assist. For example, if a specific migrant population is at risk of isolation, recruiting workers or volunteers from that migrant community can enhance the effectiveness of support efforts.

- **Support continued access to a range of services and resources that maintain social connectedness**. Ongoing support is crucial for rebuilding social lives, especially during crises like public health emergencies, which can exacerbate loss of social connections, isolation, and loneliness. Technology, such as video conferencing, helps maintain services and enables online support groups. Continuing these tools beyond crises, alongside in-person interactions, can strengthen social connectedness. Mental health services can better provide ongoing support through strong partnerships with social services, community organizations, crisis phone lines, and other support networks. Including strategies to foster social connection and support in emergency response planning is also essential.

REFLECTION on addressing social isolation, loneliness and stigma. Stigma and misconceptions often shrink social networks for people with mental health conditions, especially for individuals experiencing multiple forms of discrimination. Mental health services should not overlook the importance of supporting social connections. Services should support socially isolated people but also people who feel lonely despite being socially engaged, because social isolation and loneliness are separate.

Strategy 2.3.2

Strengthen partnerships between mental health services and other sector services, including housing, education, employment, justice, and social protection

Actions

- **Liaise and collaborate with wide-ranging partners, and explore ways to formalize links and to strengthen referral pathways**. Mental health services should actively engage with NGOs, private organizations, and government services in areas such as social affairs and social protection, including housing, education (schools, universities, and other institutions), employment, culture, media, arts, and sports. Box 3 outlines key stakeholder groups to engage. To strengthen collaboration, mental health services could implement joint training (see the next action); hold regular meetings to exchange ideas and share information and resources; formalize partnerships through agreements outlining joint activities, roles, and responsibilities; and initiate joint projects. For example, mental health professionals or peer supporters could accompany police during patrols to connect individuals with community-based mental health services, multidisciplinary crisis teams, or crisis hotlines *(58)*.

- **Organize joint training with various organizations and sectors so they better-understand mental health, and rights-based services, actions and support**. For example, joint training on mental health and human rights for first responders, such as police, ambulance personnel, and mental health services, can enhance their ability to handle mental health crises, alcohol and other psychoactive substance use incidents, and houselessness. By exploring innovative roles and collaborative approaches, this training can improve intervention strategies in crisis situations, leading to more effective crisis management. Through information exchange on the unique challenges faced by different responders, and collaboration on overcoming these obstacles, such training promotes a shared understanding of human rights, effective de-escalation techniques, and the communication skills essential for non-coercive responses. This approach equips first responders to navigate crises while fully respecting individuals' rights. See also Strategy 2.2.2 on respect for human rights, eliminating coercion, promoting recovery, and continually improving services and also Strategy 5.2.2 on collaborating to agree and implement changes to government policies that address social and structural determinants of mental health.

- **Advocate for increased social sector funding, services and programmes for people with mental health conditions and psychosocial disabilities and for people belonging to groups facing discrimination**. While providing a full range of community services and supports is not solely the responsibility of the mental health sector, it is crucial to acknowledge their importance, advocate for them, and connect individuals to these services and supports where available. See also Strategy 1.2.3 on allocating sectoral budgets and financing to protect and promote mental health according to both joint and sector-specific responsibilities.

KEY POINT: there are critical gaps in services Inadequate and poorly coordinated services for housing, employment, education, social protection, and disability benefits are critical gaps in service provision. Mental health services should prioritize facilitating access to local programmes and advocating for their development where they are lacking.

Strategy 2.3.3

Establish accessible disability and social protection benefits and schemes for people with mental health conditions and psychosocial disabilities.

Actions

- **Establish dialogue with the social protection sector to address gaps in disability benefits and social protection schemes for people with mental health conditions and psychosocial disabilities**. Often, social protection schemes do not cover individuals with mental health conditions or psychosocial disabilities, even when these benefits are available to other marginalized groups. The mental health field can play a crucial role by examining the eligibility criteria for these schemes to identify whether they unfairly exclude people with mental health conditions or psychosocial disabilities. Based on these findings, stakeholders could advocate for changes that ensure inclusion. Potential schemes to examine include: support mechanisms; accommodations and adjustments such as tax credit exemptions; cash transfers; economic empowerment programmes; education grants; back-to-work training; transport grants; trade tool grants (for example for purchasing work tools); or cost waivers for income-generating opportunities like market stall fees. Partnerships with other stakeholders, such as local authorities, the transport sector, employers, and other partners, could be negotiated to implement these schemes and waivers. Additionally, it is important to consider benefits and social protection schemes for families and carer givers. See also Policy directive 5.2 on joint actions on social and structural determinants and society-wide issues, and its associated strategies and actions.

- **Collaborate with the social protection sector to simplify procedures and establish support mechanisms that help people navigate social protection and disability schemes**. Accessing these benefits is often challenging and time-consuming. Collaboration with the social protection sector is crucial to simplify procedures and establish support mechanisms that help individuals with mental health conditions or psychosocial disabilities access benefits. See Strategy 2.1.3 on rights-based community mental health centres and outreach services and also Policy directive 5.2 on joint actions on structural and society-wide issues, and its associated strategies and actions.

Strategy 2.3.4

Develop tailored services for people with long-term needs and support requirements.

Actions

- **Link to, or create, diverse housing options for varying support needs**. Develop a variety of housing options tailored to people with different support needs. This could include housing with varying levels of support based on individual choice and requirements, reuniting or reconnecting individuals with families or social networks if they wish, or providing medium to long-term family-like group housing with needed support. New services may be required, especially for those with long-term intensive needs. Supported housing options should be integrated into the community rather than isolated facilities that replicate an institutional setting. Consider programmes such as Housing First *(131)* and Home Again *(132)*, which aim to promote long-term housing stability.

- **Link to, or create, supported education services and resources for varying support needs**. Examples include individual assistance programmes that provide one-on-one support as someone pursues their education, services that help people navigate the education system, and retraining opportunities and vocational training to help people acquire new skills and transition into new careers.

- **Link to, or create, supported programmes and services for work and income generation**. This may include transitional employment programmes, supported employment initiatives, or assistance in developing independent employment, such as small businesses and livelihood programmes. Support could also involve helping people maintain their current employment or return to their previous jobs. New services may be needed, especially for people with long-term intensive needs.

- **Link to, or create, programmes and services that provide personal assistance**. People with mental health conditions and psychosocial disabilities may need support in many different areas of their lives, such as managing household tasks, personal care, organizing appointments, transport, financial matters, and decision-making more generally. The goal should be to help people live active and autonomous lives. Assistance should always be wanted and never imposed.

KEY POINT: equal access and specific support are both needed. It is crucial that people with mental health conditions and psychosocial disabilities have equal access to mainstream services, as well as access to services that cater to their specific needs and requirements.

Strategy 2.3.5

Engage with families and other informal care providers in local communities, including religious centres, family homes, schools, and villages.

Actions

- **Map and highlight community resources and support to address inclusion, socio-economic development, and rights**. Mental health services can collaborate closely with local community groups to map and highlight local resources, services, organizations, social and cultural networks. Often, services are unaware of the full range of available community resources. Creating local-community working groups can facilitate this mapping process, ensuring that local knowledge is incorporated and that no resources are overlooked. Inclusive mapping, which considers organizations representing diverse identities and those facing multiple forms of discrimination, can create stronger connections between mental health services and the community. This collaboration fosters social inclusion by promoting social connectedness, sharing essential information on housing, education, and benefits, and assisting individuals in navigating social systems. Ensuring that information about these resources is accessible in various languages and formats, such as Easy Read, Braille, and sign language, is crucial for broad reach and effectiveness.

- **Engaging communities in mental health awareness and dialogue**. Mental health service-led activities in the community can raise awareness about mental health issues, help services understand local concerns, and provide information on available support. These activities, which can be held in public spaces such as parks, leisure centres, and museums, help build stronger connections between services and communities. Public meetings, community dialogues, and discussion forums allow deeper exploration of mental health concerns, generate actionable ideas, and challenge misconceptions. These discussions can create a supportive environment for groups facing discrimination and promote appreciation for the cultural, social, and economic contributions of marginalized groups.

During humanitarian emergencies, forums for open discussion play a vital role in addressing mental health challenges, supporting marginalized groups, and gathering community feedback on available services and improvements, though it is important to note that they should not be used for psychological debriefing. Partnerships with local groups (for example, youth groups, women's safe spaces) can help identify, support, and refer people to mental health and psychosocial support services. Additionally, cross-sector services (for example for health, nutrition, livelihoods, education, protection) can work together to promote mental health and resilience by disseminating messages that encourage effective coping and stress management strategies *(113)*.

- **Engage with stakeholders embedded in local communities to understand and address the local drivers of poor mental health**. Engage with community stakeholders, such as hairdressers, traditional and faith-based groups, civic organizations, local businesses, and local politicians, to understand and address what drives poor mental health within their communities. Mental health services can empower these stakeholders to identify factors affecting mental health and well-being in their networks, develop tailored solutions, and collaborate in identifying, supporting, and where appropriate, referring individuals in emotional distress. Mental health representatives can undertake an assessment of the skills and expertise required by local groups and provide necessary training. Utilizing trusted local settings and organizations can foster collective recovery *(133)*.

- **Collaborate with and train families, traditional and faith-based leaders and healers, schools and communities to improve literacy on mental health and human rights, and to support people in distress**. Training well-trusted community members can enhance mental health literacy, protect human rights, and dispel myths. Families, volunteers, traditional and faith-based leaders and healers, and schools can develop skills to support those in mental distress. However, some stakeholders may engage in harmful practices, such as secluding or restraining individuals at home or in religious centres due to stigma, lack of knowledge, or limited resources *(134)*. Establishing respectful dialogue is essential to understanding these practices and promoting more positive, culturally appropriate approaches to mental health. Collaboration with religious and community leaders, police, and others may be needed to address religious, cultural, or other forms of intolerance related to suicidal thinking. Gatekeeper training for these groups, as well as other community actors such as NGOs, OPDs, and teachers, can equip them to identify and support individuals at risk, connect them to services, manage crises, and provide suicide prevention interventions (see Policy directive 5.1 on programmes to improve understanding and change negative attitudes on mental health, including combating stigma and discrimination, for the population as a whole) *(135, 136)*.

For practical resources related to Policy directive 2.3 Partnerships for community inclusion, socioeconomic development, and for protecting and promoting rights see the relevant section of the annex.

2.4 Policy directive 2.4 Deinstitutionalization

Many adults and children with mental health conditions, psychosocial and developmental disabilities continue to live in large, segregated psychiatric hospitals and social care facilities known collectively as institutions. These institutions are often linked to human rights violations, including poor living conditions, coercive practices, violence, and abuse *(30, 137)*. residents may be detained for months or years against their will, with no autonomy over daily decisions, isolated from their communities, families, and social networks. Institutions lead to poor mental and physical health outcomes *(162)*, especially for children and adolescents, who face dire consequences for their health, development, and future life *(138, 139)*. During health emergencies like COVID-19, institutional residents had higher infection risks and worse outcomes due to close living quarters. Restricting visitors and group activities further harmed their physical and mental well-being *(140)*. Despite common beliefs, institutions are more costly per service user than community-based services, while serving only a small subset of the population *(141)*. Concentrating care in these settings also prevents people from living in their communities.

Illustrative example text

This policy directive promotes a deinstitutionalization process, transitioning from institutions to community-based care in line with CRPD obligations. This includes downsizing and eventually closing all psychiatric and social care institutions and other forms of institutional care, alongside and in pace with the development of community services to support former residents. Building new institutions will be prevented. All institutional residents, including those with complex needs, will be covered by the deinstitutionalization policy. Staged transitioning, as community care is established, will prevent adverse outcomes like houselessness, deaths, incarceration, or rehousing in inappropriate settings. The focus on person-centred, recovery-oriented, and rights-based community mental health services will ensure that new mini-institutions do not emerge in the community.

Strategy 2.4.1

Establish the foundation and enabling environment for successful deinstitutionalization.

Actions

- **Document the characteristics and location of institutions and discuss deinstitutionalization with staff to bring them on board**. Countries often have numerous institutions, many of which, particularly in the private sector, are not well documented. Understanding who lives in these institutions and their support needs is crucial for guiding the development of community services that can replace institutional care and for setting realistic timeframes for this transition. Additionally, it is important to document the characteristics of the staff working in these institutions as part of efforts to retrain and relocate them to community-based services. This documentation process provides opportunities for focused discussions with staff to bring them on board and address their concerns. Job insecurity is a key factor behind staff resistance to deinstitutionalization, so it is important to reassure staff about future employment when they are willing to work in a new environment and learn the necessary skills.

- **Implement a communication strategy to support deinstitutionalization**. Success in deinstitutionalization relies on the commitment of all stakeholders, including institutional leaders, policy-makers, civil society, and local communities. Changing attitudes and practices that favor institutionalization is crucial to gaining stakeholder support throughout the planning and implementation process. A well-crafted communication strategy should present clear arguments for deinstitutionalization, grounded in international human rights standards and positive outcomes for those leaving institutions. This strategy should target all institutions and their staff, stakeholders in health, social, and other sectors, as well as local communities. Effective communication can help pre-empt resistance and remove barriers, and it should begin at the ideas stage and continue through planning and implementation. It is important to emphasize that simply transitioning to smaller community-based residential settings is not true deinstitutionalization if rigid routines and an over-reliance on medical interventions still limit individuals' autonomy. It is also important to note that different stakeholders may have varying concerns about deinstitutionalization, and tailoring communication messages to address these specific concerns is key to gaining broader support.

- **Train service providers and key stakeholders on the human rights-based approach in mental health and tackling stigma and discrimination**. Many stakeholders will need more than just persuasion; they require a comprehensive understanding of human rights-based approaches in mental health, covering all age groups, and the skills to apply this understanding in practice. Training should be provided to everyone involved in health and social services, as well as other community services that need to respond to mental health issues or to support people who have left institutions.

- **Hold focused discussions in the new community locations where people leaving institutions will be living, in order to assuage community reservations and prepare for deinstitutionalization**. These discussions should include all stakeholders in health, social, and related sectors, as well as members of the local community. Listening to and responding to stakeholders' specific concerns can help mitigate resistance to newly established living arrangements.

- **Make person-centred and rights-based community mental health and physical health services available and accessible to people leaving institutions**. In addition to standard physical health services, special attention should be given to reproductive health and dental care: areas often neglected and in need of targeted support. Many individuals with long-term support needs may require specialized, tailored services. Moreover, people with complex physical and mental health needs are frequently overlooked during the planning stage or classified as 'too difficult', resulting in them being the last to transition out of institutions. Their needs should feature in plans from the beginning to ensure they are not left behind. Services should centre on individual agency and human rights and should engage directly with the person, listening to their will and preferences to understand the specific support measures they require, ensuring that these effectively overcome the barriers they face (see Policy directive 2.1 on coordinated rights-based community mental health and primary care services and support and Policy directive 4.2 on physical health and lifestyle, psychological, social and economic interventions).

- **Create or link with a variety of services beyond the health sector to facilitate community inclusion and participation**. These connections should include housing and social sectors, supported education services, work and income generation opportunities, personal assistance, and other forms of support. When linking individuals to these resources, it is crucial to recognize their potential for independent living over time and avoid making judgments about their level of functioning based on their previous life in institutions, where opportunities for autonomy and independence were often lacking. See also Policy directive 2.3 on partnerships for community inclusion, socio-economic development and for protecting and promoting rights.

- **Budget sufficient funds, including double funding for the first phase of deinstitutionalization, and eliminate financial barriers**. Double funding will be required during the initial phase of deinstitutionalization to ensure a successful transition from institutions to community-based services. Initially, funds will be needed to develop and expand new community services while temporarily maintaining existing institutions. This double funding is a temporary measure. It is crucial to also plan how longer-term financial resources will be obtained, how funds will gradually be reallocated from institutions to community-based services, and to budget for people's daily needs when living in the community. Additionally, funds will be needed to train institutional staff on human rights and other skills necessary to support people in community-based services. Resources allocated for deinstitutionalization should not be diverted to improve institutions, though some funding may be necessary to prevent ongoing violations and meet basic needs during the transition. Financial incentives that currently maintain institutions, such as budgets based on occupancy, should also be restructured to support deinstitutionalization and community living (see also Strategy 2.4.2 on developing and implementing deinstitutionalization plans).

KEY POINTS: action is needed to avoid the deinstitutionalization process stagnating, even when commitments have been made.

Setting a roadmap with clear timeframes, milestones, and budgets is essential. Carefully considered and phased implementation approaches and plans are needed, for example by institution, by district/region, or another suitable approach.

Where mental health institutions are privately operated under government contracts, deinstitutionalization could lead to lost income. Consider restructuring contracts to incentivize the shift to community-based care.

Strategy 2.4.2

Develop and implement a deinstitutionalization plan for each institution that immediately improves rights and quality for all residents.

Actions

- **Establish a deinstitutionalization management committee in each institution to develop and implement the deinstitutionalization process**. The committee should include staff representatives, people living in the institution, their supporters, organizations of people with disabilities, representatives from community services, other local community members, and external experts in areas such as planning, financial management, and budgeting. If local expertise is limited, external experts from other countries who have been actively involved in previous deinstitutionalization processes can provide useful operational-level advice.

- **Develop and implement a deinstitutionalization plan for each institution**. The plan should outline specific actions, timeframes (including for closing the institution), milestones, and budgets. Ongoing monitoring and evaluation of progress are essential to ensure the plan's effectiveness and to make necessary adjustments. The operational plan should also include actions to immediately improve the rights and quality of life for residents, addressing issues such as poor living conditions, neglect, abuse, and coercive practices. These actions should be limited to practices, rather than refurbishing, rebuilding, or building new departments within institutions, and this should be emphasized. Inputs into the plan should be sought from members of the key stakeholder groups represented on the management committee.

- **Train staff working in institutions on rights-based and recovery-oriented approaches in mental health**. Training should include the recovery approach, legal capacity, supported decision-making and advance directives, eliminating coercive responses, independent living and community inclusion, and psychological intervention.

- **Train staff to develop individualized plans for people leaving institutions**. Individualized plans need to be based on individuals' will and preferences, and to incorporate choice. These plans should address physical and mental health care options, housing, education and training, employment opportunities, economic assistance or benefits, and personalized support. External experts may be needed to provide training and assist staff in developing these plans effectively.

- **Identify community-based mental health services to which staff can apply for work and be deployed as part of deinstitutionalization transitioning**. The plan for each institution should address both moving residents into community living and transitioning staff into community-based services. This transition should be managed safely and promptly, with decisions based on an appraisal of each staff member's work, qualifications, and background, as well as their willingness to engage in any additional training required for the role and their commitment to human rights-based and recovery-oriented practices.

Strategy 2.4.3

Create individualized support plans for each resident transitioning to the community.

Actions

- **Assess each person's need for support**. This assessment should include physical health needs, mental health support, social care, independent living skills, income generation and work, education and training, and social support. Special attention should be given to residents with complex conditions and disabilities, such as neurological, developmental, and intellectual disabilities. A knowledgeable and experienced assessment team is essential to fully understand and address these medical and social support needs whilst respecting the wishes and preferences of the person concerned.

- **Provide individuals with accessible and understandable information on all aspects of the deinstitutionalization process**. Long-term residents of institutions may struggle with the idea of deinstitutionalization, feeling overwhelmed by change and new responsibilities. It is essential to provide them with accessible and understandable information about what this process means for them, including details on social and recreational activities, health, housing, and financial support, such as social protection and disability benefits. It can be helpful to explain the changes that will occur and organize visits to the community and potential living options to ease the transition. Providing information on the various options available, the challenges that might arise, and the supports in place can give individuals a clearer sense of what their new life might look like. It is also important for staff to listen to and address individuals' specific concerns.

- **Develop an individualized plan for each person based on their active participation, support needs and choices**. Each person should actively participate in creating, developing, and reviewing their individualized plan, benefiting from supported decision-making to ensure the plan truly reflects their will and preferences. The plan should outline the person's strengths and challenges, how they envision their day-to-day life, their hopes and goals, and what they want to avoid or achieve. It should also include strategies, action steps, and the necessary support to help them reach these goals. It is important to keep friends and couples together

and offer them the option to live together in the community. Where appropriate and desired, families and other caregivers can be involved in developing the plan. They may also need support to help them effectively assist the person concerned (see Policy directive 4.1 on assessing mental health and support needs).

- **(Re-) establish and support contact with families and other caregivers and general social networks if residents leaving institutions want this**. If residents leaving institutions wish to reconnect, it is important to (re)establish and support contact with families, caregivers, and social networks. Some families may prefer institutional care due to perceived better support, financial constraints, or fear of stigma. Understanding these motivations is essential for exploring support options for reunification if both parties are interested. For example, where financial barriers exist, support could include financial assistance and care support for families who wish to be reunited. Safeguards should be in place to prevent potential abuses, especially when financial support is involved. In many cases, residents or their families may not choose to live in the same household, but families may still genuinely wish to be involved in other ways. Support could include financial assistance and care support for families who wish to engage. A supporter may also be involved throughout the deinstitutionalization process to ensure the resident's choices and rights are fully respected.

- **Assign everyone leaving institutions a focal point person to assist them through the transition process**. Assigning a focal point person to each individual leaving an institution is crucial for a smooth transition. Having a single focal point helps build a relationship, facilitates a better understanding of each person's needs, ensures continuity, and aids in coordination. Importantly, the focal point should be someone the resident chooses, or agrees to.

- **Identify, secure and document each person's living arrangements and personalised support needs**. Before transitioning into the community, it is essential to identify, secure, and document each person's living arrangements and personalized support needs. These details should be recorded in the person's plan, reflecting their will and preferences. Living arrangements should align with individual needs and desires, with options such as independent living, supported housing, shared housing, transitional housing, or family-based housing considered. Personalized support may include assistance with daily living, employment or vocational training, social integration activities, and support for accessing and navigating health, mental health, and social services, as well as medication management.

- **Conduct formal discussions with each individual and their service providers about their care plan before transitioning to the community**. These discussions should involve both formal and informal providers to ensure that appropriate services and support are in place, promoting a successful transition to the community.

Strategy 2.4.4

Repurpose suitable infrastructure, buildings and land into centres of excellence and/or community-based services for rights-based integrated care and support.

Actions

- **Identify institutions whose infrastructure, buildings and land can be repurposed**. Some of these institutions can be transformed to provide general healthcare services with integrated mental health care, while others could be developed into centres of excellence for health teaching, training, research, or community-based services offering integrated mental health care and support. Selection should consider the infrastructure's

quality, location, and accessibility to the population. Institutions with well-constructed buildings, good transport links, and that are close to active population centres may be particularly suitable for repurposing. If psychiatric hospital land is sold or rented, the proceeds should be reinvested in transforming and improving mental health care. Policies should ring-fence this value towards mental health and person-centred, rights-based approaches.

- **Develop a vision and concept paper for repurposing institutions, to ensure that plans align with needs and a human rights-based approach**. It is crucial that any repurposing of infrastructure, buildings, and land does not merely rebrand existing institutional care, such as by renaming it a centre of excellence. The focus should be on promoting a paradigm shift from the old institutional model to person-centred, rights-based community mental health services. For example, a new teaching centre could pioneer curricula that move away from traditional biomedical models, inviting stakeholders such as mental health staff, civil society organizations, OPDs, traditional and faith-based healers and leaders, and community leaders to participate. When creating a new research centre, the concept paper could outline focus areas that align mental health practices with human rights and evidence-based approaches, could detail methodologies, and identify potential collaboration partners. For integrated, human rights-based services, a concept paper could identify innovative, community-based services and outline steps for scaling them locally or nationally.

- **Appoint a multidisciplinary management and leadership team with demonstrated expertise, and core values aligned with the centre's goals and a human rights-based approach**. This team should include researchers, mental health professionals, and individuals with lived experience of using services, including people from groups that face discrimination. The team members should all have a track record of innovative thinking in mental health.

- **Create close partnerships with academic and research institutions to support research, teaching and training**. These partnerships should broadly encompass disciplines, universities, teaching and research institutions, or community networks that share aligned interests and vision. Senior management should actively engage in generating ideas and negotiating collaboration agreements. Joint research and teaching initiatives should be explored, with a focus on defining the scope, duration, funding, and responsibilities of each party involved.

- **Collaborate with innovative services and organizations to develop, provide, and evaluate a person-centred rights-based community service**. To foster new and effective services, it can be valuable to visit good practice services both nationally and internationally. Such exchange programmes offer opportunities to build skills, increase capacity, and learn from other people's experiences of setting up, implementing, and evaluating their services. These visits should extend beyond health services to include a broad range of services that support independent living, education, employment programmes, and supported living. Examples of evaluated good practice services can be found in *Guidance on community mental health services: promoting person-centred and rights-based approaches (55)*.

For practical resources related to Policy directive 2.4 Deinstitutionalization see the relevant section of the annex.

Special considerations for diverse groups
Policy area 2. Service organization and development

Children and adolescents

Continuity of care

- Integrate child and adolescent mental health care into paediatric hospitals, paediatric departments within general hospitals, and other relevant child and adolescent health services.
- Provide a full range of specialized services across the continuum of promotion, prevention and care including early childhood mental health services, parenting programmes, school-based mental health support, encompassing social emotional learning programmes, among others.

Community-based services

- Embed services for children and adolescents in schools, early childhood development and learning centres, family guidance centres, youth centres, sports facilities and other similar settings.
- Design friendly, age-appropriate and rights-based services with input from young people and families/caregivers.
- Provide peer support for young people and family members and other caregivers offering them a network of individuals with shared experiences to foster understanding, resilience, and mutual support.
- Establish safe, child-friendly spaces where young people can openly discuss how social and structural factors impact their mental health.

Accommodations for overnight stays

- For any overnight stays, accommodate children and adolescents separately from adults.
- Allow a family member or caregiver to stay with their child.

Evolving capacities

- Involve children and adolescents in healthcare decisions in line with their evolving capacity, providing age-appropriate information and supported decision-making options, and gradually reduce parental or legal guardian involvement as the young person's decision-making abilities grow.

Transition support

- Improve transitions from child to adult mental health services with better coordination and referral mechanisms within the mental health sector and across sectors, taking into account differing needs across developmental stages, with particular attention to continuity of care/relationships.

Participation

- Provide opportunities and spaces for children and adolescents that foster their meaningful inclusion and participation. They should be able to discuss issues that affect them, share their experiences, and participate in decision-making processes for service development and other areas.

Social isolation

- Provide face-to-face and online support groups for children and adolescents to reduce loneliness and encourage social connections while implementing digital literacy and online safety programmes to protect against cyberbullying and online exploitation.

Educational needs assessment

- Conduct thorough assessments of the educational needs of children and adolescents, recognizing how mental health challenges impact learning and school attendance.

Deinstitutionalization

- Advocate for deinstitutionalization by developing a communication strategy that highlights the harmful effects of institutionalization on child development and promotes family and community-based environments.
- Support family reunification with clear safety protocols in collaboration with child and youth services.
- For those unable to return to families, ensure safe, homelike alternative living arrangements such as foster families that do not recreate institutional settings.

Suicide prevention

- Provide training to assess and address suicide risks specific to adolescents, focusing on factors such as bullying (including cyberbullying), social isolation, identity challenges, academic pressures, and struggles related to gender identity and sexual orientation.
- Partner with schools and community organizations to identify and address risk factors for diverse groups and implement evidence-based, age-appropriate suicide prevention strategies, involving young people, parents/caregivers, teachers, and other key stakeholders. See *Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors* – Mental health in the education Sector *(58)*.

Maternal mental health promotion

- Address the adverse effects of maternal mental stress on children's physical growth and development of cognitive and socio-emotional skills, leading to long-term health risks, reduced life satisfaction, and increased risky behaviours into adulthood.
- Provide comprehensive mental health support for mothers during and after pregnancy, with early interventions to prevent the intergenerational transmission of poor mental health outcomes and promote healthy development in children *(142)*.

Older adults

Integrated care for older adults

- Address complex health needs by coordinating with various health services, ensuring comprehensive and continuous care for older adults.
- Develop individualized plans for older adults, particularly those who have spent most of their lives institutionalized and have lost skills. Focus on restoring abilities and addressing their unique needs.
- Incorporate physical rehabilitation and occupational therapy into care plans to help restore and maintain motor skills (which may be diminished for people living in institutions), and enhancing opportunities for community participation and potentially for reintegration into the workforce.

Specialized services

- Develop specialized mental health services tailored to older adults, including memory clinics, late-life depression programmes, and palliative care.

Overmedication and coercion prevention

- Implement protocols and training to monitor and prevent overmedication and oversedation in older adults, both in hospitals and community settings like care homes.

Suicide prevention

- Train service staff to assess and address suicide risk among older adults, especially those facing social isolation, chronic illness, or bereavement.
- Create accessible support networks, including phone and online counselling, for older adults who may have limited mobility or access to in-person services.

Social connection

- Provide community spaces or facilitated group activities where older adults can build and maintain connections offline, ensuring everyone has access to meaningful social support.
- Create diverse opportunities for social interaction that meet the needs of older adults, including in-person and phone-based options for those who may not have access to, or familiarity with, online platforms.
- Offer digital literacy and online safety training to help those interested in connecting with peers, friends, and family online, thereby enhancing confidence in digital communication.

Financial support

- Regularly review the financial needs and eligibility of older adults who are at high risk of poverty.
- Help older adults access benefits for health conditions, nursing support, and disability, as part of comprehensive mental health care.

Accessibility

- Provide older adults with homes that have accessibility features like ramps, grab rails, and adapted washing facilities.
- Facilitate easy access to healthcare services, whether older adults remain at home or are transitioning out of institutions.

Women, men and gender diverse persons

Gender-responsive safety, support, and violence prevention

- Create referral systems for those experiencing domestic or gender-based violence, connecting them with specialized support services.
- Consider developing gender-specific services, such as crisis centres.
- Provide separate spaces, sanitary areas, and sleeping rooms to accommodate diverse genders overnight. Private or gender-neutral options, such as single-occupancy rooms, can be offered to accommodate diverse preferences and privacy needs.

Gender appropriate services

- Train providers in non-stigmatizing, non-discriminatory, and gender-appropriate care for gender-diverse persons.
- Where appropriate, offer support for those undergoing gender-affirming treatments.

Prohibit coercion

- Prohibit forced admission to mental health services based on gender identity, recognizing it as a rights violation.
- Implement clear protocols to prevent such practices and ensure policies explicitly ban forced contraception for women and forced sterilization for women and gender-diverse individuals.

Support for people experiencing gender-based violence

- Establish a mechanism to refer anyone experiencing domestic violence and abuse to specialized gender-based violence services.
- Offer emergency accommodation with mental health support for victims of domestic violence.
- Consider direct cash transfers where these give people experiencing, or at risk of, gender-based violence greater control over their support.

Suicide prevention

- Build capacity to assess and address suicide risk factors. These include gender-based violence, poverty, social discrimination, employment insecurity, social isolation, and pressures related to traditional gender roles.
- Partner with women's organizations to deliver mental health and crisis counselling, prioritizing accessibility in rural and underserved areas.

Persons belonging to the LGBTIQ+ community

Prohibit coercion and conversion therapy

- Prohibit forced admission to mental health services based on sexual orientation, recognizing it as a rights violation.
- Train staff on how to prevent discriminatory treatment of LGBTIQ+ individuals in mental health settings.
- Implement policies that explicitly ban conversion therapy and other forced practices aimed at changing a person's sexual orientation.

Inclusive services

- Train providers in non-stigmatizing, non-discriminatory, and gender-appropriate care.
- Provide crisis and other support for people experiencing rejection, discrimination, or violence due to their sexual orientation or gender identity and expression.
- Provide support services in schools for adolescents questioning their sexual orientation.

Suicide prevention

- Train service staff to assess and address suicide risks specific to LGBTIQ+ people, and to promote services that are inclusive, nonjudgmental, and affirming.
- Establish anti-bullying and cyberbullying interventions in schools and communities to address harassment and provide safe spaces for LGBTIQ+ young people and adults.

Persons with disabilities

Accessibility

- Address physical barriers to mental healthcare for people with disabilities by investing in accessible equipment and ensuring accessibility in buildings (for example with elevators, ramps).
- Provide information in accessible formats so people with disabilities can give informed consent (see Box 7).
- Budget for and implement specific communication strategies, such as translation, sign language, Easy Read, Braille, as well as text-based options, video relay services, TeleTYpewriter (TTY) for phone-based services, or artificial intelligence tools.
- Train staff to respect individuals' preferences and to use these strategies to communicate effectively.

Coordinate for complex health needs

- Address the complex health needs of people with disabilities by coordinating with various health services and maintain continuity of care across different conditions and impairments.

Prohibit sterilization

- Implement policies to prohibit forced sterilization.

Reasonable accommodations

- Facilitate accessibility assessments in workplaces and schools to identify and implement necessary accommodations for individuals with disabilities.

Social connection

- Link individuals to accessible in-person social opportunities, such as different interest groups, and community meetups, to reduce loneliness and build connections.

- Connect people to accessible online social or peer groups, providing necessary software or tools for participation, along with digital literacy and safety training to enhance confidence in digital spaces.

Deinstitutionalization planning

- Include people with disabilities in deinstitutionalization plans, addressing their specific needs early.

Migrants and refugees

Overcoming language and cultural barriers

- Provide interpretation services and culturally appropriate information and care for migrants and refugees.

Integration with resettlement Services

- Integrate mental health services within broader resettlement and integration support rather than creating stand-alone services for migrants and refugees.

Access to care for undocumented migrants

- Increase access to mental health care for undocumented migrants by collaborating with local organizations and addressing administrative and practical barriers.

Suicide prevention

- Train health care and support workers to assess and address suicide risks specific to refugees and migrants, focusing on factors such as trauma, displacement, cultural adaptation, and social isolation.
- Promote services that are culturally appropriate, accessible, and responsive to these people's unique experiences.
- Collaborate with local NGOs to establish support networks for refugees experiencing social isolation, discrimination, or trauma.

Community and cultural supports

- Work with local organizations that understand migrants' and refugees' languages and cultures to provide support, especially for those without family or social networks.

Continuous care and support in camps

- Provide access to continuous mental health care and support for long term migrants and refugees living in camps, beyond immediate basic and psychological first aid and crisis management.
- Support social connection for refugees and migrants, coordinating with community organizations and resettlement services to rebuild social networks.

Social and economic integration

- Promote migrants' and refugees' full participation and inclusion in society, by connecting them with opportunities for education, employment, and community support networks.

Persons from minoritized racial and ethnic groups

Specialized services for populations experiencing racism

- Develop and integrate specialized services, such as racial and cultural identity affirmation services, trauma-informed care, and anti-racism and advocacy programmes.

Overcoming access barriers

- Implement measures to overcome system mistrust and provide financial support or health insurance.
- Build staff capacity on cultural issues and on addressing deep-rooted bias, including by recruiting therapists and other staff from minority groups.

Removing coercion and involuntary treatment

- Implement policies and protocols to eliminate coercion and monitor service provision, recognizing that racial and ethnic minorities often face higher rates of involuntary treatment *(74–76)*.

Indigenous Peoples

Indigenous services

- Recognize and incorporate Indigenous community-based services and supports by embedding traditional knowledge and practices into mental health services, fostering culturally aligned approaches to well-being.
- Promote collaboration between public mental health services and these local initiatives to enhance accessibility, trust, and alignment with Indigenous cultural values.

Specialized and culturally safe services

- Address the unique needs of Indigenous Peoples, related to historical colonization and dispossession, by providing specialized services and supports including high-quality interpretation, culturally safe care, and healing practices. Specialized care can also be integrated into existing services.

Access to a full range of services and support

- Overcome barriers in accessing housing, education, income opportunities, and disability benefits by creating local assistance hubs or mobile units staffed by individuals and peers who speak Indigenous languages and understand the culture.

Suicide prevention

- Implement culturally grounded suicide prevention strategies that incorporate Indigenous ways of knowing, healing practices, and community-driven approaches.
- Provide mental health training so community leaders, elders, and healers can recognize and support those at risk, ensuring culturally respectful and locally relevant intervention strategies.

Persons who are houseless or with unstable housing

Access to services

- Revise eligibility criteria to ensure that people who are houseless or with unstable housing are not excluded from mental health services.
- Allow flexibility for missed appointments and incorporate active outreach *(132)*.

Collaboration with local organizations

- Establish collaborative care services by working with local organizations, leveraging existing relationships in order to engage directly with people in night shelters, day centres, or on the street to improve access to care and support.

Housing prioritization

- Collaborate with other sectors to prioritize housing provision through programmes like Housing First *(131)* and Home Again *(132)*, promoting stable housing as a foundation for recovery.

Suicide prevention

- Incorporate suicide prevention strategies in all services for people who are houseless or have unstable housing.
- Provide specialized training for health staff and workers in shelters and day centres.

3

Policy Area 3: Human resource and workforce development

Key challenges

The mental health workforce faces several key challenges worldwide, influenced by varying population needs, service delivery systems, and resources *(143)*. Workforce development depends on many factors including recruitment, retention, deployment, motivation, and continuous professional development. Transitioning to person-centred, recovery-oriented, and human rights-based mental health services demands significant changes in the knowledge, skills, and attitudes of service providers (55). Governments need to address both barriers and gaps.

- **Staff shortages**. Many countries, especially low-income ones, lack sufficient mental health workers to meet population needs *(143, 144)*. Globally, the median number of mental health workers is just nine per 100,000 people, or fewer than one mental health worker for every 10,000 people, with numbers as low as one per 100,000 in some low-income countries compared to 72 per 100,000 in high-income regions *(38)*. This shortage is exacerbated by mental health workers migrating to better-paying countries, leaving nonprofessionals, including families, to fill the gap *(145, 146)*. Additionally, many mental health professionals are drawn to more attractive opportunities in the private sector, further reducing the number of professionals available in public health systems.

- **Limited and non-diverse workforce**. The mental health workforce is often both small and lacking diversity. Even in better-resourced countries, it is predominantly composed of psychiatrists, nurses, and psychologists. This narrow, health-focused approach may overlook people's wider needs within their communities. A multidisciplinary approach is necessary for a more holistic and inclusive response to mental health (see Box 3 for key actors and groups/organizations to engage).

- **Inequitable distribution of mental health workers**. The mental health workforce is predominantly concentrated in large institutional settings, leading to inequitable distribution of expertise. Mental health workers are often concentrated in urban areas, where better training, support and career opportunities exist, leaving rural and marginalized communities particularly underserved. Staffing in remote or rural areas remains a significant challenge *(147, 148)*.

- **Lack of knowledge and skills**. In many countries, mental health workers lack the necessary knowledge, skills and competencies to provide comprehensive care *(38, 143, 145)*. There is a notable lack of training in evidence-based treatment and care, preventing mental health professionals from applying the most effective interventions for diverse needs *(55)*. Some countries lack training facilities or programmes for specialist mental health workers. Moreover, available training often focuses on diagnosis and symptom reduction, neglecting the recovery approach, which emphasizes lifestyle, psychological, social, and economic interventions to address the full range of social determinants impacting mental health. Additionally, human rights training for health professionals is rare, resulting in limited awareness of service users' rights and providers' responsibilities *(149, 150)*.

- **Stigma and negative attitudes**. Mental health workers sometimes harbour stigmatizing and negative attitudes toward people with mental health conditions. This can manifest in discriminatory behaviours, such as derogatory language, assumptions about decision-making capacity, and coercive practices *(3, 41, 80, 151–155)*. Changing these attitudes and practices is crucial to improving care and overall population well-being.

- **Demoralization and staff burnout**. The general population, as well as medical students, other health professionals, and the media have a poor image of mental health work *(156)*. Many studies show that mental health professionals often feel under-appreciated, stigmatized, and discriminated against because of their profession *(157, 158)*. Several factors compound the low morale, including: low rates of pay; high workloads; role ambiguity; conflicts with families and service users; frequent use of coercive practices; and lack of resources *(159)*. These factors may discourage students from enrolling in mental health studies, or cause them to leave their mental health career, worsening staff shortages *(160–163)*.

3.1 Policy directive 3.1 A multidisciplinary workforce with task sharing, training and support

Human resources are the most valuable assets in mental health services. Developing and nurturing the workforce is key to providing responsive, high-quality care. Transitioning towards a community-based, person-centred, and rights-oriented model requires a well-resourced multidisciplinary workforce (see Box 8). Education, training, and deployment should adapt to these changing roles and tasks.

Illustrative example text

This policy directive will guide service planners in reorganizing staff roles and tasks based on a situational analysis of human resources (including staffing numbers, distribution, competencies, and skills) within existing health and mental health services. It can help reorganise staff roles and tasks according to new functions and approaches being introduced. Psychiatrists, doctors, psychologists, nurses, social workers, and other staff will be trained for their new roles, with core training in alternatives to coercion, recovery approaches, and key techniques like advance directives and supported decision-making. These changes will broaden access to specialist competencies and ensure high standards of care for all.

Education and training will expand, including in-service training and opportunities for study abroad, where necessary. College and university courses will be updated to meet new standards and continuing professional development (CPD) will be available to maintain staff skills over time. A mix of in-person and online training will increase accessibility and reach.

Multidisciplinary teams will allow skill sharing at local levels and create opportunities for close supervision, mentoring, and for disseminating specialist knowledge. Specialists will provide formal supervision and support to ensure that consistently high service standards are maintained. These services will be formally assessed for quality and effectiveness at regular intervals.

Committees supporting this policy directive, such as those analyzing human resources or overseeing recruitment and retention, curricula and training, will include experts from marginalized groups, including people with lived experience. This ensures the workforce is responsive to the needs and challenges of those facing discrimination.

Box 8. Staff that can make up a multidisciplinary workforce

Core mental healthcare workers can include: psychiatrists; nurses; medical doctors; psychologists; peer supporters and workers; social workers; community health workers; occupational therapists; counsellors; clinical staff; and community volunteers.

In addition, other important roles within a multidisciplinary approach include: other health professionals such as nutritionists, physiotherapists, and dentists; neurologists; pharmacists; employment and education specialists; physical activity trainers and sports coaches; art and music therapists; speech therapists; legal advisers; traditional and faith-based leaders or healers

Families and other caregivers are crucial resources for supporting people, and it is important that they receive appropriate training and support to fulfil this role (see Strategy 2.3.5 on engaging with families and other informal care workers). However, they are not part of the formal support system, unless they have been engaged as family/caregiver peer supporters (see Strategy 2.1.4 on creating and expanding rights-based peer support services).

A multidisciplinary team can be based across the public, private, NGO or OPD sectors.

Strategy 3.1.1

Leverage regulatory and administrative processes to introduce role and task sharing.

Actions

- **Achieve consensus among professional groups, policy-makers and administrators on role changes and task sharing needed to strengthen mental health services and support**. In this context, task sharing means sharing responsibilities for a mental health task in a way that strengthens interventions and support through a multidisciplinary workforce (see Box 8). It does not involve abdicating responsibility for any task. Task sharing may be implemented differently across varying settings and countries (see the discussion below). During the consensus-building process, it is valuable to consider how task sharing can meet service needs without overburdening staff with increased workload, while also ensuring that quality of care is not compromised.

- **Use current or newly revised regulatory tools (laws and proclamations, rules and regulations, policies) to enable staff to practice their redefined roles**. For example, it may be necessary to redefine regulations to establish a new cadre of worker, or to allow staff other than medical doctors to prescribe medication, or allow professionals beyond psychologists to provide psychological interventions. Depending on the setting, it may be necessary to redefine conditions for insurance reimbursements or similar to allow for these new roles (see Strategy 1.2.2 on reorientating funding and insurance schemes). A fast-track strategy should be considered to allow quick implementation, while pursuing longer-term measures within a comprehensive and nationally endorsed regulatory framework.

- **Create job descriptions that align with new roles, responsibilities, and tasks**. Job descriptions should set the foundation for recruiting and retaining people, and should clarify the job purpose, duties, and responsibilities. They might cover tasks to be performed, such as delivering lifestyle, psychological, or social

and economic interventions. They might specify the type of contact with service users, family members and other individuals in the community; and the level of supervision provided or to be provided to others. Job descriptions record the role's required qualifications. These might include degrees/certifications on peer support or culturally appropriate and trauma informed care, and knowledge and competencies on human rights or interventions to tackle social and structural determinants of mental health. Job descriptions may specify how many years of experience is expected. They may also specify expected results, mechanisms for evaluating performance, and the role's working conditions (for example, specifying outreach work in the community rather than work on a hospital ward, or changes from having fixed hours to joining an on-call rota).

- **Create or modify certification/accreditation/licensing mechanisms for newly created staff roles**. Certification is needed to ensure quality. New roles, such as peer support workers, community health volunteers, or liaison staff, may need a new or modified certification mechanism. Mechanisms should be based on standardized competency assessments to ensure that all staff are competent in their role and tasks. It is important to note that requiring formal education or degrees may restrict recruitment, especially for those with limited educational opportunities. Peer workers' expertise, and also their roles, are based on lived experience. Certification should avoid burdening them with protocols or regulations that are only appropriate for medical roles.

- **Prepare and implement continuing professional development (CPD) schemes**. CPD schemes can help thoroughly evaluate staff competencies, can consolidate existing skills, develop new ones, and keep staff up to date with new developments in mental health. CPD should be a key pre-requisite for holding and maintaining a professional licence. CPD scheme design requires careful attention to the menu of training opportunities, the format of training programmes, the type of assessments/evaluations, and how often staff are expected to undertake training.

SPOTLIGHT on role and task sharing

Role and task sharing can transform mental health services by redistributing work across professional levels. For example, prescription management tasks can be delegated from doctors to specially trained nurses. This is especially helpful in regions with limited specialist staff or recruitment challenges.

Services can be reshaped alongside role and task sharing. For example, staff can transition from institutions to community-based settings. Roles can be realigned to deliver person-centred, rights-based, and recovery-oriented care by introducing new practices for all staff, such as using recovery plans and advance directives.

New cadres of staff can be created through role and task sharing. New mental health nurses, peer support specialists, and community mental health workers can bring fresh perspectives to transforming services. The effectiveness of this approach may vary across regions and countries, proving particularly beneficial in rural or resource-poor settings facing staff shortages. But it should not be viewed as a cost-saving measure. Instead, it is a means of optimizing expertise and skills, enabling specialists to focus on more complex cases. Any costs saved should be redeployed: continued investment in mental health services is essential to achieving parity with physical health.

Anticipating resistance is crucial, particularly from professions that may see task sharing as a challenge to their traditional authority. Therefore, it is important to present task sharing as a way to enhance care quality, ensuring that new roles are clearly defined, inclusive, and contribute to a more collaborative and integrated approach to mental health services.

Strategy 3.1.2

Implement staff training initiatives across and within services.

Actions

- **Identify (re)training requirements for services**. Training or retraining may be required for staff across both mental health, general health and specialized health services (See Policy directive 2.1 on coordinated rights-based community mental health services) with training needs depending on the specific context. For example, all service staff may need to be trained on evidence-based mental health care, as well as on the person-centred, rights-based, and recovery approach, particularly if there has been a policy shift in this direction and they have not been previously taught these concepts. Non-specialized staff may also require additional foundational and clinical training in mental health. Additionally, staff from other services may require more focused training in areas such as trauma-informed care, gender-based violence support, disability inclusion, cultural sensitivity, addressing stigma, discrimination unconscious biases and micro-aggressions, as well as in specific lifestyle and physical health, psychological, social, economic, and drug-based interventions. A variety of tools are available from WHO to assist with the training (see the annex for practical resources for developing a multidisciplinary workforce).

- **Schedule in-person and online training and assemble a diverse training team**. This team should have wide-ranging skills and knowledge, including individuals with lived experience of mental health conditions, representatives from groups that face discrimination, staff from local education institutions or universities, clinical experts, and human rights experts. Online courses with remote support and supervision or hybrid models combining in-person and online training can offer flexibility, reduce travel and time commitments, and maximize reach, enabling large-scale impact *(115, 164)*.

- **Set-up a training mechanism within each service**. This mechanism should be formalized to facilitate efficient training for both existing and new staff and should manage long-term ongoing training.

- **Seek collaborations outside the country to access and provide quality training**. When in-country training is unavailable and short-term development is not feasible, it is useful to form partnerships with universities, mental health services, and research institutions in other countries, as well as with international organizations and professional bodies with the required expertise. Identifying and collaborating with suitable partners can help ensure access to high-quality, specialized training. Collaboration agreements can outline the programme's duration, funding, and responsibilities of each party to ensure clarity and sustainable impact.

Strategy 3.1.3

Establish supervision and support for staff working within mental health and other health services.

Actions

- **Identify and enable supervisory staff for each service or group of services**. Supervisory staff should have clinical experience in mental health, should be knowledgeable about rights-based approaches; and, where possible, should have lived experience of mental health conditions or psychosocial disability. They may be recruited from any staff category, as long as they have the requisite skills. Revising terms of reference to make supervision a core responsibility with dedicated time allocation can prevent it from being seen as an extra burden or chargeable service.

- **Train supervisors**. Training should equip supervisors to provide ongoing quality control for clinical skills and human rights practices. Supervisors should be trained to provide feedback to staff in a non-judgmental atmosphere and supervision model/mechanisms. How supervisors operate should be flexible and should respond to feedback from staff.

- **Create one-to-one and group supervision mechanisms**. Effective supervision involves a mutual exchange of expertise between supervisor and supervisee, offering a confidential space for reflection, learning, and addressing clinical and human rights dilemmas in everyday practice. Key topics include user-staff relationships, challenging scenarios, ethical dilemmas, the personal impact of mental health work and reflective practice to allow staff to critically examine their experiences and actions to improve their skills and service delivery. Staff taking on new roles and task-sharing responsibilities require tailored supervision from trained specialists who previously held sole responsibility for these tasks. Supervision may start frequently but can be reduced as staff gain competence and confidence. Group supervision can convene supervisees from diverse roles, combining skills training with role-play and feedback from group members.

- **Use referral pathways to improve staff knowledge and skills**. Referral pathways can be leveraged to enhance staff knowledge and skills. Staff from specialist services who receive referrals can offer valuable advice on supporting service users, which can then be integrated into the practices of the referring service.

REFLECTION on twinning. Twinning is a supervision approach that can be useful in humanitarian emergencies. Newly arrived mental health professionals work under the supervision of local professionals, sometimes after additional training. This collaboration helps manage the influx of new arrivals, maximizes the effectiveness of trained staff, and provides culturally appropriate support to refugees in their own language. Twinning can also be worth considering at the service level, pairing a mental health service experienced in emergencies with another to share expertise and improve services. When implementing twinning, it is important to factor in the cost and time required for supervision and case discussions.

For practical resources related to Policy directive 3.1 A multidisciplinary workforce with task sharing, training and support see the relevant section of the annex.

3.2 Policy directive 3.2 Recruitment, retention and staff well-being

Recruiting and retaining skilled staff are essential for a sustainable, effective, and responsive mental health system, including during the transition to community-based services. This policy directive prioritizes recruiting and retaining staff across disciplines to meet the growing demand for holistic, person-centred, rights-based, and recovery-oriented care. It addresses the significant shortage of specialist mental health workers in many countries, many of whom have left their home countries for better opportunities.

Illustrative example text

Diversity and equality will be central to recruitment drives, allowing for more culturally appropriate services. Recruitment will extend beyond traditional medical professions to include social workers, occupational therapists, peer supporters, and allied professionals among others. Retention strategies will focus on providing good working conditions, fair pay, and equitable treatment regardless of gender, disability, race, or other identities. Staff from mental health institutions will have opportunities for retraining and reassignment to community-based services, while new recruits will join new or expanded community-based services.

Strategy 3.2.1

Recruit staff from a broad array of disciplines and ensure diversity.

Actions

- **Develop a recruitment strategy and budget to diversify the workforce and fulfil recruitment requirements**. The mental health workforce should encompass a broad range of professions (see the *Which human resources?* band within Fig. 2). It is important not to rely solely on traditional roles like nursing, psychology, and psychiatry, but also to include and reflect the diversity of service users and the broader community, including groups that face discrimination. A mental health service that mirrors the local community's diversity — across age, gender, disability, race, religion, and more, including groups that face discrimination — improves the quality of care by making it more welcoming and culturally appropriate. Identifying under-represented groups and implementing effective diversity policies and reasonable accommodation measures at all employment levels is essential for improving recruitment in the mental health sector. This can be facilitated by including positive, non-discriminatory messages about mental health and mental health services in recruitment materials and offering good working conditions. However, initial research may be needed to pinpoint where and why diversity is lacking.

- **Collaborate with universities, training institutions, government bodies and professional organizations to encourage diverse student enrolment**. To achieve diversity in the mental health workforce, it is crucial to have a diverse student population in undergraduate and graduate programmes. Collaboration with universities, colleges, and government bodies is essential to encourage and incentivize students from diverse backgrounds to enrol in these courses. This includes promoting diversity based on culture and ethnicity, socioeconomic status, gender, geography, disability, language, and age.

- .**Standardize recruitment processes and requirements to ensure quality and accountability**. This is crucial. It can involve implementing centralized interview processes that may include exams, establishing trial and training periods supported by competency-based assessments, and conducting background or criminal record checks. A formal application and interview process is central to achieving quality recruitment. Additionally, involving people with lived experience of mental health conditions or psychosocial disabilities throughout the recruitment process from planning to active recruitment is essential.

KEY POINT: international recruitment is a poor long-term solution for skill shortages. Skill shortages are common, often due to a limited pool of skilled professionals, a lack of local education in relevant areas, and scarce further education opportunities. Many graduates relocate for better pay and conditions, exacerbating these shortages. While international recruitment can provide a short-term fix, it can also contribute to the brain drain from lower-resource settings. A more sustainable long-term strategy is to move towards self-sufficiency by aiming to recruit a specific percentage of staff from local training programmes within a set number of years.

Strategy 3.2.2

Distribute staff equitably across the country.

Actions

- **Establish dialogues to explore solutions for the challenges in recruiting and retaining staff in less popular and rural areas**. Recruiting and retaining staff is challenging, particularly as large urban areas with access to universities and diverse health services are more attractive, leaving rural regions struggling with recruitment. Professionals trained in urban areas often prefer to stay there due to concerns about isolation, heavy workloads, limited resources, fewer amenities, and their partners' employment prospects in rural areas. To address these challenges, engaging in dialogues with government bodies, professional organizations, and training institutes is crucial for generating ideas, developing strategies, and creating targeted recruitment efforts. For example, providing training opportunities in rural areas can help professionals feel valued and connected to these communities, increasing their likelihood of practicing in rural settings long-term *(165)*.

- **Develop flexible job roles that attract specialist staff to hard-to-fill positions**. Specialized services, like child and youth mental health, or mental health services for older people, are often concentrated in urban centres. To improve their provision in rural or less popular areas, incentives are needed. City-based jobs could include requirements for regular visits to regional settings. Workplace flexibility policies might allow employees to split their time between urban and rural locations or enable skilled personnel to supervise rural areas online. Digital tools like video conferencing can help distribute expertise more evenly, bringing specialized skills to rural areas but their use should be aligned with global standards around the accessibility of digital health *(111, 112)*.

- **Offer professional, personal, and economic incentives for working in underserved regions**. Incentives include grants, increased starting salaries, or tuition fee reimbursements for newly qualified staff taking on roles in less popular areas. Base pay could be raised in these regions, or a tax incentive might be provided. Working in under-served areas could also count as credit towards career progression. Mentoring schemes could help mitigate the perceived risk of professional isolation. Additionally, mental health services could help partners find work, cover relocation costs, and provide help with housing. Extended parental leave, free childcare, or additional vacation time are other possibilities. Alternatively, a period of work in rural areas could be made a mandatory requirement for new graduates entering the national service.

- **Collaborate with universities and institutes for higher training to develop regional training schemes close to where mental health services are provided**. National mental health training schemes for nurses, medical doctors, psychologists, social workers, and allied professionals are often concentrated in large urban areas. To address this, it is crucial to collaborate with universities and higher training institutes to redistribute training schemes or offer placements across all regions. For example, satellite campuses could be established. This approach will help facilitate recruitment and retention of staff in more remote areas over the long term.

KEY POINT: private sector staff can also be encouraged to work in under-served areas. In countries where the mental health workforce is predominantly in the private sector, distributing staff equitably across regions presents particular challenges. Private sector employees may have fewer incentives or obligations to work in under-served or rural areas. Addressing this requires targeted policies and partnerships with private institutions, along with incentives that encourage private sector staff to engage with public or rural services.

Strategy 3.2.3

Foster a positive and inclusive work environment, with equitable pay and conditions, and measures to promote staff mental health and well-being.

Actions

- **Create and implement a charter outlining the working conditions and support that staff can expect**. Poor working conditions, low salaries, and experiences of discrimination hinder staff retention and care quality. A charter could outline the right to safe working environments and the right to self-organize into unions. It could establish rights to paid holidays, sick leave, sufficient breaks, written employment contracts, access to training and professional development, and high-quality ongoing supervision. Additionally, the charter can promote staff engagement in activities that maintain their physical and emotional well-being by providing access to self-care training and mental health and emotional support programmes, such as Employee Assistance Programmes (EAPs). It can include provisions for work-life balance, such as flexible working hours, regular breaks, and limiting after-hours communication. To foster a family-friendly workplace, the charter can include options for job sharing, part-time roles, extended maternity, paternity, and parental leave, and dedicated spaces for breastfeeding, along with flexible arrangements for those caring for family members, including children, older adults, and individuals with disabilities. To recruit and retain professionals with disabilities, including mental health conditions and psychosocial disabilities, the charter can include provisions for reasonable accommodations *(166, 167)*. See *Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors (58)*. See also Strategy 3.2.2 on distributing staff equitably across the country.

- **Implement transparent and equitable pay scales as well as career progression pathways for all staff**. Pay and progression should be based on levels of expertise, experience and responsibility, regardless of gender, disability, or any other personal or social attributes.

- **Implement transparent and equitable staff performance incentives**. These could include financial and/or non-financial incentives, performance-based incentives or other ways to encourage (re)training and to reward enhanced performance of roles and responsibilities.

- **Implement transparent and fair complaints mechanisms to deal with workplace harassment and disputes**. These should include mechanisms to report discrimination based on characteristics that are part of (or are perceived as part of) staff identify and/or status. The complaints procedure should be independent. For example, it might appoint external parties to review and address the complaints. It should be transparent: the process should be clearly explained to all people involved, and everyone should be kept informed. Complaints procedures should also be accessible to everyone. This may require language translations and information provided in different formats. Processes should be fair both for the person complaining and the person complained about. Information should be kept confidential within the complaints process, and the process should be efficient and timely.

- **Provide access to mental health care and support for service staff, including frontline workers**. All staff, especially frontline workers like ambulance staff and those in humanitarian contexts, face significant stress and pressure. Training in self-care, stress management, and positive coping strategies is essential for their well-being. They should also be able to access mental health services and support when needed *(168)*.

For practical resources related to Policy directive 3.2 Recruitment, retention and staff well-being see the relevant section of the annex.

3.3 Policy directive 3.3 Competency-based curricula for mental health

Health curricula at college and university level lay the foundation for all staff working in the mental health field, equipping them with the knowledge, skills, and competencies for evidence-based, rights-based, and recovery-oriented practice. These curricula are vital for eliminating discriminatory attitudes and practices toward people with mental health conditions and psychosocial disabilities.

Illustrative example text

University and college curricula for mental health will be grounded in the core competencies required for person-centred, rights-based, and recovery-oriented services. To deliver a truly inclusive education, curricula will be co-produced by experts with lived experience alongside clinical and academic professionals. Graduates will be competent in understanding psychosocial disability and mental health, and in delivering human rights standards, recovery, advanced communication skills, culturally appropriate approaches and non-coercive practices. Those responsible for psychological, social, or economic interventions, or prescribing psychotropic drugs, will receive more in-depth training.

Strategy 3.3.1

Develop or adapt core competency-based curricula for mental health.

Actions

- **Convene stakeholders and get consensus for change**. Political support from the education and health departments, as well as from educational institutions, is crucial for the long-term success and rollout of new mental health curricula. It is important to convene government representatives, professional bodies, universities, further and higher education facilities, service user organizations, and experts in human rights and recovery to build a broad consensus for change before developing new curricula.

- **Establish working groups responsible for developing or adapting curricula based on core and on specialist competencies in mental health**. The working group should comprise stakeholders who can contribute to different elements of the curriculum development including education professionals from training colleges and universities, clinical mental health practitioners, people from NGOs, OPDs, and people with lived experience of mental health conditions (including people from groups that face discrimination).

- **Evaluate, update, or develop curricula for mental health**. A first step in improving mental health curricula is to identify the strengths and gaps in existing programmes and teaching methods. This evaluation should include formal assessments of curricula and staff, along with feedback gathered from group discussions and questionnaires from both staff and students. These findings will guide working groups in drafting new curricula tailored to the specific needs of each mental health profession, clearly defining core and specialized competencies for roles such as psychiatrists, nurses, doctors, psychologists, peer supporters, social workers, community health workers, occupational therapists, counsellors, clinical officers, and community volunteers. Additionally, curricula should be developed for roles outside the mental health sector, such as school counsellors (see *Guidance on policy directives and strategic actions to promote and protect mental health and well-being across government sectors (58)*). Curricula should explicitly link competencies with learning activities and outcomes. The design process should involve experts from relevant fields, academic institutions, individuals with lived experience, and representatives from marginalized groups, ensuring that curricula are comprehensive and equitable (see Box 9 for key topics that could be covered). Using digital technologies to enhance learning should be considered, as these can expand opportunities. However, the importance of in-person training, supervision, and real-world experience should be maintained. The WHO EQUIP platform can serve as a valuable resource in this process, offering tools and guidance on competency-based curriculum development to ensure high-quality, standardized training across settings.

KEY POINT: students need broad perspectives. Curricula should expose students to diverse viewpoints and emphasize critical thinking. Training placements should be in varied community services, not just psychiatric institutions, or hospital-based services.

- **Create a framework for assessing students and trainees across various professions**. Create a framework for regularly and consistently assessing students and trainees across various professions. Assessments should encompass written exams, interview-based evaluations, and structured observations of clinical and communication skills. Evaluations should also examine the practical application of recovery-oriented and human rights-based approaches, including de-escalation techniques, supported decision-making, and planning. People from marginalized groups are often at a disadvantage in exams due to various biases, such as language barriers, promotion of dominant values, and bias in exam questions or from examiners. Identifying and overcoming these biases is crucial, such as by including diverse examiners and developing assessments with input from diverse groups.

- **Regularly convene the working groups to review progress**. Regularly convene the working groups to review progress. These meetings not only provide essential technical input for curriculum development but also foster ongoing ownership, engagement, and commitment to the new curricula.

Box 9. Topics to cover in curricula on mental health

Curricula should be customized, considering the specific roles and tasks of each profession. These are some essential topics.

- **Human rights, community inclusion and recovery approaches**. Using human rights frameworks to underpin care and support, including to combat stigma and discrimination, eliminate coercive practices, ensure respect for legal capacity, and meet the needs of people with disabilities.
- **Comprehensive assessment of mental health support needs**. Undertaking and understanding diagnosis, and identifying individuals' specific needs across various life areas to provide appropriate support, to enhance quality of life, and to promote community inclusion (see Strategy 4.1.1 on developing frameworks for assessing mental health needs).
- **Physical health, lifestyle, psychological, social, and economic interventions**. Understanding how to deliver and refer people to a range of interventions that are evidence- and rights-based in order to provide a comprehensive approach to addressing mental health.
- **Drug interventions**. Including safe prescribing, use, discontinuation, and management of withdrawal and adverse effects.
- **Public health issues**. Addressing public health policy, service organization, epidemiology, statistics, and coordination with government and other stakeholders, including the voluntary and private sectors.
- **Understanding and responding to the social and structural determinants of mental health in clinical and community settings**. These determinants include: stigma and discrimination; exclusion; marginalization; poverty; gender (for example, inequality and harmful gender norms); lack or lower levels of education; unemployment; housing instability; food insecurity; health emergencies; climate change; pollution; humanitarian crises; forced displacement and migration; violence and abuse; and loneliness and social isolation.
- **Culturally appropriate approaches**. Understanding diverse cultural backgrounds and mental health conceptions, and training students to engage inclusively with diverse populations.
- **Responding to the needs of diverse groups including those that face discrimination**. Understanding the needs of groups facing discrimination, the impact of factors like age, gender, sexual orientation, disability, immigration status, race, and ethnicity on mental health and best practices for addressing discrimination.
- **Responding to emergencies**. Addressing mental health aspects of health emergencies, humanitarian crises, and natural hazards.
- **Mental health and development issues across the lifespan**. Understanding and responding to prenatal influences, childhood and adolescence through to adulthood, and older age.
- **Participatory approache**s. Collaborating with people who have lived experience, families, professionals from different sectors, and other relevant groups in order to value and capitalize on stakeholders' knowledge and expertise.
- **Interpersonal skills**. Developing qualities such as empathy, warmth, and genuineness to build trust and foster effective supportive relationships.
- **Leadership and management**. Developing skills for effective team and resource management, policy and strategic planning, and advocacy to lead mental health services that are collaborative, inclusive, and responsive to community needs.

Strategy 3.3.2

Implement competency-based curricula for mental health.

Actions

- **Establish an action plan with milestones and timeframes for implementing new curricula for mental health**. This plan should result from ongoing dialogue and collaboration between national committees and working groups overseeing the curricula and ministries of health and education.

- **Train staff from each academic institution in new curricula**. Academic teaching staff, clinical supervisors, assessors, and clinical professionals will need training. It is also crucial for those developing curricula to plan how to update colleagues who may not have been closely involved in the process. Engaging individuals with lived experience in delivering curricula is essential. They can co-deliver content, participate in teaching sessions, and share testimonials, thereby enriching the learning experience for students and trainees.

- **Launch an information and marketing campaign for new curricula**. Multimedia information campaigns about new curricula are crucial for raising awareness among professional groups. These campaigns can also signal broader shifts in mental health approaches and foster conversations among professionals and the public about moving away from outdated and discriminatory practices in mental health and psychosocial disability. Information should be provided in accessible formats, including translations, Easy Read versions, and documents for screen readers. Additionally, marketing efforts should extend to rural and isolated areas to ensure comprehensive outreach.

- **Hold an official launch of new mental health curricula well before the academic year in which they will be implemented**. This advance notice is crucial to allow academic institutions ample time to prepare for delivering the new materials. The launch serves as an opportunity to raise awareness and generate positive publicity among administrators, educators, students (including school-leavers), mental health professionals, the media, and other stakeholders.

- **Identify and solve problems in the rollout and implementation**. A formal review into successes and challenges connected to new curricula should take place immediately after the first delivery cycle. It should be evidence based and independent of the initial committee and stakeholders that developed the curricula.

For practical resources related to Policy directive 3.3 Competency-based curricula for mental health see the relevant section of the annex.

Special considerations for diverse groups
Policy area 3. Human resource and workforce development

Children and adolescents

Support for young caregivers

- Train staff to recognize and support children and adolescents who are in caregiver roles, addressing their unique challenges and ensuring their well-being.

Training on child and adolescent development

- Educate staff across within the health sector (for example, paediatricians, family doctors, nurses, psychologists amongst others) and across other sectors (education, child protection and justice among others) on child development, including attachment theory and family dynamics, so they understand how stress manifests in children.
- Train staff to identify and support victims of abuse and violence, including understanding their responsibilities for reporting, safeguarding and providing support.
- Avoid pathologizing children. This often occurs when signs of abuse are mistaken for mental health conditions.

Multidisciplinary MHPSS workforce in humanitarian contexts

- Develop and implement strategies for sustained investment in building and supporting a skilled multidisciplinary MHPSS workforce, focusing on the diverse mental health needs of children and adolescents and ensuring accessibility across all communities.

Older adults

Coordinated care roles

- Create liaison roles to bridge physical and mental health services, ensuring comprehensive care for older people with complex health needs.

End-of-life care training

- Include training on end-of-life care, understanding and supporting goals in late life stages, promoting hope and working with families.

Inclusive recruitment and retention

- Open recruitment to older workers, offering part-time or reduced hours.
- Retain and utilize older staff for their expertise and involve them in training or supervision roles to capitalize on their wealth of experience.

Women, men and gender diverse persons

Workforce retention and support

- Create family-friendly workplaces by offering job sharing, extended maternity, paternity and parental leave, part-time roles, nurseries and spaces for breastfeeding and sick leave for severe period pain.
- Promote gender-sensitive mental health support with specialized resources and peer networks tailored for women, men, and gender-diverse staff.
- Ensure equitable access to career advancement by offering mentorship programmes and addressing unconscious bias in promotions and performance evaluations across all genders.

Persons belonging to the LGBTIQ+ community

Specialized roles and task sharing

- Develop roles in child and adolescent mental health teams to specifically support young LGBTIQ+ people, addressing their higher rates of specific mental health challenges.

Workplace Inclusivity

- Create service environments in which LGBTIQ+ staff can openly express their identity without risk of stigma or discrimination.
- Conduct workplace diversity training and anti-discrimination campaigns to foster a supportive environment.

Persons with disabilities

Inclusive hiring practices

- Work with professional bodies to prevent accreditation or licensing requirements excluding people with disabilities.
- Provide accommodations for people with disabilities during recruitment processes, providing necessary assistive devices, Augmentative and Alternative Communication or sign language, or extended time for assessments.

Workplace accessibility

- Assess and implement reasonable accommodations for accessibility, such as communication devices, accessible equipment, and modifications to buildings and physical spaces, to enable employees with disabilities to perform their work on an equal basis with others.

Disability inclusion training

- Incorporate comprehensive training on disability inclusion for health and care workers, ensuring staff understand how to support colleagues with disabilities.

Migrants and refugees

Creating new roles and training

- Create new roles to address the specific mental health needs of migrants and refugees.
- Train staff in trauma-informed care and culturally appropriate practices, addressing issues like loss of home, identity, and family, impact of injuries and financial uncertainty.

Persons from minoritized racial and ethnic groups

Addressing institutional racism

- Provide training to challenge racial and cultural biases, educating staff on the experiences of minoritized groups.
- Connect health professionals with community organizations and leaders to enhance cultural understanding and collaboration.

Recognizing and addressing discrimination

- Train health professionals to identify and explore internalized racism using tools like the EveryDay Discrimination Scale *(169)* to improve care.
- Educate staff on how racial discrimination can cause psychological distress and lead to misdiagnoses.
- Train staff to recognize and address these situations, avoiding pathologizing normal responses to discrimination.

Indigenous Peoples

Recruitment and retention in remote areas

- Offer economic and professional incentives to attract specialist staff, including from Indigenous communities, to work in remote areas where mental health services are limited.

Inclusive recruitment

- Address barriers Indigenous Peoples face during recruitment, such as language difficulties, lack of job opportunity information, biased recruitment committees.

Cultural competence training

- Train health professionals to provide culturally safe interventions and treatments, with an understanding of Indigenous Peoples' spiritual and traditional values, ensuring respectful and effective care.

Persons who are houseless or with unstable housing

Hiring peer advocates

- Employ peer advocates with lived experience to conduct active outreach and build trust with people who are houseless, thereby facilitating better engagement and support.

Training for health professionals in mainstream and specialized services

- Educate staff on engaging people who are houseless or who have unstable housing, providing trauma-informed care, and addressing housing insecurity.
- Assist with housing searches and relevant home modifications.

4

Policy Area 4: Person-centred, recovery-oriented and rights-based assessment, interventions and support

Key challenges

Mental health care needs redirecting towards a person-centred, recovery-oriented, and rights-based approach that includes non-pharmacological options (which are crucial for mental well-being). Assessments and interventions should be high-quality, acceptable, available, and accessible to all *(170)*. It is essential that these are discussed with the individual involved, including potential benefits, limitations, and risks. Ultimately, the assessment, intervention and support should always align with the individual's will, preferences, and informed consent *(171)*. The following are some of the main barriers and gaps.

- **The lack of recovery-oriented and person-centred focus for assessing mental health and support needs**. Current assessment tools and practices focus mainly on identifying problems and symptoms and evaluating decision-making capacity, rather than addressing a person's comprehensive psychological, social, and economic needs. They are neither comprehensive nor effective *(172, 173)*. Mental health assessments should address the full spectrum of an individual's needs, including psychological, social, and economic factors. They should focus on how the person can be supported in various aspects of their life, rather than just formally diagnosing or trying to fix perceived conditions. It is essential to consider the individual's and community's strengths, successes, resources, goals and hopes to create a holistic and supportive care plan *(172, 174)*.

- **Over-reliance on biomedical approaches to mental health care and support**. Worldwide, mental health services primarily rely on psychotropic drugs and biomedical interventions *(89)*. Although these can be important for recovery, there is an overemphasis on them, and studies have raised major concerns about the over reliance on psychotropic drugs and problematic aspects including: incomplete information on adverse effects (including the serious withdrawal syndrome that can occur when some people stop taking psychotropic drugs) *(175–178)*; potential drug interactions where people are taking many medicines (polypharmacy) *(179, 180)*; lack of safe monitoring, and prescription without informed consent *(30, 31, 89)*; and high prescription rates *(2, 181, 182)*; amongst others. Services should prescribe psychotropic drugs cautiously, support safe tapering, and provide effective lifestyle, physical, psychological, social, and economic interventions to improve mental well-being *(183–188)*.

- **Poor and unreliable access to interventions and support**. Many countries struggle to provide consistent access to psychological, social, and economic interventions as well as physical health and lifestyle interventions due to limited funding, insufficient trained staff, and limitations in cross-sector collaboration needed to tackle macro-level social challenges and inequities *(3, 96, 189–196)*. Even access to psychotropic drugs can be unreliable due to costs, supply chain issues, and centralization of supplies in specialist settings *(3, 51, 197)*.

- **Lack of training in holistic mental health care and support**. Reflecting the above challenges, training for mental health professionals also often prioritizes diagnosis and drug prescribing, neglecting the comprehensive assessment of psychological, social, and economic needs *(2, 55, 89)*. This narrow focus leads to gaps in the knowledge, skills, and competencies required for non-drug interventions and safe medication tapering, leaving professionals ill-equipped to address the broader aspects of mental health care *(55, 172, 189)*.

4.1 Policy directive 4.1 Assessment of mental health and support needs by multidisciplinary teams

Mental health assessment and diagnosis traditionally drives treatment approaches within services, often focusing on medication to reduce symptoms and, when available, therapy such as counselling, which often emphasizes insight into diagnosis and compliance with taking medications. Assessments should be reframed to adopt a holistic approach that considers the full range of people's support needs.

Illustrative example text

This policy directive shifts from the biomedical model to a holistic, person-centred, recovery-oriented, and rights-based approach, with informed consent and the person's right to decide at its core. A new framework will be established for assessing people with mental health conditions and distress, focusing on their support needs and challenges. Assessments will adopt a strengths-based approach, focusing on individuals' abilities, skills, and resources rather than just their challenges. They will prioritize important life areas such as relationships, work, education, housing, and community inclusion while also evaluating any discrimination or barriers people may face. The framework will avoid pathologizing and over-medicalizing mental health conditions and distress.

Strategy 4.1.1

Develop a person-centred, recovery-oriented and rights-based framework and guidelines for assessing mental health and support needs.

Actions

- **Re-evaluate and broaden the approach to assessing mental health**. Current mental health assessments primarily focus on symptoms and diagnosis, using standardized guidelines like ICD-11 *(198)* and DSM-V *(199)*, along with tools such as MINI *(200)*and SCID I/II *(201)*, which are integral to health insurance and disability schemes. However, in advancing a rights-based recovery framework, it is essential to move beyond diagnosis and symptom reduction to a more comprehensive assessment of individuals' support needs.

- **Identify the areas and items to assess and draft the guidelines**. Multiple domains should be considered to ensure a person-centred, rights-based approach in assessing mental health support needs. These domains include, but are not limited to, those listed in Box 10. The assessment framework and guidelines should also incorporate a culturally appropriate, trauma-informed and gender-responsive approach that acknowledges the challenges individuals face but emphasizes each person's strengths rather than focusing solely on their difficulties. Since support-based mental health assessments are relatively new, it may be beneficial to review and adapt successful models from other countries, especially when local examples are scarce.

- **Consult with all stakeholder groups and conduct pilot studies to finalize the assessment framework and guidelines**. Consultations should include both in-person and written feedback to ensure full engagement from all groups, including people with lived experience of mental health conditions, groups that face discrimination, their respective organizations, families, other supporters, and relevant professional groups.

KEY POINT: support needs are not static. Support needs change throughout recovery, varying widely between crises and stability. So assessment guidelines should ensure comprehensive reviews after interventions to see if adjustments are needed or if support is no longer required.

Box 10. Domains to cover when assessing mental health and support needs

Assessments should cover:

- physical health and lifestyle;
- mental health, emotional well-being and coping mechanisms;
- meeting basic needs (for example, food, clothing, hygiene);
- relationships, family, and social networks (including social isolation and loneliness);
- other social and structural determinants (see Box 1);
- community inclusion and access to community services and support;
- exercise of legal capacity;
- diagnosis, suicide risk or attempts, and how the person frames their mental health issues; and
- the person's will and preference for receiving treatment, care and support.

Strategy 4.1.2

Implement the newly developed framework and guidelines for assessing mental health and support needs.

Actions

- **Develop multidisciplinary training on the new assessment framework and guidelines for all health and social care service staff**. The training should cover all domains of the new framework (see Box 10) and should foster active discussion, comparing the new framework with traditional diagnostic approaches, while exploring the challenges associated with each. For instance, while mental health diagnoses can guide effective interventions, some individuals may find them stigmatizing or unhelpful, making it important to discuss how to provide high-quality support and explore strategies for accommodating individuals' preferences.

- **Train staff to use the new assessment framework and guidelines in a phased approach across the health and social care system**. Staff need to understand how to conduct holistic assessments of mental health and support needs under the new framework and how this impacts the care they provide. Training should equip them to perform culturally appropriate, trauma-informed assessments, address the needs of marginalized groups using age-appropriate language, provide access to accessible communication tools and formats including Augmentative and Alternative Communication, Braille, and Easy Read. Before or alongside the framework's introduction, building capacity in human rights-based and person-centred care among practitioners, families, and communities is essential.

For practical resources related to Policy directive 4.1 Assessment of mental health and support needs by multidisciplinary teams see the relevant section of the annex.

4.2 Policy directive 4.2 Physical health and lifestyle, psychological, social and economic interventions

Access to high-quality, person-centred, recovery-oriented mental health support and treatment that respects human rights should be the hallmark modern mental healthcare. To move beyond a narrow drug treatment focus, people should have access to diverse evidence and rights-based interventions and support options within their local communities. These should be scaled up across services at all levels of the health system and through community initiatives and programmes.

Illustrative example text

This policy directive establishes a person-centred, rights-based, recovery-oriented approach, offering a wide range of treatment and support interventions. The recovery approach requires that care is tailored to individual needs, wishes and preferences, and is proactive, adapting to changing circumstances such as during crises or challenging external circumstances. To promote inclusion, support options will be made available within communities where people live.

Strategy 4.2.1

Identify the physical health and lifestyle, psychological, social and economic interventions for inclusion in Universal Health Care and community initiatives and programmes.

Actions

- **Identify the physical health and lifestyle, psychological, social and economic interventions for integration into all levels of the health and social care system and community initiatives**. A national working group can be convened to determine the physical, psychological, social, and economic interventions (including sub-categories for different support needs) to be integrated into national healthcare systems as part of the Universal Health Care package (UHC) and community programmes. These should be evidenced based and consistent with national or international guidelines. See Box 11 for a non-exhaustive menu of interventions covered by WHO's Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders and other WHO guidance for mental health treatment, support and promotion. Person-centred mental health services need to offer choice to address people's diverse needs and preferences, with a focus on gender-responsive approaches that account for the unique experiences of women, men, and gender diverse individuals, including those facing discrimination. Some interventions may already exist, while others can be introduced within a rights- and recovery-based approach. Consider costs, feasibility, acceptability, and available training (domestic or international) to prioritize interventions to introduce in the short to medium term.

- **Develop a clear and coordinated system for delivering the physical health and lifestyle, psychological, social and economic interventions at all levels of health services and within the community, including the necessary collaborations**. It is crucial to specify the levels and types of health services that will be responsible for delivering these interventions and to identify the multidisciplinary staff groups who will be involved (for example, psychiatrists, nurses, psychologists, peer supporters, social workers, community health workers, occupational therapists, education and employment specialists, see Fig. 2 *Which human resources?* band. While all staff should have a basic understanding of the interventions, not all will deliver them. For instance, psychologists or social workers or non-specialists such as community health workers may provide psychological interventions at community mental health centres, while economic and social interventions may involve collaboration with government sectors or contracted NGOs (see Policy area 4 of this Guidance and *Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors (58, 202)*).

- **Identify the delivery mode for remote, in-person, and combined delivery interventions**. Interventions should be tailored to individual needs, with in-person delivery prioritized for those with complex needs or in crisis. For individuals with milder concerns, online delivery can be a suitable option. Guided self-help, available in various formats, is also an effective approach for these individuals. Whenever possible, prioritize interventions that have been evaluated and are readily available. All interventions, regardless of delivery method, should adhere to consistent standards, addressing legal, ethical, and safety concerns, including privacy, data protection, and the security of the intervention environment. Developing these protocols should involve input from legal, ethical, and mental health professionals, as well as service users and digital experts. In-person options should always be available for those at risk of digital exclusion (due to cost, access limitations, sensory impairments, or low technology skills) or for those who prefer face-to-face support.

Box 11. Flexible and non-exhaustive menu of physical health and lifestyle, psychological, social and economic interventions for treatment and well-being

There are many interventions that promote and support mental health, and that provide effective treatment without the use of psychotropic drugs.

Physical health and lifestyle interventions

- physical activity and sport *(203, 204)*;
- nutrition and healthy diet *(205, 206)*;
- sleep (*207, 208)*;
- sexual and reproductive health *(209, 210)*;
- stress management and relaxation techniques (for example, mindfulness-based interventions, yoga) *(3, 211, 212)*;
- art and culture-based therapy *(213–215*);
- nature-based green and blue interventions *(3, 105, 216)*;
- harm reduction interventions (for example, needle and syringe programmes) *(217, 218)*;
- screening, brief interventions, and referral to treatment for hazardous substance use and substance use disorders *(217)*;
- tobacco cessation *(219, 220)*;
- collaboration/referral for screening and treatment of physical health conditions as appropriate (for example, diabetes, CVD, cancer, HIV/AIDS) *(221–223)*.

Psychological interventions

- cognitive behavioural therapy, interpersonal therapy, behavioural activation therapy, brief psychodynamic therapy, third-wave therapies, trauma-informed approaches (for example, psychotherapy with a trauma focus, eye movement desensitization and reprocessing), and — mainly in relation to alcohol and other psychoactive substance use — contingency management therapy, motivational interviewing and enhancement therapy, positive affect therapy, supportive expressive therapy *(202, 224)*;
- eye movement desensitization and reprocessing (EMDR) *(225)*;
- family therapy (for example, parenting programmes including home visits for pregnant or postpartum mothers, their partners, and their children, couples therapy, family-focused interventions) (*3, 226–228)*;
- family and other care giver interventions (for example, support interventions, education and guidance) *(202, 229, 230)*;
- problem-solving therapy and skills training *(202, 231, 232)*;
- psychoeducation *(3, 233)*;
- interpersonal and social skills, cognitive and organizational skills and self-regulation-based interventions *(202, 224)*;
- cognitive stimulation therapy and cognitive training *(202, 224*), mainly in relation to dementia;
- beginning-to-read interventions, early communication interventions and specialized instructional techniques *(202, 224)*, mainly for children and adolescents;
- recovery, advance, and crisis response plans *(119, 123, 124, 234)*.

Social interventions

- social prescribing *(214, 235, 236)*;
- housing assistance (for example, Housing First, other supported social housing programmes) *(3, 131)*;
- personal assistance (for example, supported decision-making, assistance for daily activities) *(237–239)*;
- peer support and mutual help groups (1:1, group and online) *(109, 122, 240)*;
- social support and community reinforcement approaches (including to build meaningful social connection and combat isolation and loneliness) *(3, 241, 242*);
- occupational therapy *(3, 243, 244)*;
- community-led interventions and bottom-up interventions *(245–248)*.

Economic interventions

- access to income generation and employment (for example, individual placement and support, supported employment and other employment schemes) *(3, 55, 249, 250)*;
- housing assistance (for example, rental assistance programmes) *(251, 252)*;
- cash transfer (*3, 253, 254)*;
- personal budget *(3, 255, 256)*;
- disability allowances and concessions, (for example, disability pensions, living allowances, tax exemptions, discounts) *(239, 257, 258)*.

Note on electroconvulsive therapy (ECT)

In countries where electroconvulsive therapy (ECT) is used, this intervention must only be administered with the written or documented, free and informed consent of the person concerned. ECT should only be administered in modified form: with anaesthesia and muscle relaxants. Using ECT for children is not recommended and should be prohibited through legislation *(22)*.

SPOTLIGHT on forgotten issues

Supporting families in recovery. Families play a crucial role in promoting recovery, and support and interventions should be made available to them, either directly through health services or via community programmes. Some NGOs offer programmes that assist families in supporting relatives with mental health conditions.

Tailoring physical health and lifestyle interventions. Physical health and lifestyle interventions should be tailored to meet the needs of specific groups, such as older adults, children and young people, people with disabilities, and those with specific cultural preferences, including migrants, racially minoritized groups, and Indigenous Peoples. However, the focus should remain on individual needs rather than assigning a group identity.

Improving access to assistive products. This is crucial, as one in three people worldwide need assistive products, ranging from glasses and hearing aids to mobility aids like crutches and prosthetics, or communication devices such as speech-generating tools. Yet access remains limited, especially in low- and middle-income countries *(259)*. Providing access is essential for promoting mental health and reducing reliance on human support, including unpaid care by families.

Strategy 4.2.2

Implement and scale up physical health and lifestyle, psychological, social and economic interventions across all levels of the health system and through community initiatives and programmes.

Actions

- **Prepare and conduct training for delivering physical health and lifestyle, psychological, social, and economic interventions**. This training can be delivered within mental health services or through community initiatives, using remote, phone-based or face-to-face interactions. Groups of services or professionals may be required to deliver these interventions, and many staff will require training. In addition, some interventions, for example, guided self-help, can be implemented by non-specialist facilitators with the appropriate training. Where accreditation mechanisms exist, it is crucial to have new programmes accredited (for example, through CPD schemes) to keep staff knowledge up to date and ensure quality, effectiveness, and adherence to guidelines. When local capacity is limited, external experts may be needed to build capacity and support for training.

- **Introduce online psychological and self-help interventions accessible through a dedicated website**. These interventions should be evidence and rights-based, potentially delivered via dedicated websites managed by local, regional, or national organizations, or provided through videos or other media. Pilot programmes should first establish the efficiency and effectiveness of these interventions before broader implementation. Consider using existing online interventions that have been piloted, implemented, and evaluated by WHO (for example, see WHO's Psychological intervention implementation manual) *(202)* and other academic and training.

- **Develop comprehensive and accessible information to guide people to interventions and support**. Each intervention could be accompanied by a description, purpose, and details about efficacy, benefits, limitations, and risks. The information should be accessible to those using mental health services and to the broader community, including groups facing discrimination. The description should be available in multiple languages and formats, such as age-appropriate language, Braille and Easy Read.

For practical resources related to Policy directive 4.2 Physical health and lifestyle, psychological, social and economic interventions see the relevant section of the annex.

4.3 Policy directive 4.3 Psychotropic drug interventions

Psychotropic drugs are currently central to treatment for mental health conditions and psychosocial disabilities. However, the very high prescription rates, particularly in high-income countries, are concerning *(2, 181, 182, 260, 261)*.

Evidence shows that while psychotropic drugs can help manage symptoms and distress, it is crucial they are not overused or abused. Both service providers and people prescribed these drugs should be fully informed of their positive and negative impacts, including potential side effects and withdrawal effects *(262)*. For example, antidepressants may cause serious withdrawal symptoms when discontinued *(175, 176, 263)*. This is especially concerning given their widespread and increasing prescription rates in many countries *(264–266)* and the mixed and contested evidence regarding their efficacy *(267-269)*. Although many benefit from antipsychotic (neuroleptic) drugs, evidence of harmful effects, such as metabolic syndrome with long-term use, highlights the need for

cautious prescribing *(177, 178)*. While psychotropic drugs can be effective in managing symptoms for many, they do not cure mental health conditions in the way antibiotics target infections. Additionally, they cannot resolve life challenges, such as financial difficulties, social isolation, or unemployment, which may contribute to the onset and persistence of these conditions. Therefore, a holistic approach to treatment, care, and support is essential.

Illustrative example text

Under this policy directive, psychotropic drug interventions will be prescribed based on evidence-based guidelines, with informed consent, and, as much as possible, after non-pharmacological options have been fully implemented. The consent process will ensure that individuals understand the potential benefits, limitations, and harms of these treatments. Within a person-centred, rights-based, and recovery-oriented approach, drug treatment is viewed as one option or tool to help during intense crises or extreme distress. Health care staff will avoid reinforcing misconceptions about 'broken' or 'disordered' brains or biochemical imbalances. To change current practices, prescribing practitioners will be trained in the safe use of psychotropic drugs, including how to help people reduce or discontinue use when appropriate, and the importance of avoiding polypharmacy (the use of multiple interacting medications).

Strategy 4.3.1

Identify psychotropic drug interventions and develop guidelines for their safe prescribing, use and discontinuation, including managing adverse effects and withdrawal.

- **Identify psychotropic drug interventions to be integrated into care across all levels of the health system**. It may be necessary to convene a national working group to review the medications currently available and their evidence base across different population groups. Psychotropic drugs are often believed to correct so-called brain abnormalities or biochemical imbalances, and their benefits are assumed to outweigh the risks. However, there is growing evidence they can cause long-term harm *(270)*. Therefore, they should only be prescribed when supported by robust evidence and with careful consideration of the person's physical health and other conditions. The working group should determine which psychotropic drug interventions will be included in Universal Health Care, considering sub-categories for different support needs. Decisions should align with WHO model list of essential medicines and take into account costs, mode of administration, risk/benefit balance, health insurance coverage *(271)*

- **Establish or designate a committee for national guidelines on safely prescribing, using, and discontinuing psychotropic drugs**. If a committee already exists, its primary goal should be to review the latest evidence and update the guidelines accordingly (see Box 12 for key areas to cover). These guidelines should standardize practice, be based on comprehensive, unbiased res earch, free from conflicts of interest or any influence from pharmaceutical companies. To ensure they incorporate user perspectives, individuals with lived experience of psychotropic drugs should be included on the advisory committee, and the final guidelines, or an accessible version, should be made available to those using these medications.

Box 12. Topics for psychotropic drug prescribing and usage guidelines

Guidelines for prescribing psychotropic drugs should cover these topics

- **Assessing indications and contraindications:** how to evaluate individuals' need for psychotropic drugs, identifying contraindications, and assessing likely interactions before prescribing.
- **Alternatives and combined interventions:** consideration of alternatives to psychotropic drugs and their use in combination with other interventions, such as lifestyle changes, psychological support, social interventions, and economic assistance as part of a comprehensive recovery plan.
- **Informed consent:** ensuring free and informed consent before prescribing, with clear explanations of potential adverse effects, side effects, and possible complications discussed in advance.
- **Avoiding polypharmacy:** strategies to avoid using multiple interacting medications, and guidelines for reducing or discontinuing unnecessary psychotropic medications, while ensuring safe withdrawal management and preventing health complications.
- **Monitoring and maintenance**: how to monitor the effects of drugs, ensure safe maintenance, and provide follow-up for individuals taking psychotropic drugs, including access to adequate laboratory equipment for monitoring medication levels and organ functions, along with regular follow-ups and specialist reviews.
- **Communication and coordinated care:** ensuring effective communication and coordinated care between the individual's primary and specialist health care teams when psychotropic drugs are prescribed or adjusted.
- **Supported decision-making:** providing supported decision-making processes for individuals considering psychotropic drug use.

Guidelines for safely tapering or discontinuing psychotropic drugs should cover these topics

- **Routine discussions:** providing regular opportunities for service users to discuss the possibility of discontinuing psychotropic drugs.
- **Comprehensive information:** offering detailed information to all service users about what to expect during the tapering and discontinuation process.
- **Safe tapering and discontinuation practices:** ensuring that tapering is done slowly over months rather than weeks to maximize safety and efficacy *(272)*. Withdrawal symptoms from psychotropic drugs can be more severe than previously thought *(273-275)* and may be mistaken for relapse *(276)*.
- **Specialist support:** guaranteeing access to specialist medical support (for example, psychiatrists or doctors with expertise in psychopharmacology) to facilitate safe withdrawal.
- **Recovery plan review**: revising each person's recovery plan to anticipate the need for additional support, adjustments to crisis plans, or more intensive support during withdrawal.
- **Follow-up care:** providing access to follow-up and ongoing review after individuals discontinue using psychotropic drugs.

Strategy 4.3.2

Implement the guidelines for safe prescribing, use and discontinuation from psychotropic drugs.

Actions

- **Develop and implement training programmes on safe prescribing, use, and discontinuation from psychotropic drugs, including managing adverse effects and withdrawal**. All service staff require training on prescribing practices and safely withdrawing from psychotropic drugs. Those who will be prescribing need detailed training. Every training is an opportunity to reframe approaches to treatment and support within the broader context of a person-centred, recovery-oriented and rights-based model. Consider establishing certified training programmes where feasible.

- **Link training programmes on safe drug prescribing, use and discontinuation from psychotropic drugs with professional bodies and professional accreditation processes**. It is essential to regularly address quality, effectiveness and adherence to guidelines for staff with prescribing responsibilities. Staff prescribing psychotropic drugs should also be primed to collaborate with, or refer to, physical health providers for screening and treatment of service users' side effects and pre-existing physical health conditions.

- **Develop comprehensive and accessible information materials to educate service users, their families and other caregivers about psychotropic drug use, including benefits, adverse effects, and withdrawal**. These materials should be co-developed with service users to ensure their perspectives are reflected and should include the latest guidelines and scientific knowledge, enabling informed decision-making. When caregivers are equipped with this information, they can better assist in managing withdrawal symptoms as individuals taper or stop using psychotropic drugs. Since withdrawal symptoms can provoke fear and misconceptions about deterioration, providing clear information on what to expect can help build confidence and support effective management.

KEY POINT: overcoming pressure to prescribe psychotropic drugs needs a comprehensive approach. Psychotropic drug treatment may appear simpler and quicker than psychological and social interventions. Service users and families may be drawn to apparently quick solutions. Addressing this requires a comprehensive approach, including giving people information on non-pharmacological options, keeping staff updated on alternatives, reorganizing services so that they are community-based, and using resources more broadly to support other approaches.

For practical resources related to Policy directive 4.3 Psychotropic drug interventions see the relevant section of the annex.

Special considerations for diverse groups
Policy area 4. Assessment, interventions and support

Children and adolescents

Comprehensive assessment

- Incorporate an understanding of school and family environments in mental health and support assessments.
- Address challenging family dynamics and consider family therapy, focusing on these relationships rather than attributing issues solely to the child or adolescent.
- Incorporate developmental milestones and age-appropriate mental health indicators into assessments, integrating input from children and adolescents (based on their evolving capacity), as well as from caregivers and educators. Use child-friendly language and tools to ensure inclusivity, understanding, and comfort.

Early support and intervention

- Provide early support, adopting a life course approach to child and adolescent mental health, including during the perinatal period. This can have a preventive effect and positive mental health impact later in life.
- Include physical health, psychological, and social and economic support at all ages to promote positive outcomes.
- Promote and maximize the implementation of school-based mental health programmes.

Parenting and early childhood development

- Offer home visit programmes for the postpartum period for families and caregivers, focusing on the critical early years (especially the first 1,000 days) to promote healthy brain development and emotional bonding.
- Provide guidance on responding to children's struggles and creating supportive environments for adolescents, including early interventions that address physical, emotional, and cognitive growth.
- Include social support for new parents, education on child and adolescent development, and positive parenting techniques that foster school readiness, early learning, and well-being.
- Support caregivers in areas such as health and nutrition for young children, early education, and positive parent-child interactions to promote holistic development in the early years.

Peer support groups

- Embed peer support groups in settings like youth clubs and sports facilities, with trained adults facilitating these groups depending on the age range and other contextual factors.

Digital therapies and interventions

- Use digital interventions for children and adolescents familiar with the online world, ensuring these are supported by a functioning referral system for specialized or crisis care. Balancing digital interventions with in-person interactions to enhance effectiveness and prevent digital exclusion.

Careful use of psychotropic drugs

- Prioritize non-pharmacological interventions for children and adolescents (such as psychological and social interventions), reserving psychotropic drugs as a last option after thorough exploration and alignment with the young person's preferences, and after considering developmental risks.
- Ensure informed consent by providing clear, age-appropriate explanations to the child, their family and other caregivers.
- Promote early support through psychological interventions and school-based mental health programmes.

Older adults

Diagnostic overshadowing

- Address diagnostic overshadowing, where presumed mental health diagnoses become a lens for understanding thoughts, emotions, and behaviours. This can result in missing important physical health conditions and symptoms, such as pain or signs of abuse.
- Update assessment frameworks to highlight and reduce diagnostic overshadowing.

Supported decision-making

- Implement training on supported decision-making and advanced planning, ensuring older adults' preferences are documented and respected, should their condition decline.

Inclusive health interventions

- Include older adults in physical health, lifestyle and other interventions, addressing any stigma or discrimination that may exclude them.

Safe prescribing practices

- Emphasize correct dosages and potential interactions, especially for psychotropic drugs, to avoid polypharmacy.
- Monitor older adults closely due to changing medication metabolism.
- Highlight severe side effects of antipsychotics in older adults with cognitive impairments and increased risk of premature death.
- Warn against using antipsychotics as sedatives and recommend monitoring to prevent this practice.

Women, men and gender diverse persons

Safe spaces and interventions

- Develop assessment frameworks that accommodate non-binary gender identities, ensuring inclusivity.
- Provide safe spaces for women and gender-diverse individuals, especially those exposed to gender-based violence.
- Support survivors of sexual assault and gender-based violence and those undergoing gender transition with tailored interventions.
- Consider the diverse contexts in which women and girls, and men and boys live when providing interventions, including, for example, the impact of child marriage, age disparities in various cultures, and the caregiving responsibilities that women disproportionately shoulder. Recognize how these roles can affect their access to resources, time, and mental health support *(277)*.

Psychotropic drug guidelines

- Include information on impacts of psychotropic drugs on sexual function, fertility, and safety during pregnancy and breastfeeding.

Persons belonging to the LGBTIQ+ community

Inclusive assessment frameworks and tools

- Use inclusive language and questions in assessment frameworks and tools, avoiding assumptions of heterosexual orientation and considering all sexual orientations and identities.

Affirming interventions

- Provide support interventions for survivors of sexual assaults and violence, and support those questioning their sexual orientation or facing discrimination.

Persons with disabilities

Diagnostic overshadowing

- Train staff to recognize and properly address other health conditions beyond the primary disability, avoiding misinterpretation of symptoms because thoughts, moods, and behaviours are seen through the lens of the disability.
- Update assessment frameworks to highlight and address the risk of diagnostic overshadowing.

Supported decision-making and accommodations

- Train staff to provide reasonable accommodations, supported decision-making, and advanced planning for people with disabilities.
- Use tools like sign language interpretation, Easy Read questionnaires, or screen reader-accessible versions to enable people with disabilities to document and share their support preferences.

Inclusive health interventions

- Ensure accessibility in all health interventions, overcoming barriers including stigma, and discrimination. For example, avoid excluding people with disabilities from sexual and reproductive health services based on assumptions that they are not sexually active.
- Enhance accessibility by using tools like sign language interpreters or Augmentative and Alternative Communication.

Safe prescribing practices

- Tailor medication guidelines to avoid polypharmacy and to prevent overmedication and ensure appropriate dosages, particularly monitoring those with disabilities for side effects and changes in health status.
- Provide suitable medication forms for those with swallowing difficulties, needing enteral feeding, or with allergies.

Migrants and refugees

Culturally appropriate assessment

- Develop assessment frameworks that are culturally aware and linguistically appropriate, ensuring they are meaningful for the population served.

Holistic needs assessment

- For those living in precarious situations, comprehensive assessments should include housing, economic situations, and social integration, supporting a holistic recovery journey.
- Consider the specific challenges of cultural adaptation in the host country, including barriers to social inclusion and accessing services.

Safe prescribing practices

- Address potential differences in drug metabolism and drug effectiveness due to genetic factors or dietary practices common in specific cultural groups.

Persons from minoritized racial and ethnic groups

Culturally appropriate and inclusive assessment tools

- Ensure assessment tools and materials reflect the diversity of the population using appropriate imagery and language.

Collective trauma

- Create interventions that address the impacts of stigma, discrimination, and collective trauma, including experiences of genocide, racist violence, and systemic oppression that affect entire communities and societies.

Indigenous Peoples

Culturally appropriate assessments

- Ensure assessments respect Indigenous cultures, languages, and spiritual values.

Faith-based healing practices

- Collaborate with faith-based healers or leaders respected by their communities and incorporate culturally appropriate healing practices, such as healing circles and ceremonies, while avoiding harmful methods.

Persons who are houseless or with unstable housing

Assessments and basic needs

- Include assessments of housing status (for example, long-term or temporary lack of housing), basic needs (food, clothing, hygiene), and history with mental health services. Consider barriers to accessing services and suicide/self-harm risks.

Trauma-informed approach

- Provide trauma-informed care that acknowledges the higher prevalence of trauma and violence among houseless people, ensuring sensitive and supportive interventions.

5

Policy Area 5: Mental health sector contributions to addressing social and structural determinants and society-wide issues impacting mental health and well-being

Key challenges

Mental health and associated conditions are significantly influenced by social and structural factors *(3, 276, 278)*. Some key interactions are covered in the discussion *Social and structural determinants and their impacts on mental health* below. To improve mental health and well-being, the mental health sector should collaborate with other sectors (see Box 2) to change mindsets, address determinants and build inclusive communities that embrace diversity. This point is underscored in the WHO *world report on the social determinants of health equity* *(279)*, which emphasizes that achieving health equity, including mental health equity, requires a coordinated, multi-sectoral approach to tackle inequity's underlying social and structural determinants, and society-wide issues, such as economic instability, structural discrimination, and climate change.

- **Stigma and discrimination**. People with mental health conditions and psychosocial disabilities often face stigma and discrimination, including from government sector employees, who may view them as unproductive, socially inadequate, unpredictable or dangerous *(40, 41, 280)*. This stigma is compounded by discrimination based on other identity factors such as age, gender, sexual orientation, disability, immigration and refugee status, race and ethnicity, indigeneity, or houselessness. For example, people from minoritized racial and ethnic groups who have a mental health conditions or psychosocial disability often experience poor healthcare because of racism. Such discrimination leads to social isolation, exclusion, and poor mental health outcomes *(133, 281)*. Overall, there is a strong and consistent relationship between stigma and discrimination and poor mental health outcomes *(282–284)*.

- **Lack of joint sector actions**. Addressing social and structural determinants and society-wide issues impacting on mental health requires whole-of-government and whole-of-society approaches. Intersectoral collaborations and aligned or joint policies and community-led initiatives are needed. However, creating and implementing these is challenging due to differing sectoral goals and interests. Roles and responsibilities among sectors need to be clearly defined, with shared budgets and accountability mechanisms. Government employees often lack awareness of how cross-sector collaboration on social and structural determinants can benefit their own sector's goals. Additionally, excluding local communities from these joint efforts leads to a lack of ownership, making initiatives difficult to sustain.

Global suicide rates highlight the need for a society-wide approach. With over 700,000 suicides annually, and one death every 40 seconds, suicide prevention is a critical issue *(285)*. While mental health conditions can increase suicide risk and attempts, many social and structural determinants also play a significant role. This risk is further exacerbated by inappropriate media coverage and easy access to means of suicide *(135, 286–288)*. Despite the importance of an intersectoral approach to suicide prevention, such collaboration is still rare.

Social and structural determinants and their impacts on mental health

Poverty

Poor mental health and well-being are prevalent among people with low incomes and those undergoing financial strain *(194, 289, 290)*. For instance, people who have debts have higher rates of depression and are at higher risk of suicide than people who do not *(291)*. Studies show that living in conditions such as poor housing, food insecurity (including poor or insufficient nutrition), and with limited access to resources, increase the risk of developing mental health conditions *(278, 292, 293)*.

Lack of, low, or interrupted education levels

Lack of, low, or interrupted education is linked with poor mental health. It can increase vulnerability to rights violations and limits access to healthcare, employment, social capital, and other community support *(278, 294, 295)*.

Unemployment and job insecurity

Unemployment and job insecurity are tied to increased psychological distress, lower self-esteem, reduced self-confidence, and declining income, all of which have risks for mental health and well-being. Low rates of benefits further contribute to poverty, compounding mental health risks *(296)*.

Houselessness or unstable housing

Houselessness and housing insecurity are often driven by upstream factors, for example gentrification leading to housing shortages, or people's inability to afford rent due to widening income disparities. Extensive, decades-long research demonstrates that insecure housing has detrimental effects on mental health *(297)*. Children and adolescents are especially vulnerable to the psychological effects of housing instability *(298)*.

Climate change

The ongoing impact of climate change is increasingly damaging mental health and well-being, leading to feelings of loss, helplessness, and distress, anger, isolation among both younger and older people *(299–303)*. Climate-related hazards are linked to intense stress, emotional suffering, disrupted relationships (including family separation and disconnection from social support systems), and the development of mental health conditions *(304–308)*.

Poor urban planning

Poorly designed urban environments, characterized by air and water pollution, overcrowding, poor infrastructure, noise pollution, lack of access to green spaces, or to nutritious foods or safe places to exercise, can all harm mental health *(309–311*).

Social isolation and loneliness

Social isolation and loneliness are strongly linked to poor mental health and premature mortality, with the effect of being lonely comparable to smoking 15 cigarettes a day *(125, 126)*. Recent population surveys show a significant rise in these issues, especially among older and younger adults, exacerbated by the COVID-19 pandemic *(127, 312)*. Minority groups, those living in non-diverse neighborhoods, people in poverty, single parents or caregivers, and individuals with mobility-limiting disabilities are particularly vulnerable to isolation and loneliness *(313, 314)*.

Humanitarian emergencies

Humanitarian emergencies such as natural disasters, conflicts, wars, and epidemics cause significant psychological and social distress, increasing the risk of mental health conditions like depression, PTSD, and abuse of alcohol and other psychoactive substances *(315, 316)*. This reduces individuals' ability to cope and heightens their risk of neglect, isolation, marginalization, financial hardship, discrimination and exclusion from humanitarian assistance, education, livelihood opportunities, health care or other vital services. Displaced people are at a heightened risk due to inadequate protections in emergency settlements. People facing discrimination, especially people with disabilities including psychosocial disabilities, are often overlooked in humanitarian efforts despite being disproportionately affected by crises *(317)*. At the same time, people affected by emergencies demonstrate a strong capacity for resilience. MHPSS responses should prioritize creating an environment that fosters resilience and community support, while also ensuring access to specialized services for those who need them.

5.1 Policy directive 5.1 Improved literacy and transformed mindsets to promote mental health and well-being and combat stigma, discrimination and exclusion

While awareness is growing, myths and misconceptions still hinder discussions on mental health and investment in community support and services. Stigma and discrimination associated with having a mental health condition or psychosocial disability significantly contribute to mental health challenges. Additionally, other discriminatory factors, such as ableism, ageism, racism, and various biases further exacerbate these challenges. These negative attitudes profoundly impact lives, leading to disempowerment, loss of identity and hope, isolation, rejection, loneliness, and self-stigma, where individuals internalize discriminatory messages making them feel worthless and undeserving of equal rights and a meaningful life. Higher mortality rates can be higher in these groups due to suicide, unaddressed physical health issues, and poverty.

Illustrative example text

This policy directive will enable the mental health sector to collaborate with other government sectors to raise awareness and provide training on mental health and well-being to their employees. This effort aims to combat stigma and discrimination, transform mindsets, and simultaneously improve employees' own mental health and well-being. These actions will enhance government employees' capacity across sectors to design and implement programmes and strategies that promote and protect mental health within their sector.

Strategy 5.1.1

Implement awareness strategies for staff of all government sectors to transform mindsets, improve understanding on mental health, and to combat stigma and discrimination.

Actions

- **Establish commitment to raising awareness and combating stigma and discrimination by convening senior staff to discuss the benefits**. Many senior managers or officials across government sectors may not fully recognize the significant impact of employees' mental health on performance, or the harmful effects of social and structural determinants (see the discussion within the Key challenges section for Policy area 5) and the support needed to address them. It is also crucial to understand how stigma and discrimination erode trust, motivation, and teamwork, worsening mental health and undermining workplace performance**.** Engaging in dialogue to secure high-level commitment to improving mental health awareness and addressing stigmatizing attitudes and practices can contribute to a more supportive workplace environment.

- **Support each sector to implement a communication strategy to tackle stigma and discrimination among government employees**. A first step in developing this strategy is to explore the underlying assumptions driving stigmatizing attitudes and practices, allowing for the formulation of effective counter-messages. Internal communication expertise within government sectors should be leveraged in collaboration with individuals who have experienced stigma and discrimination. All messaging and campaigns should be grounded in a rights-based perspective and an understanding of mental health. Inclusive communication strategies should involve individuals from discriminated-against groups or those with relevant knowledge, ensuring cultural sensitivity, inclusive language, and that messages address the needs of these groups.

- **Support each sector to implement a training programme for all government employees to improve understanding of mental health and combat stigma and discrimination**. The training can be delivered in person, or online or through a combination of methods. WHO QualityRights face to face training *(115)* and e-training *(121)* are examples of rights- and evidence-based trainings that can be used. Training can be complemented by discussions, talks and workshops led by internal and external experts and champions of change or good practices. Input from people with lived experience of mental health conditions or psychosocial disabilities, or those who have faced stigma and discrimination, is essential. Additionally, training programmes should address the specific issues affecting various discriminated-against groups to ensure relevance and effectivenes.

KEY POINT: effective campaigns bring people together. Studies show that campaigns bringing individuals with lived experience of discrimination together with the target audience are effective in challenging stereotypes, misconceptions, and negative behaviours around mental health. It is important to actively engage people with lived experience in awareness strategies, campaigns, and programmes as trainers or speakers to maximize impact *(318)*.

Strategy 5.1.2

Implement initiatives within government sector programmes to improve understanding and change negative attitudes on mental health among the general population, including combating stigma and discrimination.

Actions

- **Collaborate with each sector to develop and implement information campaigns in communities to improve understanding of mental health and change negative attitudes**. These campaigns should be based on in-depth understanding and should involve people with lived experience of psychosocial disability and discrimination. Use focused group discussions and interviews with people from groups that face discrimination, as well as with wider groups in the community holding stigmatizing attitudes, to understand what the focus for change should be. Use the understanding gained to formulate campaign messages, strategies and choose the type of media to be used. Campaign and communication experts need to work closely with people with lived experience, key opinion leaders, and influencers to implement the strategy. Many groups facing discrimination have a long history of political activism, including lobbying, street marches, and social groups. Leveraging their expertise in national campaigns to change mindsets on mental health and address stigma and discrimination can be helpful.

- **Partner with sectors to hold community forums at national, regional and local levels to change mindsets and challenge stigma and discrimination**. Local community forums can allow open dialogue to understand pressing mental health issues, the reasons behind these and to stimulate a variety of local actions to promote change. Locations for community forums should reflect need and the community's willingness to engage. Speakers at the forums should always include people with lived experience. Community discussions should be accessible to people from groups facing discrimination, with information provided in accessible formats at places these groups use.

- **Provide opportunities for people with lived experience to participate in and inform all sector initiatives and programmes**. Increased meaningful social contact with people who have mental health conditions and with other groups that face or are at risk of discrimination can help the wider population understand the issues affecting people experiencing stigma and discrimination and is a direct way to dispel myths and misconceptions. Contact can be face to face, via traditional media, or via social media.

KEY POINTS: use positive images and accessible language.

Do not use images or language that could reinforce harmful stereotypes, such as the idea that people with mental health conditions are less trustworthy, socially inadequate, dangerous, or incapable of managing personal and civic responsibilities. Instead, show people in active, positive roles within workplaces, schools, and the broader community.

Use culturally appropriate and inclusive language, and provide campaign materials in various accessible formats, including different languages, Braille, sign language interpretation, and Easy Read. Additionally, key messages should be tailored to ensure they are understandable for all stakeholders, including people with varying literacy levels, young people, older adults, and others.

For practical resources related to Policy directive 5.1 Improved literacy and transformed mindsets to promote mental health and well-being and combat stigma, discrimination and exclusion see the relevant section of the annex.

5.2 Policy directive 5.2 Joint actions on social and structural determinants and society-wide issues.

Within communities, numerous social, physical, and economic conditions, such as discrimination, houselessness, lack of education, unemployment, isolation, violence, and conflicts, can harm mental health and well-being (see Box 1 and the discussion *Social and structural determinants and their impacts on mental health* within the key challenges section for Policy area 5). Addressing these underlying social and structural determinants requires a comprehensive approach that includes both prevention and promotion efforts.

Illustrative example text

This policy directive will strengthen government sector capacity to address the social and structural determinants of mental health and support communities in establishing strong networks of support, initiatives, and resources. These efforts will be designed with broad participation to ensure they are accessible and acceptable to the target populations. The mental health sector will collaborate with communities and government sectors to prioritize, advocate for, and implement programmes that address key determinants affecting the population's mental health.

Strategy 5.2.1

Advocate for policy changes in government sectors outside mental health to address key social and structural determinants of mental health.

Actions

- **Establish a coalition with civil society groups, professional groups and other community groups**. Use these to discuss the determinants of mental health in the community and recommendations for actions. Organizations of people who face discrimination, and other community groups with knowledge and skills related to the specific issues faced by these groups, should be involved. Conversations between diverse groups allow a deeper understanding of the most pressing issues for mental health, the contributing factors, and potential solutions.

- **Prepare position papers on mental health that recommend policy actions for each government sector**. These papers should involve collaborations and working groups that include experts from the specific sector, mental health professionals, related specialists, civil society actors, and representatives from discriminated groups or those with relevant knowledge. Where available, existing working groups should be engaged. The position papers should outline the key determinants affecting mental health, clearly articulate the negative impact of social and structural factors and explain how policy changes and actions can mitigate these harms. For instance, a position paper for the education sector can describe how programmes can focus on life and social skills, can promote mental health, prevent suicide, and reduce dropout rates. The papers should also demonstrate how actions can benefit other sectors. For example, better mental health within education might reduce incarceration rates, enhance employment, and promote mental health and well-being. Additionally, the papers should realistically assess barriers to change and propose strategies to overcome these.

- **Establish contact with senior politicians and government managers to convey key messages and proposed policy changes**. Policy dialogues can be held with strategic actors across sectors who have the authority to decide and implement changes. This initial advocacy can generate interest and motivation for long-term discussions and actions within their respective sectors.

- **Engage traditional and social media to disseminate information, evidence, and key messages for change**. Providing data on outcomes and impacts, along with case examples and human stories, can help the public connect with the messages.

Strategy 5.2.2

Collaborate to agree on, and implement changes to, government sector policies that address social and structural determinants of mental health.

Actions

- **Organize planning meetings to discuss the case for change, drawing upon position papers backed by evidence and rights obligations**. Addressing social and structural determinants of mental health through policy and programme changes requires constructive dialogue to understand challenges, highlight benefits, and generate solutions. When engaging with policy-makers, anticipate potential disagreements by identifying controversial topics and preparing a strong rationale for change. Ensure that representatives from organizations of people facing discrimination are included in these meetings.

- **Collaborate to review sector-specific policies and strategies, recommending changes that reduce harm to mental health and promote well-being**. Establish working groups within each sector, including mental health experts, sector-specific policy experts, and civil society representatives, especially those who have experienced the issues being discussed. Draw on this collective expertise to generate meaningful suggestions for policy change.

- **Negotiate, obtain consensus on, and implement new or reformed policy**. Policy reform will likely be multifaceted, requiring changes to administrative processes and regulations, including forms and documentation. Training will be essential to help stakeholders understand the required actions, including educating leaders, managers, and other key players on the reasons for and specifics of the reforms. A budget and timeframe will be necessary to support these efforts. For example, a suicide prevention strategy banning highly hazardous pesticides might involve awareness campaigns, penalties for sales violations, enhanced training on pesticide inspections and controls, new regulations for safer alternatives, and support for no-pesticide agriculture and agroecology.

SPOTLIGHT on sector specific policy options. Each sector can consider which mental health issues are priorities. Also see *Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors (58)*. The following list gives some examples.

Culture, art, and sports. Investigate how culture, art, and sports can benefit mental health and support targeted initiatives that increase engagement opportunities for groups facing discrimination.

Defence and veterans. Raise awareness of mental health challenges, provide training to combat stigma and discrimination, introduce suicide prevention programmes and support veterans transitioning to civilian life, including offering opportunities for social connection and volunteering.

Education. Ensure accessibility, reasonable accommodations, and support for students with mental health conditions, psychosocial disabilities, or those experiencing mental health challenges. Establish evidence-based programmes for issues like bullying, stigma and discrimination. Support socio-emotional skills development, encouraging help seeking.

Employment. Support people with mental health conditions or psychosocial disabilities, and other discriminated-against groups, in finding and keeping jobs, including through supported employment initiatives and improvements to work environments (such as safe lighting, temperature, noise levels, and protection from harmful substances).

Environment, conservation and climate protection. Research how climate affects physical and mental health and collaborate with the climate sector to create low-carbon mental health services with sustainable design, green spaces, energy waste and emissions reductions, digitalization, and sustainable foods.

Health. Make general health services more accessible. Enhance social connection, community inclusion, and prevent isolation and loneliness by promoting social prescribing, peer support groups, and mobile in-home support teams; Establish mental health indicators within the national health information system, including service availability, coverage, continuity, prevalence of conditions, psychosocial disabilities, and suicide rates.

Interior. Mandate training in crisis intervention, mental health, and psychological first aid for workers who have first contact with disaster or emergency victims. Establish alternatives to police responses for mental health crises, such as 24/7 crisis lines, peer navigator programmes, and multidisciplinary mobile crisis teams. Implement mental health promotion and protection measures for first responders. Integrate mental health measures into humanitarian preparedness plans.

Justice. Train judiciary, lawyers, and legal practitioners on human rights and mental health, including rights-based legal reforms. Establish evidence-based suicide prevention and mental health programmes during custody and incarceration. Review and revise solitary confinement regulations, implementing alternatives such as full days out-of-cell, peer-led programmes, and separation without isolation. Train staff of legal aid programmes and services to support people with mental health conditions, ensuring they receive fair legal representation.

Social protection. Finance social activities for people at high risk of poor physical and mental health. Deinstitutionalize social care settings. Provide social benefits and income supports to mitigate financial stress and poverty. Provide financial literacy training, legal protections, and emotional support for those facing financial strain. Establish supportive services like income coaching and health care for people receiving housing assistance.

Urban and rural development. Incorporate green and blue spaces into urban areas, including street trees, flowers, urban gardening, pocket parks, and walkable green areas. Improve disability inclusion with better access to roads, housing, public buildings, basic services, and transportation. Create accessible spaces and events for social interaction and community engagement, such as at community centres.

Finance and treasury. Ensure sufficient mental health resources by reallocating public expenditure, potentially increasing income tax, adopting low-cost targeted programmes when resources are limited, and providing financial support for disadvantaged and discriminated-against groups.

Strategy 5.2.3

Co-develop and implement community prevention and promotion initiatives with other sectors to tackle social and structural determinants and society-wide issues affecting mental health and well-being.

Actions

- **Hold public discussions and door-to-door conversations to identify and prioritize factors affecting mental health and well-being in the community**. Engage with the community to discuss the social and structural determinants of mental health, generate solutions, and create a comprehensive, up-to-date directory of local resources (for example, financial support, income-generating opportunities, peer groups, services to tackle loneliness and isolation). It is important to conduct these activities in hard-to-reach and under-resourced areas, involving residents from diverse demographics and backgrounds. Additionally, involve community organizations, local authorities, and representatives from other relevant sectors in these discussions.

- **Develop media campaigns to spur community action on society-wide issues**. Engage people with lived experience, key influencers, and high-profile personalities in these campaigns to raise awareness, inspire action, and drive change within the community. Media campaigns can leverage memorable personal stories and narratives to create a lasting impact, using both social and traditional media to effectively reach target groups. Collaborate with communication experts, individuals with lived experience, community organizations, and local influencers to ensure messaging resonates with specific groups, including those facing discrimination. To maximize impact, deliver content in different languages, ensure cultural relevance, and use accessible formats. The campaigns should also clearly demonstrate how specific and actionable steps will lead to successful outcomes.

- **Develop and implement community-level solutions for the main issues identified, working with a multistakeholder group**. Community engagement research, outlined above, along with surveys and focus groups, can prioritize and shape solutions that are person-centred and human rights-based. While various evidence-based interventions can address social and structural determinants (see the discussion below), it is crucial to continuously monitor and evaluate their impact, as implementation contexts may vary.

Evidence-based community interventions

Widely documented and evaluated evidence-based community interventions include the following approaches.

Recovery colleges

These offer training to increase knowledge and skills in mental health and recovery, reduce stigma, and promote social inclusion. Training is co-designed, co-produced, and co-facilitated by people with lived experience and mental health professionals *(319, 320)*.

Community centres

Local community centres provide a space to engage in social, educational, cultural, and recreational activities. They promote social connectedness, reduce isolation, and foster a sense of belonging, which are all key elements for mental health.

Intergenerational initiatives

These engage varying age groups, fostering social connectedness, preventing isolation, and addressing stigma between generations *(321)*. Collaboration among communities, local governments, schools, universities, and businesses is often involved. Examples include intergenerational housing, senior mentorship and tutoring in schools, cultural exchanges between older adults and children, as well as intergenerational childcare and family support initiatives *(321)*.

Early childhood and parenting support

Support for families during pregnancy, new parenthood, and early childhood can include information on child development, parenting tips, stress management, and referrals to community services and resources. Support can be delivered through home visits, individual sessions, or group settings *(3)*.

Youth development programmes

These programmes develop social and emotional skills, leadership, and aim to prevent harmful behaviours such as violence, alcohol and other psychoactive substance use, and early school leaving *(322, 323)*. Initiatives may include youth hubs, social, educational, or recreational activities, youth-adult mentoring, and volunteer programmes.

Education and career outreach

Education influences physical and mental health, as well as economic prospects *(3)*. Workshops, counselling, and outreach initiatives can help adolescents and young adults apply for further education and reduce dropout rates.

Work and employment programmes

Unemployment is strongly associated with mental health problems, poverty, and various social and economic challenges. Initiatives may include job search assistance, supported employment, internships, or vocational training for those facing barriers in the job market due to social, demographic, or health or gender-related factors *(3)*. Tailoring support to address specific challenges, such as gender discrimination or caregiving responsibilities, can help individuals gain stable employment and economic independence.

Housing and homelessness prevention

Overcrowded, unaffordable, insecure or inadequate housing poses risks to physical and mental health *(3, 324)*. Programmes can assist individuals and families to secure and maintain affordable housing, improve financial planning, and access government housing benefits or supported housing schemes.

Empowering discriminated-against groups

Discriminated-against groups often face barriers in accessing education, housing, work, or healthcare *(325)*. Community initiatives can address these issues, such as assisting migrants in finding housing or advocating for the LGBTIQ+ community in the job market.

Violence prevention initiatives

Violence causes lasting physical, mental health, and economic problems (*326–328)*. It manifests in various forms, including elder abuse, child abuse, gender-based violence, sexual violence, youth and gang violence, shootings, and intimate partner violence *(329)*. Community initiatives may include one-on-one counselling and peer support for people affected by violence, as well as street outreach targeting young people at-risk.

Addressing loneliness and isolation

Social isolation and loneliness pose serious risks to mental and physical health, comparable to major mortality risk factors like obesity *(313, 330)*. Conversely, social connections protect mental health and support recovery *(331, 332)*. Key interventions include strengthening social networks, home visits for those living alone, language and cultural courses for migrants, and digital skills training for online support. Reducing transport costs can also help maintain these connections *(333, 334)*.

SPOTLIGHT on inter-sectorial solutions for society-wide mental health challenges.

Discrimination. Collaborations across sectors could launch campaigns that educate the public on stereotypes and misconceptions, that address the mental health impact of discrimination by motivating attitude and behaviour changes, and that analyze and revise discriminatory policies within each sector.

Gender-based violence. Collaborations could involve sectors such as gender affairs, justice, and health. Actions could create safe houses and provide psychological support to survivors of violence, educate the public on mental health issues related to gender-based violence, engage violent men in rehabilitation programmes, and train law enforcers and other relevant professionals to support survivors.

Climate change. Collaborations could involve sectors such as environment, education, and health. For example, campaigns could recognize eco-anxiety as a common reaction to environmental decline, and underpin coping techniques, such as taking breaks from constant news feeds, and taking individual or collective action over something controllable.

Student debt and poverty among young people. Collaborations between sectors such as education, finance, treasury, and health could provide resources such as financial workshops to improve literacy, hotlines, and information on student loan cancellation and financial entitlements. Self-care resources could include stress management techniques during financial strain, work-life balance, and support for young people who don't yet feel confident in their place in the world (so-called imposter syndrome).

Child abuse. Collaborations between sectors such as child protection, education, justice, and health could train educators and school staff on identifying victims of abuse and children at risk, and to provide emotional support.

Child poverty. Collaborations between sectors such as education, child protection, social protection, nutrition, and health could increase social benefits for children and their families (for example, cash transfers, integrated support systems); could educate families about children's entitlements and about programmes for children living in poverty; and could monitor and address factors contributing to childhood poverty (for example, health conditions, medical expenses, food shortages, migration).

Early childhood development. Collaborations between education, food and nutrition, child protection, and health sectors could introduce early childhood development programmes that promote psychosocial development across the entire population, including groups facing discrimination. Programmes can also address childhood adversity issues such as maltreatment and household dysfunction.

Social isolation and loneliness. Collaborations between sectors such as social protection, health, older people's affairs, sports, and culture, entertainment and the arts could map opportunities for building social connections and reducing loneliness.

Humanitarian emergencies. Collaborations between sectors such as health, social protection, interior affairs, and humanitarian organizations could ensure disadvantaged people, especially institutionalized individuals, have their basic needs met during crises (for example, their needs for water, food, clothing, sanitation, mental and physical health treatment, and medications). During infectious disease outbreaks, mental health and psychosocial support considerations should be integrated into clinical case management and also into the broader public health emergency response *(113)*.

Suicide. Collaborations could involve sectors such as agriculture, industry, education, justice, labour, media, social welfare, transport, energy, construction, youth, minority affairs, defence, and food and drug authorities to reduce access to means for self-harm or suicide. This includes promoting responsible media reporting, decriminalizing suicide, reducing school pressures and introducing socio-emotional skills training in schools, and providing poverty alleviation schemes and mental health support for farmers.

For practical resources related to Policy directive 5.2 Joint actions on social and structural determinants and society-wide issues see the relevant section of the annex.

Special considerations for diverse groups
Policy area 5. Mental health sector contributions to addressing social and structural determinants and society-wide issues

Children and adolescents

Challenging stereotypes and promoting participation

- Incorporate the importance of listening to children and adolescents into communication strategies, campaigns, and training, while challenging the misconception that they are too immature to contribute meaningfully to discussions on a wide range of societal issues. Consider and address factors impacting the mental health and well-being of children, such as family environment, childhood adversity, maltreatment, neglect and household dysfunction, school conditions, peer relationships, and community safety.
- Provide children and adolescents with information so they can meaningfully contribute to decision-making processes, consistent with their evolving capacity.

Well-being at home and school

- Collaborate with education and social protection sectors to address social and structural determinants affecting mental health. For example, develop training programmes for parents or provide support staff to improve children's well-being at school and home. Such actions will support long-term benefits like increased educational attainment and reduced reliance on social support.

Addressing bullying and violence

- Work with the education, social protection, justice, and health sectors to create awareness programmes on the mental health impact of bullying and violence in schools.
- Develop coordinated, accessible, and child-friendly reporting mechanisms and support systems for survivors of violence, including psychological, legal, and social assistance.

Older adults

Challenging misconceptions

- Develop or incorporate communication strategies, campaigns, and training to counter stereotypes that older people are child-like, need close supervision, are out of touch, or cannot contribute to society.

Coordinated initiatives for older adults' well-being

- Work with education, social protection, justice, and health sectors to address elder abuse, ageism, financial insecurity, and social isolation. For example, increase awareness among caregivers, train stakeholders on identifying and reporting abuse, create accountability systems, support caregivers to prevent burnout, and allocate resources to welfare needs and inter-generational solidarity.

Women, men and gender diverse persons

Challenging gender stereotypes

- Develop communication strategies, campaigns, and training to challenge discriminatory beliefs about gender roles, including societal expectations that women focus on caregiving and household responsibilities while men are expected to earn an income. These efforts should challenge misconceptions about individuals whose gender does not align with their biological sex, emphasizing that gender diverse identities are not mental health conditions.
- Promote inclusive language, including preferred titles and pronouns, in communications and training initiatives.

Addressing gender-based violence

- Collaborate with the mental health, social protection, education, and justice sectors to highlight the impact of gender-based violence on mental health.
- Implement joint programmes to prevent violence, support survivors, and provide education for perpetrators.
- Offer social and economic support to women and gender-diverse people to address power imbalances, in order to reduce potential future violence and related costs (for example, costs related to social support and justice procedures).

Workplace equality and inclusion

- Work with the employment and education sectors to address sexism and eliminate the gender pay gap.
- Collaborate with the employment sector to implement policies and strategies to create family-friendly workplaces offering flexible work patterns, job sharing, extended maternity, paternity, and parental leave, part-time roles, nurseries, and breastfeeding rooms, and sick leave for severe period pain.
- Provide training on gender diversity and inclusion, and develop supportive workplace policies, including gender-neutral toilets options.

Persons belonging to the LGBTIQ+ community

Challenging heteronormative beliefs

- Develop or incorporate communication strategies, campaigns, and training that challenge the belief that only heterosexual beaviours are acceptable and that other sexual orientations should be changed through conversion therapy.

Support and education for LGBTIQ+ communities

- Collaborate with the education, social protection, and health sectors to foster greater understanding and empathy for the experiences of individuals questioning their sexual orientation during childhood and adolescence.
- Develop programmes and services for the LGBTIQ+ community, including peer-support groups.
- Provide training for school psychologists, counsellors, and staff on LGBTIQ+ issues.

Persons with disabilities

Challenging misconceptions

- Develop or incorporate communication strategies, campaigns, and training that counter beliefs that people with disabilities have less value, need healing, or have a limited or unhappy life.
- Avoid portraying people with disabilities as inspirational for handling routine tasks.

Accessible environments

- Work with mental health, urban and rural development, and social protection sectors to address how poor housing and outdoor environments (for example, curbs, steps, inaccessible doors, loud sounds) create barriers for people with disabilities, excluding them and thus potentially harming their mental health.
- Implement design criteria for accessible development in towns, streets, and homes to enable safe community engagement, activity, and social participation. Keep in mind that these strategies also benefit older adults and families with young children.

Migrants and refugees

Challenging misconceptions

- Develop or incorporate communication strategies, campaigns, and training to dispel myths that immigrants, migrants, and refugees commit more crimes, take jobs from others, or unfairly receive social benefits.

Overcoming legal, social, and cultural barriers

- Collaborate across mental health, health, justice, and education sectors to address legal status insecurity, disrupted social networks, and language barriers. For example, mental health, health, justice, and education sectors can jointly address the barriers migrants and refugees face when accessing healthcare.
- Train healthcare professionals to provide care that is culturally appropriate.
- Develop policies to allow undocumented migrants and immigrants access to healthcare without fear of reporting.
- Provide healthcare information in multiple languages, offer translation services, and facilitate language courses and assistance with obtaining legal documentation.

Persons from minoritized racial and ethnic groups

Combating racism

- Develop communication strategies, campaigns, and training that address racism, including the misconception that race is a biological construct or that it determines behavioural traits.
- Collaborate across mental health, health, and education sectors to highlight how racism affects mental health.
- Promote actions to combat racism, such as providing implicit bias training for health professionals and developing policies to report and address systemic racism in healthcare.

Housing stability

- Work with mental health, health, urban development, and social protection sectors to address the impact of poor housing on mental health among minoritized racial and ethnic groups.
- Develop policies to prevent gentrification. For example, tax policies could protect long-time residents or prohibit large-scale luxury development in neighborhoods where people from minoritized racial and ethnic groups live.

Indigenous Peoples

Challenging harmful beliefs about indigenous cultures

- Implement or incorporate messaging in communication strategies, campaigns, and training that challenge beliefs that indigenous languages, cultures, and values are inferior to those of the general population.

Climate Change and indigenous mental health

- Collaborate with health, environment, conservation, and climate protection sectors to address climate change impacts on the mental health of Indigenous Peoples.
- Develop policies to protect indigenous lands, such as restricting deforestation and creating protected areas or parks managed by Indigenous Peoples.

Persons who are houseless or with unstable housing

Challenging misconceptions about houseless people

- Develop or incorporate messaging into communication strategies, campaigns, and training that counter the belief that houseless people are lazy or choose their situation.
- Provide information on supporting their basic needs, such as food, hygiene, and clothing, and on how to find and maintain affordable, stable housing.

Training for support services staff

- Collaborate across education, health, social protection, and urban and rural development sectors to train staff in shelters, day centres, soup kitchens, public transport, and public facilities on skills to help houseless people and those with unstable housing to meet their basic needs and to transition to more stable accommodation.

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 (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/A/HRC/35/21, accessed 10 December 2024).
3. World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/356119).
4. Convention on the Rights of Persons with Disabilities, preamble, para. 5 (A/RES/61/106). New York: United Nations, General Assembly; 2006 (https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html, accessed 10 December 2024).
5. Marginalized groups. In: Glossary & Thesaurus [website]. Vilnius: European Institute for Gender Equality; n.d. (https://eige.europa.eu/thesaurus/terms/1280?lang=en, accessed 10 December 2024).
6. 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 10 December 2024.)
7. 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 10 December 2024).
8. Ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people. New York/Geneva: World Health Organization; 2015 (https://www.who.int/news/item/29-09-2015-ending-violence-and-discrimination-against-lesbian-gay-bisexual-transgender-and-intersex-people, accessed 10 December 2024).
9. Mental health and psychosocial support in humanitarian emergencies: what should protection programme managers know? Geneva: Inter-Agency Standing Committee (IASC) Global Protection Cluster Working Group and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings; 2010 (https://interagencystandingcommittee.org/sites/default/files/migrated/2018-10/MHPSS%20Protection%20Actors.pdf, accessed 10 December 2024).
10. 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 10 December 2024).
11. Boardman J, Dave S. Person-centred care and psychiatry: some key perspectives. BJPsych Int. 2020;17:65–8 (https://doi.org/10.1192/bji.2020.21).
12. Šiška J, Beadle-Brown J. Transition from institutional care to community-based services in 27 EU Member States: Final report. Research report for the European Expert Group on Transition from Institutional to Community-based Care. 2020 (https://deinstitutionalisationdotcom.files.wordpress.com/2020/05/eeg-di-report-2020-1.pdf), accessed 10 December 2024).
13. 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 10 December 2024).
14. 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/crpdc5-guidelines-deinstitutionalization-including, accessed 10 December 2024).
15. Convention on the Rights of Persons with Disabilities (A/RES/61/106). New York: United Nations, General Assembly; 2006 (https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html), accessed 10 December 2024).
16. Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329577).
17. 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 10 December 2024).
18. 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 10 December 2024).
19. 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 10 December 2024).
20. Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/345301).
21. Framework on integrated, people-centred health services. Report by the Secretariat to the Sixty-ninth World Health Assembly, Geneva, 23–28 May 2016. Geneva: World Health Organization; 2016 (https://iris.who.int/handle/10665/250704).
22. 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 (https://iris.who.int/handle/10665/373126).
23. Lora A, Lesage A, Pathare S, Levav I. Information for mental health systems: an instrument for policy-making and system service quality. Epidemiol Psychiatr Sci. 2017;26:383–94 (https://doi.org/10.1017/S2045796016000743).
24. Kaufman EA, McDonell MG, Cristofalo MA, Ries RK. Exploring barriers to primary care for patients with severe mental illness: frontline patient and provider accounts. Issues Ment Health Nurs. 2012;33:172–80 (https://doi.org/10.3109/01612840.2011.638415).
25. Tabril T, Chekira A, Housni Touhami YO. [The role of the general practitioner in management of psychiatric disorders]. Revue D'epidemiologie et de Sante Publique. 2020;68:185–92 (https://doi.org/10.1016/j.respe.2020.05.002).
26. Curtis D. Analysis of 50,000 exome-sequenced UK Biobank subjects fails to identify genes influencing probability of developing a mood

disorder resulting in psychiatric referral. J Affect Disord. 2021;281:216–9 (https://doi.org/10.1016/j.jad.2020.12.025).

27. Martin CL, Wain KE, Oetjens MT, Tolwinski K, Palen E, Hare-Harris A et al. Identification of neuropsychiatric copy number variants in a health care system population. JAMA Psychiatry. 2020;77:1276–85 (https://doi.org/10.1001/jamapsychiatry.2020.2159).
28. Winter NR, Leenings R, Ernsting J. More alike than different: quantifying deviations of brain structure and function in major depressive disorder across neuroimaging modalities. arXiv. 2021 (https://doi.org/10.48550/arXiv.2112.10730).
29. Star neuroscientist Tom Insel leaves the Google-spawned verily for ... a startup? In: WIRED [website]. San Francisco: WIRED; 2017 (https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/stopping-antidepressants, accessed 10 December 2024).
30. 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 (https://doi.org/10.1016/S0140-6736(11)61458-X).
31. Mfoafo-M'Carthy M, Huls S. Human rights violations and mental illness: implications for engagement and adherence. SAGE Open. 2014:1–18 (https://doi.org/10.1177/2158244014526).
32. Karni-Vizer N, Salzer MS. Verbal violence experiences of adults with serious mental illnesses. Psychiatr Rehabil J. 2016;39:299–304 (https://doi.org/10.1037/prj0000214).
33. Friedman C, Crabb C. Restraint, restrictive intervention, and seclusion of people with intellectual and developmental disabilities. Intellect Dev Disabil. 2018;56:171–87 (https://doi.org/10.1352/1934-9556-56.3.171).
34. McLaughlin P, Giacco D, Priebe S. Use of coercive measures during involuntary psychiatric admission and treatment outcomes: data from a prospective study across 10 European countries. PLoS One. 2016;11:e0168720 (https://doi.org/10.1371/journal.pone.0168720).
35. Belete H. Use of physical restraints among patients with bipolar disorder in Ethiopian mental specialized hospital, outpatient department: cross-sectional study. Int J Bipolar Disord. 2017;5:17 (https://doi.org/10.1186/s40345-017-0084-6).
36. McCann TV, Baird J, Muir-Cochrane E. Attitudes of clinical staff toward the causes and management of aggression in acute old age psychiatry inpatient units. BMC Psychiatry. 2014;14:80 (https://doi.org/10.1186/1471-244X-14-80).
37. Fariña-López E, Estévez-Guerra GJ. Uso de la restricción físic. A abordaje hasta la era moral [Historical aspects of the use of physical restraint: from antiquity to the era of moral treatment]. Rev Enferm. 2011;34:14–21. (https://pubmed.ncbi.nlm.nih.gov/21553511/, accessed 10 December 2024).
38. Mental health atlas 2017. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/272735).
39. Huskamp HA. Pharmaceutical cost management and access to psychotropic drugs: the U.S. context. Int J Law Psychiatry. 2005;28:484–95 (https://doi.org/10.1016/j.ijlp.2005.08.004).
40. Angermeyer MC, Dietrich S. Public beliefs about and attitudes towards people with mental illness: a review of population studies. Acta Psychiatr Scand. 2006;113:163–79 (https://doi.org/10.1111/j.1600-0447.2005.00699.x).
41. Schomerus G, Schwahn C, Holzinger A. Evolution of public attitudes about mental illness: a systematic review and meta-analysis. Acta Psychiatr Scand. 2012;125:440–52 (https://doi.org/10.1111/j.1600-0447.2012.01826.x).
42. Ryan RM, Deci EL. Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. Am Psychol. 2000;55:68–78 (https://doi.org/10.1037//0003-066x.55.1.68).
43. Ng JY, Ntoumanis N, Thogersen-Ntoumani C, Deci EL, Ryan RM, Duda JL et al. Self-determination theory applied to health contexts: a meta-analysis. Perspect Psychol Sci. 2012;7:325–40 (https://doi.org/10.1177/1745691612447309).
44. Jeste DV, Eglit GML, Palmer BW, Martinis JG, Blanck P, Saks ER. Supported decision making in serious mental illness. Psychiatry. 2018;81:28–40 (https://doi.org/10.1080/00332747.2017.1324697).
45. Blanck P, Martinis JG. "The right to make choices": The National Resource Center for Supported Decision-Making. Inclusion 2015;3:24–33 (https://doi.org/10.1352/2326-6988-3.1.24).
46. Jameson JM, Riesen T, Polychronis S. Guardianship and the potential of supported decision making with individuals with disabilities. Research and Practice for Persons with Severe Disabilities. 2015;40:36–51 (https://doi.org/10.1177/1540796915586189).
47. Bhugra D, Pathare S, Nardodkar R, Gosavi C, Ng R, Torales J. Legislative provisions related to marriage and divorce of persons with mental health problems: a global review. Int Rev Psychiatry. 2016;28:386–92 (https://doi.org/10.1080/09540261.2016.1210577).
48. Bhugra D, Pathare S, Joshi R, Nardodkar R, Torales J, Tolentino EJJr. Right to property, inheritance, and contract and persons with mental illness. Int Rev Psychiatry. 2016;28:402–8 (https://doi.org/10.1080/09540261.2016.1210576).
49. Bhugra D, Pathare S, Gosavi C, Ventriglio A, Torales J, Castaldelli-Maia J. Mental illness and the right to vote: a review of legislation across the world. Int Rev Psychiatry. 2016;28:395–9 (https://doi.org/10.1080/09540261.2016.1211096).
50. WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities. Geneva: World Health Organization; 2012 (https://iris.who.int/handle/10665/70927).
51. Mental health atlas 2020. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/345946).
52. Cuijpers P, Chisholm D, Sweeny K, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. Lancet Psychiatry. 2016;3 (https://doi.org/10.1016/S2215-0366(16)30024-4).
53. Chisholm D, Docrat S, Abdulmalik J, Alem A. Mental health financing challenges, opportunities and strategies in low- and middle-income countries: findings from the Emerald project. BJPsych Open. 2019;5:e68 (https://doi.org/10.1192/bjo.2019.24).
54. Report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, 16 July 2018 (A/73/161). Geneva: United Nations, Human Rights Council; 2018 (https://undocs.org/en/A/73/161, accessed 10 December 2024).
55. Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341648).
56. Investing in mental health: evidence for action. Geneva: World Health Organization; 2013 (https://iris.who.int/handle/10665/8723).
57. Mental health investment case: a guidance note. Geneva: World Health Organization & United Nations Development Programme; 2021 (https://iris.who.int/handle/10665/340246).
58. WHO guidance on policy directives and strategic actions to promote and protect mental health and well-being across government sectors. Geneva: World Health Organization; forthcoming 2025.
59. Loubière S, Lemoine C, Boucekine M, Boyer L. Housing First study group. Housing First for homeless people with severe mental illness:

extended 4-year follow-up and analysis of recovery and housing stability from the randomized un chez soi d'abord trial. Epidemiol Psychiatr Sci. 2022;31:e14 (https://doi.org/10.1017/S2045796022000026).

60. Un chez soi d'abord. In: Ministère de la Transition écologique et de la Cohésion des territoires [website]. Paris: Ministère de la Transition écologique et de la Cohésion des territoires; 2020 (https://www.ecologie.gouv.fr/chez-soi-dabord, accessed 10 December 2024).
61. Projet en coopération – «Un chez soi d'abord», quand logement rime avec accompagnement. In: La Fonda [website]. Vincennes: La Fonda; n.d. (https://fonda.asso.fr/ressources/projet-en-cooperation-un-chez-soi-dabord-quand-logement-rime-avec-accompagnement, accessed 10 December 2024).
62. Mental health information systems. Geneva: WHO/HQ; 2005 (https://iris.who.int/handle/10665/205531).
63. Robey JM, Lee SH. Information system development in support of national health programme monitoring and evaluation: the case of the Philippines. World Health Stat Q. 1990;43:37–46. (https://pubmed.ncbi.nlm.nih.gov/2375128/, accessed 10 December 2024).
64. De Kadt E. Making health policy management intersectoral: issues of information analysis and use in less developed countries. Soc Sci Med. 1989;29:503–14 (https://doi.org/10.1016/0277-9536(89)90196-2).
65. Stephens J, Simkhada P, van Teijlingen E, et al. An analysis of Nepal's Draft Mental Health Acts 2006–2017: competing values and power. Health Policy Plan. 2024;3:czae023 (https://doi.org/10.1093/heapol/czae023).
66. Civil society organizations to promote human rights in mental health and related areas: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329589).
67. Advocacy for mental health, disability and human rights: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329587).
68. Angermeyer MC, Schulze B. Reinforcing stereotypes: how the focus on forensic cases in news reporting may influence public attitudes towards the mentally ill. Int J Law Psychiatry. 2001;24:469–86 (https://doi.org/10.1016/s0160-2527(01)00079-6).
69. Levin A. Media cling to stigmatizing portrayals of mental illness. Psychiatric News. 16 December 2011 (https://psychnews.psychiatryonline.org/doi/full/10.1176/pn.46.24.psychnews_46_24_16-a, accessed 10 December 2024).
70. LIVE LIFE: preventing suicide. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/325650).
71. Naslund JA, Grande SW, Aschbrenner KA, Elwyn G. Naturally occurring peer support through social media: the experiences of individuals with severe mental illness using YouTube. PLoS One. 2014;9:e110171 (https://doi.org/10.1371/journal.pone.0110171).
72. Naslund JA, Aschbrenner KA, McHugo GJ, Unützer J, Marsch LA, Bartels SJ. Exploring opportunities to support mental health care using social media: a survey of social media users with mental illness. Early Interv Psychiatry. 2019;13:405–13 (https://doi.org/10.1111/eip.12496).
73. Recommendations for reporting on suicide. In: Reporting on Suicide [website]. n.d.: Reporting on Suicide; n.d. (https://reportingonsuicide.org/, accessed 10 December 2024).
74. 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 (https://doi.org/10.1377/hlthaff.28.3.816).
75. Morgan C, Fearon P, Lappin J, Heslin M, Donoghue K. Ethnicity and long-term course and outcome of psychotic disorders in a UK sample: the AESOP-10 study. Br J Psychiatry. 2017;211:88–94 (https://doi.org/10.1192/bjp.bp.116.193342).
76. Carreras Tartak JA, Brisbon N, Wilkie S, Sequist TD. Racial and ethnic disparities in emergency department restraint use: a multicenter retrospective analysis. Acad Emerg Med. 2017;28:957–65 (https://doi.org/10.1111/acem.14327).
77. Hunt P, Mesquita J. Mental disabilities and the human right to the highest attainable standard of health. Human Rights Quarterly. 2006;28:332–56. (https://www.jstor.org/stable/20072740, accessed 10 December 2024).
78. Wainberg ML, Scorza P, Shultz JM. Challenges and opportunities in global mental health: a research-to-practice perspective. Curr Psychiatry Rep. 2017;19:28 (https://doi.org/10.1007/s11920-017-0780-z).
79. Pathare S, Brazinova A, Levav I. Care gap: a comprehensive measure to quantify unmet needs in mental health. Epidemiol Psychiatr Sci. 2018;27:463–7 (https://doi.org/10.1017/S2045796018000100).
80. Henderson C, Evans-Lacko S, Thornicroft G. Mental illness stigma, help seeking, and public health programs. Am J Public Health. 2013;103:777–80 (https://doi.org/10.2105/AJPH.2012.301056).
81. Patel V. Mental health in low- and middle-income countries. Br Med Bull. 2007;81-82:81–96 (https://doi.org/10.1093/bmb/ldm010).
82. Mental health systems in selected low- and middle-income countries: a WHO-AIMS cross-national analysis. Geneva: World Health Organization; 2009 (https://iris.who.int/handle/10665/44151).
83. Living in hell. Abuses against people with psychosocial disabilities in Indonesia. In: Human Rights Watch. New York: Human Rights Watch; 2016 (https://www.hrw.org/report/2016/03/20/living-hell/abuses-against-people-psychosocial-disabilities-indonesia, accessed 10 December 2024).
84. Psychiatric hospitals in Uganda. A human rights investigation. Budapest: Mental Disability Advocacy Centre; 2014 (http://www.mdac.org/sites/mdac.info/files/psyciatric_hospitals_in_uganda_human_rights_investigation.pdf, accessed 10 December 2024).
85. 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. Project report. Brussels: Mental Health Europe; 2018 (https://kar.kent.ac.uk/64970/1/Mapping-and-Understanding-Exclusion-in-Europe.pdf, accessed 10 December 2024).
86. Pūras D, Gooding P. Mental health and human rights in the 21st century. Epidemiol Psychiatr Sci. 2019;18:42–3 (https://doi.org/10.1002/wps.20599).
87. Lund C. Mental health and human rights in South Africa: the hidden humanitarian crisis. South African Journal on Human Rights. 2016;32:403–5 (https://doi.org/10.1080/02587203.2016.1266799).
88. Cohen A, Minas H. Global mental health and psychiatric institutions in the 21st century. Epidemiol Psychiatr Sci. 2017;26:4–9 (https://doi.org/10.1017/S2045796016000652).
89. 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, 4 April 2016 (A/HRC/32/32). Geneva: United Nations, Human Rights Council; 2016 (https://undocs.org/en/A/HRC/32/32, accessed 10 December 2024).
90. Shim RS, Compton MT. Addressing the social determinants of mental health: if not now, when? If not us, who? Psychiatr Serv. 2018;69:844–6

(https://doi.org/10.1176/appi.ps.201800060).

91. Compton MT, Shim RS. The social determinants of mental health. FOCUS. 2015;13:419–25 (https://doi.org/10.1176/appi.focus.20150017).
92. Shim RS, Compton MT. The social determinants of mental health: psychiatrists' roles in addressing discrimination and food insecurity. Am Psychiatr Publ. 2020;18:25–30 (https://doi.org/10.1176/appi.focus.20190035).
93. Survey of America's Physicians: examining how the social drivers of health affect the nation's physicians and their patients 2022. Austin: The Physicians Foundation; 2022 (https://physiciansfoundation.org/physician-and-patient-surveys/the-physicians-foundation-2022-physician-survey-part-1/, accessed 10 December 2024).
94. Beeker T, Mills C, Bhugra D. Psychiatrization of society: a conceptual framework and call for transdisciplinary research. Front Psychiatry. 2021;12:645556 (https://doi.org/10.3389/fpsyt.2021.645556).
95. 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 (https://doi.org/10.1016/S0140-6736(18)31612-X).
96. Firth J, Siddiqi N, Koyanagi A. The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. Lancet Psychiatry. 2019;6:675–712 (https://doi.org/10.1016/S2215-0366(19)30132-4).
97. Saxena S, Maj M. Physical health of people with severe mental disorders: leave no one behind. World Psychiatry. 2017;16:1–2 (https://doi.org/10.1016/S2215-0366(19)30132-4).
98. 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 (https://doi.org/10.1002/j.2051-5545.2011.tb00014.x).
99. Lawrence D, Kisely S. Inequalities in healthcare provision for people with severe mental illness. J Psychopharmacol. 2010;24:61–8 (https://doi.org/10.1177/1359786810382058).
100. Correll CU, Solmi M, Veronese N. Prevalence, incidence and mortality from cardiovascular disease in patients with pooled and specific severe mental illness: a large-scale meta-analysis of 3,211,768 patients and 113,383,368 controls. World Psychiatry. 2017;16:163–80 (https://doi.org/10.1002/wps.20420).
101. Vreeland B. Treatment decisions in major mental illness: weighing the outcomes. J Clin Psychiatry. 2007;68 Suppl 12:5–12. (https://www.ncbi.nlm.nih.gov/pubmed/17956150, accessed 10 November 2022).
102. Mitchell AJ, Malone D, Doebbeling CC. Quality of medical care for people with and without comorbid mental illness and substance misuse: systematic review of comparative studies. Br J Psychiatry. 2009;194:491–9 (https://doi.org/10.1192/bjp.bp.107.045732).
103. Fagiolini A, Goracci A. The effects of undertreated chronic medical illnesses in patients with severe mental disorders. J Clin Psychiatry. 2009;70 Suppl 3:22–9 (https://doi.org/10.4088/JCP.7075su1c.04).
104. World mental health report: transforming mental health for all, Figure 7.1, p 195. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/356119).
105. Cuthbert S, Kellas A, Page LA. Green care in psychiatry. Br J Psychiatry. 2021;218:73–4 (https://doi.org/10.1192/bjp.2020).
106. WHO global strategy on health, environment and climate change: the transformation needed to improve lives and wellbeing sustainably through healthy environments. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/331959).
107. Rafla-Yuan E, Chhabra DK, Mensah MO. Decoupling crisis response from policing – a step toward equitable psychiatric emergency services. N Engl J Med. 2021;384:1769–73 (https://doi.org/10.1056/nejmms2035710).
108. One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module: module slides. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329643).
109. Peer support groups by and for people with lived experience: WHO QualityRights guidance module: module slides. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329644).
110. Consolidated telemedicine implementation guide. Geneva: World Health Organization; 2022 (https://iris.who.int/bitstream/handle/10665/364221/9789240059184-eng.pdf?sequence=1).
111. Web content accessibility guidelines (WCAG) 2.1. In: World Wide Web Consortium [website]. Cambridge: World Wide Web Consortium; 2023 (https://www.w3.org/TR/WCAG21/, accessed 10 December 2024).
112. WHO'-ITU global standard for accessibility of telehealth services. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/356160).
113. The mental health and psychosocial support minimum services package (MHPSS MSP). New York: United Nations Inter-Agency Standing Committee; 2022 (https://www.mhpssmsp.org/sites/default/files/2021-10/MHPSS%20MSP%20Field%20Test%20Version_1.pdf, accessed 10 December 2024).
114. Rugkåsa J. Effectiveness of community treatment orders: the international evidence. Can J Psychiatry. 2016;61:15–24 (https://doi.org/10.1177/0706743715620415).
115. 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 10 December 2024).
116. Freedom from coercion, violence and abuse: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329582).
117. Transforming services and promoting human rights: WHO QualityRights training and guidance: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329611).
118. Legal capacity and the right to decide: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329539).
119. Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329602).
120. Strategies to end seclusion and restraint: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329605).
121. WHO QualityRights e-training on mental health, WHO Academy. In: Mental Health and Substance Use [website]. Geneva: World Health

Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training; https://whoacademy.org/, accessed 10 December 2024).

122. One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329591).
123. Person-centred recovery planning for mental health and well-being: self-help tool: WHO QualityRights. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329598).
124. Supported decision-making and advance planning: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329609).
125. Our epidemic of loneliness and isolation: the U.S. surgeon general's advisory on the healing effects of social connection and community. North Bethesda: United States Public Health Service Commissioned Corps; 2023 (https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf, accessed 10 December 2024).
126. Holt-Lunstad J, Robles TF, Sbarra DA. Advancing social connection as a public health priority in the United States. Am Psychol. 2017;72:517–30 (https://doi.org/10.1037/amp0000103).
127. Mann F, Wang J, Pearce E, Ma R. Loneliness and the onset of new mental health problems in the general population. Soc Psychiatry Psychiatr Epidemiol. 2022;57:2161–78 (https://doi.org/10.1007/s00127-022-02261-7).
128. Tachikawa H, Matsushima M, Midorikawa H, Aiba M, Okubo R, Tabuchi T. Impact of loneliness on suicidal ideation during the COVID-19 pandemic: findings from a cross-sectional online survey in Japan. BMJ Open. 2023;13:e063363 (https://doi.org/10.1136/bmjopen-2022-063363).
129. Berlingieri F, Colagrossi M, Mauri C. Loneliness and social connectedness: insights from a new EU-wide survey, JRC133351. Brussels: European Commission; 2023 (https://publications.jrc.ec.europa.eu/repository/handle/JRC133351, accessed 10 December 2024).
130. Policy brief: COVID-19 and the need for action on mental health. New York: United Nations; 2020 (https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf, accessed 10 December 2024).
131. Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health. 2019;73:379–87 (https://doi.org/10.1136/jech-2018-210981).
132. Home again: housing with supportive services for women with mental illness experiencing long term care needs. In: Mental Health Innovation Network [website]. Geneva & London: Mental Health Innovation Network; n.d. (https://www.mhinnovation.net/innovations/home-again-housing-supportive-services-women-mental-illness-experiencing-long-term-care?qt-content_innovation=2#qt-content_innovation, accessed 10 December 2024).
133. Moise N, Hankerson S. Addressing structural racism and inequities in depression care. JAMA Psychiatry. 2021;78:1061–2 (https://doi.org/10.1001/jamapsychiatry.2021.1810).
134. 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 10 December 2024).
135. LIVE LIFE: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341726).
136. Mental health and psychosocial support platform. Section 4. In: Mental health and psychosocial support [website]. Geneva: World Health Organization; n.d. (https://www.emro.who.int/mhps/suicide.html, accessed 10 December 2024).
137. Care homes and hospitals 'failing people with dementia'. In: The Guardian [website]. London: The Guardian; 2013 (http://www.theguardian.com/society/2013/mar/12/care-homes-hospitals-failing-dementia, accessed 10 December 2024).
138. Models of deinstitutionalization and methods of protecting mental health in community. Podgorica: Human Rights Action; 2017 (http://www.hraction.org/wp-content/uploads/The-report-in-ENG.pdf, accessed 10 December 2024).
139. In our lifetime: How donors can end the institutionalisation of children. New York: Lumos Foundation USA; 2019 (https://codeofgoodpractice.com/wp-content/uploads/2019/05/Lumos-In-Our-Lifetime-How-Donors-can-End-the-Insittutionalisation-of-Children.pdf, accessed 10 December 2024).
140. Issue brief: older people and COVID-19. New York: United Nations Department of Economic and Social Affairs; 2020 (https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2020/04/POLICY-BRIEF-ON-COVID19-AND-OLDER-PERSONS.pdf, accessed 10 December 2024).
141. Innovation in deinstitutionalization: a WHO expert survey. Geneva: World Health Organization; 2014 (https://iris.who.int/handle/10665/112829).
142. Bendini M, Dinarte L. Does maternal depression undermine childhood cognitive development? Evidence from the Young Lives Survey in Peru. Int J Environ Res Public Health. 2020;17 (https://doi.org/10.3390/ijerph17197248).
143. Kakuma R, Minas H, van Ginneken N, Dal Poz MR, Desiraju K, Morris JE et al. Human resources for mental health care: current situation and strategies for action. Lancet. 2011;378:1654–63 (https://doi.org/10.1016/S0140-6736(11)61093-3).
144. Human resources for mental health: workforce shortages in low- and middle-income countries. Geneva: World Health Organization; 2011 (https://iris.who.int/handle/10665/44508).
145. Human resources and training for mental health. London: Mental health Innovation; n.d. (mhinnovation.net/sites/default/files/files/4_Humanresource%26training_Infosheet%5B1%5D.pdf, accessed 10 December 2024).
146. Gibbons HM, Owen R, Heller T. Perceptions of health and healthcare of people with intellectual and developmental disabilities in medicaid managed care. Intellect Dev Disabil. 2016;54:94–105 (https://doi.org/10.1352/1934-9556-54.2.94).
147. PRIME policy brief 3. Human resources for mental health care: current situation and strategies for action. London: PRIME; 2013 (https://www.gov.uk/research-for-development-outputs/prime-policy-brief-3-human-resources-for-mental-health-care-current-situation-and-strategies-for-action, accessed 10 December 2024).
148. Mental health policy, plans and programmes, updated version. Geneva: World Health Organization; 2005 (https://iris.who.int/handle/10665/42948).
149. Erdman JN. Human rights education in patient care. Public Health Rev. 2017;38:14 (https://doi.org/10.1186/s40985-017-0061-8).
150. Hunt P. The health and human rights movement: progress and obstacles. J Law Med. 2008;15:714–24. (https://www.ncbi.nlm.nih.gov/pubmed/18575172, accessed 10 December 2024).
151. Nordt C, Rössler W, Lauber C. Attitudes of mental health professionals towards people with schizophrenia and major depression. Schizophr

Bull. 2006;32:709–14 (https://doi.org/10.1093/schbul/sbj065).

152. Loch AA, Hengartner MP, Guarniero FB, Lawson FL, Wang YP, Gattaz WF et al. The more information, the more negative stigma towards schizophrenia: Brazilian general population and psychiatrists compared. Psychiatry Res. 2013;205:185–91 (https://doi.org/10.1016/j.psychres.2012.11.023).
153. Wahl O, Aroesty-Cohen E. Attitudes of mental health professionals about mental illness: a review of the recent literature. Journal of Community Psychology. 2010;38:49–62 (https://doi.org/10.1002/jcop.20351).
154. Deng Y, Wang AL, Frasso R, Ran MS, Zhang TM, Kong D et al. Mental health-related stigma and attitudes toward patient care among providers of mental health services in a rural Chinese county. Int J Soc Psychiatry. 2022;68:610–8 (https://doi.org/10.1177/0020764021992807).
155. Ee J, Kroese BS, Lim JM, Rose J. What do specialist mental health professionals think of the mental health services for people with intellectual disabilities in Singapore? J Intellect Disabil. 2022;26:972–89 (https://doi.org/10.1177/17446295211030094).
156. Stuart H, Sartorius N, Liinamaa T, Images Study G. Images of psychiatry and psychiatrists. Acta Psychiatr Scand. 2015;131:21–8 (https://doi.org/10.1111/acps.12368)
157. Bhugra D, Sartorius N, Fiorillo A, Evans-Lacko S, Ventriglio A, Hermans MH et al. EPA guidance on how to improve the image of psychiatry and of the psychiatrist. Eur Psychiatry. 2015;30:423–30 (https://doi.org/10.1016/j.eurpsy.2015.02.003).
158. Gaebel W, Zaske H, Zielasek J, Cleveland HR, Samjeske K, Stuart H et al. Stigmatization of psychiatrists and general practitioners: results of an international survey. Eur Arch Psychiatry Clin Neurosci. 2015;265:189–97 (https://doi.org/10.1007/s00406-014-0530-8).
159. Morse G, Salyers MP, Rollins AL, Monroe-DeVita M, Pfahler C. Burnout in mental health services: a review of the problem and its remediation. Adm Policy Ment Health. 2012;39:341–52 (https://doi.org/10.1007/s10488-011-0352-1).
160. Tamaskar P, McGinnis RA. Declining student interest in psychiatry. JAMA. 2002;287:1859 (https://doi.org/10.1001/jama.287.14.1859-JMS0410-5-1).
161. Lambert T, Turner G, Fazel S. Reasons why some UK medical graduates who initially choose psychiatry do not pursue it as a long-term career. Psychol Med. 2006;36:679–84 (https://doi.org/10.1017/S0033291705007038).
162. Katschnig H. Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. World Psychiatry. 2010;9:21–8 (https://doi.org/10.1002/j.2051-5545.2010.tb00257.x).
163. Bhugra D, Moran P. Alienation of the alienist: psychiatry on the ropes? J R Soc Med. 2014;107:224–7 (https://doi.org/10.1177/0141076814525070).
164. mhGAP training manuals for the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0 (for field testing). Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/259161).
165. Seal AN, Playford D, McGrail MR, Fuller L. Influence of rural clinical school experience and rural origin on practising in rural communities five and eight years after graduation. Med J Aust. 2022;216:572–7 (https://doi.org/10.5694/mja2.51476).
166. WHO guidelines on mental health at work. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/363177).
167. Mental health at work: policy brief. Geneva: World Health Organization and International Labour Organization; 2022 (https://iris.who.int/handle/10665/362983).
168. Mental health and psychosocial support: minimum service package Geneva: United Nations Inter-Agency Standing Committee; 2022 (https://www.mhpssmsp.org/en/downloads, accessed 10 December 2024).
169. Williams DR. Everyday discrimination scale. In: Harvard University [website]. Cambridge: Harvard University; n.d. (https://scholar.harvard.edu/davidrwilliams/node/32397, accessed 10 December 2024).
170. The right to health. Fact sheet no. 31. Geneva: OHCHR with the World Health Organization; 2008 (https://www.ohchr.org/en/publications/fact-sheets/fact-sheet-no-31-right-health, accessed 10 December 2024).
171. Baker E, Fee J, Bovingdon L, Campbell T, Hewis E, Lewis D. From taking to using medication: recovery-focused prescribing and medicines management. Advances in Psychiatric Treatment. 2013;19:2–10 (https://doi.org/10.1192/apt.bp.110.008342).
172. Wand T, Buchanan-Hagen S, Derrick K, Harris M. Are current mental health assessment formats consistent with contemporary thinking and practice? Int J Ment Health Nurs. 2020;29:171–6 (https://doi.org/10.1111/inm.12656).
173. Clancy L, Happell B, Moxham L. The language of risk: common understanding or diverse perspectives? Issues Ment Health Nurs. 2014;35:551–7 (https://doi.org/10.3109/01612840.2014.880139).
174. Jorgensen K, Hansen M, Karlsson B. Recovery-oriented practices in a mental health centre for citizens experiencing serious mental issues and substance use: as perceived by healthcare professionals. Int J Environ Res Public Health. 2022;19 (https://doi.org/10.3390/ijerph191610294).
175. Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. Lancet Psychiatry. 2019;6:538–46 (https://doi.org/10.1016/S2215-0366(19)30032-X).
176. Stopping antidepressants. In: Royal College of Psychiatrists [website]. London: Royal College of Psychiatrists; n.d. (https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/stopping-antidepressants, accessed 10 December 2024).
177. Hengartner MP, Read J, Moncrieff J. Protecting physical health in people with mental illness. Lancet Psychiatry. 2019;6:890 (https://doi.org/10.21256/zhaw-18614).
178. Weinmann S, Read J, Aderhold V. Influence of antipsychotics on mortality in schizophrenia: systematic review. Schizophr Res. 2009;113:1–11 (https://doi.org/10.1016/j.schres.2009.05.018).
179. Stassen HH, Bachmann S, Bridler R, Cattapan K, Herzig D, Schneeberger A et al. Detailing the effects of polypharmacy in psychiatry: longitudinal study of 320 patients hospitalized for depression or schizophrenia. Eur Arch Psychiatry Clin Neurosci. 2022;272:603–19 (https://doi.org/10.1007/s00406-021-01358-5).
180. Halli-Tierney AD, Scarbrough C, Carroll D. Polypharmacy: evaluating risks and deprescribing. Am Fam Physician. 2019;100:32–8. (https://www.aafp.org/pubs/afp/issues/2019/0701/p32.html, accessed 10 December 2024).
181. Svensson SA, Hedenrud TM, Wallerstedt SM. Attitudes and behaviour towards psychotropic drug prescribing in Swedish primary care: a questionnaire study. BMC Fam Pract. 2019;20 (https://doi.org/10.1186/s12875-018-0885-4).
182. He Ara Oranga: report of the government inquiry into mental health and addiction. Wellington: The Government Inquiry into Mental Health and Addiction; 2018 (https://www.mentalhealth.inquiry.govt.nz/inquiry-report/, accessed 10 December 2024).
183. Cuijpers P, Donker T, Weissman MM, Ravitz P, Cristea IA. Interpersonal psychotherapy for mental health problems: a comprehensive meta-analysis. Am J Psychiatry. 2016;173:680–7 (https://doi.org/10.1176/appi.ajp.2015.15091141).

184. Carpenter JK, Andrews LA, Witcraft SM, Powers MB, Smits JAJ, Hofmann SG. Cognitive behavioral therapy for anxiety and related disorders: a meta-analysis of randomized placebo-controlled trials. Depress Anxiety. 2018;35 (https://doi.org/10.1002/da.22728).

185. Linardon J, Wade TD, de la Piedad Garcia X, Brennan L. The efficacy of cognitive-behavioral therapy for eating disorders: a systematic review and meta-analysis. J Consult Clin Psychol. 2017;85:1080–94 (https://doi.org/10.1037/ccp0000245).

186. Liu J, Gill NS, Teodorczuk A, Li ZJ, Sun J. The efficacy of cognitive behavioural therapy in somatoform disorders and medically unexplained physical symptoms: a meta-analysis of randomized controlled trials. J Affect Disord. 2019;15:98–112 (https://doi.org/10.1016/j.jad.2018.10.114).

187. DeCou CR, Comtois KA, Landes SJ. Dialectical behavior therapy is effective for the treatment of suicidal behavior: a meta-analysis. Behav Ther. 2019;50:60–72 (https://doi.org/10.1016/j.beth.2018.03.009).

188. McCartney M, Nevitt S, Lloyd A, Hill R, White R, Duarte R. Mindfulness-based cognitive therapy for prevention and time to depressive relapse: systematic review and network meta-analysis. Acta Psychiatr Scand. 2020;143:6–21 (https://doi.org/10.1111/acps.13242).

189. Gask L, Bower P, Lamb J, Burroughs H, Chew-Graham C, Edwards S et al. Improving access to psychosocial interventions for common mental health problems in the United Kingdom: narrative review and development of a conceptual model for complex interventions. BMC Health Serv Res. 2012;12:249 (https://doi.org/10.1186/1472-6963-12-249).

190. Berry K, Raphael J, Haddock G, Bucci S, Price O, Lovell K et al. Exploring how to improve access to psychological therapies on acute mental health wards from the perspectives of patients, families and mental health staff: qualitative study. BJPsych Open. 2022;8:e112 (https://doi.org/10.1192/bjo.2022.513).

191. Lovell K, Richards D. Multiple access points and levels of entry (MAPLE): ensuring choice, accessibility and equity for CBT services. Behavioural and Cognitive Psychotherapy. 2020;28:379–91 (https://doi.org/10.1017/S1352465800004070).

192. Rahman A, Waqas A, Nisar A, Nazir H, Sikander S, Atif N. Improving access to psychosocial interventions for perinatal depression in low- and middle-income countries: lessons from the field. Int Rev Psychiatry. 2021;33:198–201 (https://doi.org/10.1080/09540261.2020.1772551).

193. Burgess RA, Jain S, Petersen I, Lund C. Social interventions: a new era for global mental health? Lancet Psychiatry. 2020;7:118–9 (https://doi.org/10.1016/S2215-0366(19)30397-9).

194. Wahlbeck K, Cresswell-Smith J, Haaramo P, Parkkonen J. Interventions to mitigate the effects of poverty and inequality on mental health. Soc Psychiatry Psychiatr Epidemiol. 2017;52:505–51 (https://doi.org/10.1007/s00127-017-1370-4).

195. Johnson S. Social interventions in mental health: a call to action. Soc Psychiatry Psychiatr Epidemiol. 2017;52:245–7 (https://doi.org/10.1007/s00127-017-1360-6).

196. Manger S. Lifestyle interventions for mental health. Aust J Gen Pract. 2019;48:670–3 (https://doi.org/10.31128/AJGP-06-19-4964).

197. Todesco B, Ostuzzi G, Barbui C. Mapping the selection, availability, price and affordability of essential medicines for mental health conditions at a global level. Epidemiol Psychiatr Sci. 2022;31:e22 (https://doi.org/10.1017/S2045796022000087).

198. Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/375767).

199. Diagnostic and statistical manual of mental disorders (5th ed., text rev.). Washington, DC: American Psychiatric Association 2022 (https://doi.org/10.1176/appi.books.9780890425787).

200. Sheehan DV, Lecrubier Y, Sheehan KH, et al. The mini-international neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. J Clin Psychiatry. 1998;59 22–33. (https://pubmed.ncbi.nlm.nih.gov/9881538/, accessed 10 December 2024).

201. First MB, Gibbon M. The structured clinical interview for DSM-IV Axis I disorders (SCID-I) and the structured clinical interview for DSM-IV axis II disorders (SCID-II). In: Hilsenroth MJ, Segal DL, editors. Comprehensive handbook of psychological assessment, Vol 2 Personality assessment (pp 134–143). Hoboken: John Wiley & Sons, Inc.; 2004:13–23.

202. Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/376208).

203. Eather N, Wade L, Pankowiak A, Eime R. The impact of sports participation on mental health and social outcomes in adults: a systematic review and the 'mental health through sport' conceptual model. Syst Rev. 2023;12:102 (https://doi.org/10.1186/s13643-023-02264-8).

204. WHO guidelines on physical activity and sedentary behaviour. Geneva: World Health Organization & United Nations Development Programme; 2020 (https://iris.who.int/handle/10665/336656).

205. Firth J, Marx W, Dash S, Carney R, Teasdale SB, Solmi M. The effects of dietary improvement on symptoms of depression and anxiety: a meta-analysis of randomized controlled trials. Psychosom Med. 2019;81:265–80 (https://doi.org/10.1097/PSY.0000000000000673).

206. Grajek M, Krupa-Kotara K, Białek-Dratwa A, Sobczyk K, Grot M, Kowalski O. Nutrition and mental health: a review of current knowledge about the impact of diet on mental health. Front Nutr. 2022;9:943998 (https://doi.org/10.3389/fnut.2022.943998).

207. Scott AJ, Webb TL, Martyn-St James M, Rowse G, Weich S. Improving sleep quality leads to better mental health: a meta-analysis of randomised controlled trials. Sleep Med Rev. 2021;60:101556 (https://doi.org/10.1016/j.smrv.2021.101556).

208. Albakri U, Drotos E, Meertens R. Sleep health promotion interventions and their effectiveness: an umbrella review. Int J Environ Res Public Health. 2021;18:5533 (https://doi.org/10.3390/ijerph18115533).

209. Pandor A, Kaltenthaler E, Higgins A, Lorimer K, Smith S, Wylie K et al. Sexual health risk reduction interventions for people with severe mental illness: a systematic review. BMC Public Health. 2015;15:138 (https://doi.org/10.1186/s12889-015-1448-4).

210. Hameed S, Maddams A, Lowe H, Davies L, Khosla R, Shakespeare T. From words to actions: systematic review of interventions to promote sexual and reproductive health of persons with disabilities in low- and middle-income countries. BMJ Glob Health. 2020;5:e002903 (https://doi.org/10.1136/bmjgh-2020-002903).

211. Li SYH, Bressington D. The effects of mindfulness-based stress reduction on depression, anxiety, and stress in older adults: a systematic review and meta-analysis. Int J Ment Health Nurs. 2019;28:635–56 (https://doi.org/10.1111/inm.12568).

212. Büssing A, Michalsen A, Khalsa SB, Telles S, Sherman KJ. Effects of yoga on mental and physical health: a short summary of reviews. Evid Based Complement Alternat Med. 2012;2012:165410 (https://doi.org/10.1155/2012/165410).

213. Fancourt D, Finn S. What is the evidence on the role of the arts in improving health and well-being? A scoping review. Geneva: WHO Regional Office for Europe; 2019 (https://iris.who.int/handle/10665/329834).

214. A toolkit on how to implement social prescribing. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/354456).
215. Dâmaso M, Dowden S, Smith C. Culture for health and well-being compendium. A guide for practitioners. Brussels: Culture Action Europe; 2023 (https://www.cultureforhealth.eu/app/uploads/2023/06/C4H_Compendium_V4_LP.pdf, accessed 10 December 2024).
216. Britton E, Kindermann G, Domegan C, Carlin C. Blue care: a systematic review of blue space interventions for health and wellbeing. Health Promot Int. 2020;35:50–69 (https://doi.org/10.1093/heapro/day103).
217. International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/331635).
218. Guide to starting and managing needle and syringe programmes. Geneva: World Health Organization, UNAIDS & UNODC; 2007 (https://iris.who.int/handle/10665/43816).
219. Lightfoot K, Panagiotaki G, Nobes G. Effectiveness of psychological interventions for smoking cessation in adults with mental health problems: a systematic review. Br J Health Psychol. 2020;25:615–38 (https://doi.org/10.1111/bjhp.12431).
220. WHO clinical treatment guideline for tobacco cessation in adults. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/377825).
221. Stein B, Müller MM, Meyer LK, Söllner W. Psychiatric and psychosomatic consultation liaison services in general hospitals: a systematic review and meta-analysis of effects on symptoms of depression and anxiety. Psychother Psychosom. 2020;89:6–16 (https://doi.org/10.1159/000503177).
222. Strunz M, Jiménez NP, Gregorius L, Hewer W, Pollmanns J, Viehmann K et al. Interventions to promote the utilization of physical health care for people with severe mental illness: a scoping review. Int J Environ Res Public Health. 2022;20:126 (https://doi.org/10.3390/ijerph20010126).
223. Lamontagne-Godwin F, Burgess C, Clement S, Gasston-Hales M, Greene C, Manyande A et al. Interventions to increase access to or uptake of physical health screening in people with severe mental illness: a realist review. BMJ Open. 2018;8:e019412 (https://doi.org/10.1136/bmjopen-2017-019412).
224. Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/374250).
225. de Jongh A, Amann BL, Hofmann A, Farrell D, Lee CW. The status of EMDR therapy in the treatment of posttraumatic stress disorder 30 years after its introduction. Journal of EMDR Practice and Research. 2019;13:261–9 (https://doi.org/10.1891/1933-3196.13.4.261).
226. Barlow J, Bergman H, Kornør H, Wei Y, Bennett C. Group-based parent training programmes for improving emotional and behavioural adjustment in young children. Cochrane Database Syst Rev. 2016;16:CD003680 (https://doi.org/10.1002/14651858.CD003680.pub3).
227. Rathgeber M, Bürkner PC, Schiller EM, Holling H. The efficacy of emotionally focused couples therapy and behavioral couples therapy: a meta-analysis. J Marital Fam Ther. 2019;45:447–63 (https://doi.org/10.1111/jmft.12336).
228. Miklowitz DJ, Chung B. Family-focused therapy for bipolar disorder: reflections on 30 years of research. Fam Process. 2016;55:483–99 (https://doi.org/10.1111/famp.12237).
229. Cheng ST, Li KK, Or PPL, Losada A. Do caregiver interventions improve outcomes in relatives with dementia and mild cognitive impairment? A comprehensive systematic review and metaanalysis. Psychol Aging. 2022;37:929–53 (https://doi.org/10.1037/pag0000696).
230. Baruch E, Pistrang N, Barker C. Psychological interventions for caregivers of people with bipolar disorder: a systematic review and meta-analysis. J Affect Disord. 2018;236:187–98 (https://doi.org/10.1016/j.jad.2018.04.077).
231. Problem management plus (‍PM+)‍: individual psychological help for adults impaired by distress in communities exposed to adversity, WHO generic field-trial version 1.0. Geneva: World Health Organization; 2016 (https://iris.who.int/handle/10665/206417).
232. Group problem management plus (‍group PM+)‍: group psychological help for adults impaired by distress in communities exposed to adversity, Generic field-trial version 1.0. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/334055).
233. Rabelo JL, Cruz BF, Ferreira JDR, Viana BM, Barbosa IG. Psychoeducation in bipolar disorder: a systematic review. World J Psychiatry. 2021;11:1407–24 (https://doi.org/10.5498/wjp.v11.i12.1407).
234. House A. Safety planning-type interventions for suicide prevention: meta-analysis. Br J Psychiatry. 2022;220:246 (https://doi.org/10.1192/bjp.2021.197).
235. Chatterjee HJ, Camic PM, Lockyer B, Thomso LJM. Non-clinical community interventions: a systematised review of social prescribing schemes. Arts & Health. 2018;10:97–123 (https://doi.org/10.1080/17533015.2017.1334002).
236. Bickerdike L, Booth A, Wilson PM, Farley K, Wright K. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. BMJ Open. 2017;7:e013384 (https://doi.org/10.1136/bmjopen-2016-013384).
237. Dailey WF, Morris JA, Hoge MA. Workforce development innovations with direct care workers: better jobs, better services, better business. Community Ment Health J. 2015;51:647–53 (https://doi.org/10.1007/s10597-014-9798-4).
238. Siskind D, Harris M, Pirkis J, Whiteford H. Personalised support delivered by support workers for people with severe and persistent mental illness: a systematic review of patient outcomes. Epidemiol Psychiatr Sci. 2012;21:97–110 (https://doi.org/10.1017/s2045796011000734).
239. Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/364834).
240. Shalaby RAH, Agyapong VIO. Peer support in mental health: literature review. JMIR Ment Health. 2020;7:e15572 (https://doi.org/10.2196/15572).
241. Beckers T, Maassen N, Koekkoek B, Tiemens B, Hutschemaekers G. Can social support be improved in people with a severe mental illness? A systematic review and meta-analysis. Curr Psychol. 2022:1–11 (https://doi.org/10.1007/s12144-021-02694-4).
242. Swinkels LTA, Hoeve M, Ter Harmsel JF, Schoonmade LJ, Dekker JJM, Popma A et al. The effectiveness of social network interventions for psychiatric patients: a systematic review and meta-analysis. Clin Psychol Rev. 2023;104:102321 (https://doi.org/10.1016/j.cpr.2023.102321).
243. Ikiugu MN, Nissen RM, Bellar C, Maassen A, Van Peursem K. Clinical effectiveness of occupational therapy in mental health: a meta-analysis. Am J Occup Ther. 2017;71:7105100020p1–p10 (https://doi.org/10.5014/ajot.2017.024588).
244. Swarbrick M, Noyes S. Effectiveness of occupational therapy services in mental health practice. Am J Occup Ther. 2018;72:7205170010p1–p4 (https://doi.org/10.5014/ajot.2018.725001).
245. Mehl-Madrona L, Mainguy B. Introducing healing circles and talking circles into primary care. Perm J. 2014;18:4–9 (https://doi.org/10.7812/TPP/13-104).
246. A bottom-up approach to employment: an example of good practice. Geneva: World Health Organization. Regional Office for Europe; 2018 (https://iris.who.int/handle/10665/329685).
247. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization & United Nations

Children's Fund; 2020 (https://iris.who.int/handle/10665/337641).

248. Powell N, Dalton H, Lawrence-Bourne J, Perkins D. Co-creating community wellbeing initiatives: what is the evidence and how do they work? Int J Ment Health Syst. 2024;18 (https://doi.org/10.1186/s13033-024-00645-7).
249. Brinchmann B, Widding-Havneraas T, Modini M, Rinaldi M, Moe CF, McDaid D et al. A meta-regression of the impact of policy on the efficacy of individual placement and support. Acta Psychiatr Scand. 2020;141:206–20 (https://doi.org/10.1111/acps.13129).
250. Suijkerbuijk YB, Schaafsma FG, van Mechelen JC, Ojajärvi A, Corbière M, Anema JR. Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis. Cochrane Database Syst Rev. 2017;9:CD011867. doi: 10.1002/14651858.CD011867.pub2.
251. Denary W, Fenelon A, Schlesinger P, Purtle J, Blankenship KM, Keene DA. Does rental assistance improve mental health? Insights from a longitudinal cohort study. Soc Sci Med. 2021;282:114100 (https://doi.org/10.1016/j.socscimed.2021.114100).
252. Schapiro R, Blankenship K, Rosenberg A, Keene D. The effects of rental assistance on housing stability, quality, autonomy, and affordability. Hous Policy Debate. 2022;32:456–72 (https://doi.org/10.1080/10511482.2020.1846067).
253. Wollburg C, Steinert JI, Reeves A, Nye E. Do cash transfers alleviate common mental disorders in low- and middle-income countries? A systematic review and meta-analysis. PLoS ONE. 2023;18:e0281283 (https://doi.org/10.1371/journal.pone.0281283).
254. McGuire J, Kaiser C, Bach-Mortensen AM. A systematic review and meta-analysis of the impact of cash transfers on subjective well-being and mental health in low- and middle-income countries. Nat Hum Behav. 2022;6:359–70 (https://doi.org/10.1038/s41562-021-01252-z).
255. Micai M, Gila L, Caruso A, Fulceri F, Fontecedro E, Castelpietra G et al. Benefits and challenges of a personal budget for people with mental health conditions or intellectual disability: a systematic review. Front Psychiatry. 2022;13:974621 (https://doi.org/10.3389/fpsyt.2022.974621).
256. Cook JA, Shore S, Burke-Miller JK, Jonikas JA, Hamilton M, Ruckdeschel B et al. Mental health self-directed care financing: efficacy in improving outcomes and controlling costs for adults with serious mental illness. Psychiatr Serv. 2019;70:191–201 (https://doi.org/10.1176/appi.ps.201800337).
257. New evidence shows larger benefits of disability insurance income. Stanford: Institute for Economic Policy Research; 2018 (https://siepr.stanford.edu/publications/policy-brief/new-evidence-shows-larger-benefits-disability-insurance-income, accessed 10 December 2024).
258. Gelber A, Moore TJ, Pei Z, Strand A. Disability insurance income saves lives. Journal of Political Economy. 2023;131:11 (https://doi.org/10.1086/725172).
259. Global report on assistive technology. Geneva: World Health Organization and the United Nations Children's Fund; 2022 (https://iris.who.int/handle/10665/354357).
260. Warren JB. The trouble with antidepressants: why the evidence overplays benefits and underplays risks – an essay by John B Warren. BMJ. 2020;370:m3200 (https://doi.org/10.1136/bmj.m3200).
261. Richard Smith: psychiatry in crisis? In: The BMJ Opinion. London: BMJ Opinion; July 4, 2016 (https://blogs.bmj.com/bmj/2016/07/04/richard-smith-psychiatry-in-crisis/, accessed 10 December 2024).
262. Cosci F, Chouinard G. Acute and persistent withdrawal syndromes following discontinuation of psychotropic medications. Psychother Psychosom. 2020;89:283–306 (https://doi.org/10.1159/000506868).
263. RCPsych launches new patient resource on stopping antidepressants. In: Royal College of Psychiatrists [website]. London: Royal College of Psychiatrists; 2019 (https://www.rcpsych.ac.uk/members/your-monthly-enewsletter/rcpsych-enewsletter-september-2020/new-stopping-antidepressants-guidance?utm_campaign=1992070_eNewsletter%20-%20main%20-%2024%20September&utm_medium=email&utm_source=RCPsych%20Digital%20Team&dm_i=3S89,16P3A,2H3K2N,480UK,1, accessed 10 December 2024).
264. Lindsley CW. The top prescription drugs of 2011 in the United States: antipsychotics and antidepressants once again lead CNS therapeutics. ACS Chem Neurosci. 2012;3:630–1 (https://doi.org/10.1021/cn3000923).
265. Ilyas S, Moncrieff J. Trends in prescriptions and costs of drugs for mental disorders in England, 1998–2010. Br J Psychiatry. 2012;200:393–8 (https://doi.org/10.1192/bjp.bp.111.104257).
266. Moore TJ, Mattison DR. Adult utilization of psychiatric drugs and differences by sex, age, and race. JAMA Intern Med. 2017;177:274–5 (https://doi.org/10.1001/jamainternmed.2016.7507).
267. McCormack J, Korownyk C. Effectiveness of antidepressants. BMJ. 2018;360:k1073 (https://doi.org/10.1136/bmj.k1073).
268. Moncrieff J. What does the latest meta-analysis really tell us about antidepressants? Epidemiol Psychiatr Sci. 2018;27:430–2 (https://doi.org/10.1017/S2045796018000240).
269. Munkholm K, Paludan-Muller AS, Boesen K. Considering the methodological limitations in the evidence base of antidepressants for depression: a reanalysis of a network meta-analysis. BMJ Open. 2019;9:e024886 (https://doi.org/10.1136/bmjopen-2018-024886).
270. Read J. The experiences of 585 people when they tried to withdraw from antipsychotic drugs. Addictive Behaviors Reports. 2022;15 (https://doi.org/10.1016/j.abrep.2022.100421).
271. World Health Organization model list of essential medicines: 21st list 2019. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/325771).
272. Horowitz M, Taylor DM. The maudsley deprescribing guidelines: antidepressants, benzodiazepines, gabapentinoids and Z-drugs. London: Wiley-Blackwell; 2024.
273. Munkholm K, Horowitz MA, Moncrieff J. Maintenance antipsychotic trials and the effect of withdrawal. Lancet. 2022;400:995 (https://doi.org/10.1016/S0140-6736(22)01467-2).
274. Horowitz MA. Step change in guidance on withdrawing antidepressants. Br J Gen Pract. 2023;73:204 (https://doi.org/10.3399/bjgp23X732669).
275. Horowitz MA, Framer A, Hengartner MP, Sørensen A, Taylor D. Estimating risk of antidepressant withdrawal from a review of published data. CNS Drugs. 2023;37:143–57 (https://doi.org/10.1007/s40263-022-00960-y).
276. Hengartner MP, Plöderl M. Prophylactic effects or withdrawal reactions? An analysis of time-to-event data from antidepressant relapse prevention trials submitted to the FDA. Ther Adv Psychopharmacol. 2021;11:20451253211032051 (https://doi.org/10.1177/20451253211032051).
277. Pourtaheri A, Sany SBT, Aghaee MA, et al. Prevalence and factors associated with child marriage, a systematic review. BMC Women's Health. 2023;23:531 (https://doi.org/10.1186/s12905-023-02634-3).
278. 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 (https://doi.org/10.1016/S2215-0366(18)30060-9).
279. World report on the social determinants of health equity. Geneva: World Health Organization; forthcoming 2025.

280. Roessler W. The stigma of mental disorders. EMBO Rep. 2016;17:1250–3 (https://doi.org/10.15252/embr.201643041).
281. Shim RS. Dismantling structural racism in psychiatry: a path to mental health equity. Am J Psychiatry. 2021;178:592–8 (https://doi.org/10.1176/appi.ajp.2021.21060558).
282. Kiecolt-Glaser JK, Gouin JP, Hantsoo L. Close relationships, inflammation, and health. Neurosci Biobehav Rev. 2010;35:33–8 (https://doi.org/10.1016/j.neubiorev.2009.09.003).
283. Marin MF, Lord C, Andrews J, Juster RP. Chronic stress, cognitive functioning and mental health. Neurobiol Learn Mem. 2011;96:583–95 (https://doi.org/10.1016/j.nlm.2011.02.016).
284. Cacioppo JT, Cacioppo S. Social relationships and health: the toxic effects of perceived social isolation. Soc Personal Psychol Compass. 2014;8:58–72 (https://doi.org/10.1111/spc3.12087).
285. Global health estimates. In: Data [website]. Geneva: World Health Organization; n.d. (https://www.who.int/data/global-health-estimates, accessed 10 December 2024).
286. Jha B, Sridhar P, Mariwala R, Murali S. Suicide prevention: changing the narrative. Mumbai: Mariwala Health Initiative; 2021 (https://mhi.org.in/media/insight_files/MHI-Suicide_Prevention-Changing_the_Narrative-Sep2021_1_SAactih.pdf, accessed 10 December 2024).
287. The complex factors that heighten the risk of suicide. In: About Suicide [website]. Newcastle: Life in Mind; n.d. (https://lifeinmind.org.au/about-suicide/aboriginal-and-torres-strait-islander-communities/risk-of-suicide-in-aboriginal-and-torres-strait-islander-peoples, accessed 10 December 2024).
288. Preventing suicide: a global imperative. Geneva: World Health Organization; 2014 (https://iris.who.int/handle/10665/131056).
289. Shields-Zeeman L, Smit F. The impact of income on mental health. Lancet Public Health. 2022;7:e486–e7 (https://doi.org/10.1016/S2468-2667(22)00094-9).
290. Phelan JC, Link BG, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. J Health Soc Behav. 2010;51:Suppl:S28–S40 (https://doi.org/10.1177/0022146510383498).
291. Richardson T, Elliott P, Roberts R. The relationship between personal unsecured debt and mental and physical health: a systematic review and meta-analysis. Clin Psychol Rev. 2013;33:1148–62 (https://doi.org/10.1016/j.cpr.2013.08.009).
292. Funk M, Drew N, Knapp M. Mental health, poverty and development. J Public Ment Health. 2012;11:166–85 (https://doi.org/10.1108/17465721211289356).
293. Alegría M, NeMoyer A, Falgàs Bagué I, Wang Y. Social determinants of mental health: where we are and where we need to go. Curr Psychiatry Rep. 2018;20:95 (https://doi.org/10.1007/s11920-018-0969-9).
294. Chang-Quan H, Zheng-Rong W, Yong-Hong L, Yi-Zhou X, Qing-Xiu L. Education and risk for late life depression: a meta-analysis of published literature. Int J Psychiatry Med. 2010;40:109–24 (https://doi.org/10.2190/PM.40.1.i).
295. Porter C, Favara M, Hittmeyer A, et al. Impact of the COVID-19 pandemic on anxiety and depression symptoms of young people in the global south: evidence from a four-country cohort study. BMJ Open. 2021;11:e049653 (https://doi.org/10.1136/bmjopen-2021-049653).
296. Kousoulis A, McDaid S. Tackling social inequalities to reduce mental health problems: how everyone can flourish equally. London: Mental Health Foundation 2020.
297. Padgett DK. Homelessness, housing instability and mental health: making the connections. BJPsych Bull. 2020;44:197–201 (https://doi.org/10.1192/bjb.2020.49).
298. Bassuk E, Richard M, Tsertsvadze A. The prevalence of mental illness in homeless children: a systematic review and meta-analysis. J Am Acad Child Adolesc Psychiatry. 2015;54:86–96.e2 (https://doi.org/10.1016/j.jaac.2014.11.008).
299. Mental health and climate change: policy brief. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/354104).
300. Cianconi P, Betrò S, Janiri L. The impact of climate change on mental health: a systematic descriptive review. Front Psychiatry. 2011;11:74 (https://doi.org/10.3389/fpsyt.2020.00074).
301. Hayes K, Poland B. Addressing mental health in a changing climate: incorporating mental health indicators into climate change and health vulnerability and adaptation assessment. Int J Environ Res Public Health. 2011;15:1806 (https://doi.org/10.3390/ijerph15091806).
302. Hickman C, Marks E, Pihkala P, Clayton S, Lewandowski E, Mayall E. Climate anxiety in children and young people and their beliefs about government responses to climate change: a global survey. Lancet Planet Health. 2021;5:e863–73 (https://doi.org/10.1016/S2542-5196(21)00278-3).
303. Syropoulos S, Law KF, Mah A, et al. Intergenerational concern relates to constructive coping and emotional reactions to climate change via increased legacy concerns and environmental cognitive alternatives. BMC Psychol 2024;12:182 (https://doi.org/10.1186/s40359-024-01690-0).
304. Berry HL, Bowen K, Kjellstrom T. Climate change and mental health: a causal pathways framework. Int J Public Health. 2010;55:123–32 (https://doi.org/10.1007/s00038-009-0112-0).
305. Bell JE, Herring SC, Jantarasami L, Adrianopoli C, Benedict K. Ch. 4: impacts of extreme events on human health. The impacts of climate change on human health in the United States: a scientific assessment. Washington, DC: US Global Change Research Program; 2016 (https://health2016.globalchange.gov/low/ClimateHealth2016_04_Extremes_small.pdf, accessed 10 December 2024).
306. Bourque F, Cunsolo Willox A. Climate change: the next challenge for public mental health? Int Rev Psychiatry. 2016;26:415–22 (https://doi.org/10.3109/09540261.2014.925851).
307. Simpson DM, Weissbecker I, Sephton SE. Extreme weather-related events: implications for mental health and well-being. In: Weissbecker I, editor. Climate change and human well-being: Global challenges and opportunities. New York: Springer; 2011.
308. Kousky C. Impacts of natural disasters on children. The Future of Children 2016;26:73–92 (https://doi.org/10.1353/foc.2016.0004).
309. Moone-Heinonen J, Gordon-Larsen P, Kiefe CI, Shikany JM, Lewis CE, Popkin BM. Fast food restaurants and food stores: longitudinal associations with diet in young to middle-aged adults: the CARDIA study. Arch Intern Med. 2011;171:1162–70 (https://doi.org/10.1001/archinternmed.2011.283).
310. McCay L, Bremer I, Endale T, Jannati M. Urban design and mental health. In: Okkels N, Blanner Kristiansen C, Munk-Jørgensen P, editors. Mental Health and Illness in the City (Mental Health and Illness Worldwide). Berlin, Heidelberg: Springer; 2017.
311. Okkels N, Blanner Kristiansen C, Munk-Jørgensen P, Sartorius N. Urban mental health: challenges and perspectives. Curr Opin Psychiatry. 2018;31:258–64 (https://doi.org/10.1097/YCO.0000000000000413).
312. Dahlberg L, Agahi N, Lennartsson C. Lonelier than ever? Loneliness of older people over two decades. Arch Gerontol Geriatr. 2018;75:96–103

(https://doi.org/10.1016/j.archger.2017.11.004).

313. About loneliness. In: Loneliness [website]. Stratford: MIND; n.d. (https://www.mind.org.uk/information-support/tips-for-everyday-living/loneliness/about-loneliness/, accessed 10 December 2024).
314. The role of early-life trauma in social isolation. In: Generations Journal [website]. San Francisco: Generations: American Society on Aging; 2020 (https://generations.asaging.org/adverse-childhood-experiences-trauma-isolation, accessed 10 December 2024).
315. Ventevogel P, van Ommeren M, Schilperoord M, Saxena S. Improving mental health care in humanitarian emergencies. Bull World Health Organ. 2015;93:666–A (https://doi.org/10.2471/BLT.15.156919).
316. Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. Lancet. 2019;394:240–8 (https://doi.org/10.1016/S0140-6736(19)30934-1).
317. Mental health and psychosocial support [website]. Geneva: United Nations High Commissioner for Refugees; 2024 (https://emergency.unhcr.org/emergency-assistance/health-and-nutrition/mental-health-and-psychosocial-support-mhpss, accessed 10 December 2024).
318. Thornicroft G, Mehta N, Clement S, et al. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. The Lancet. 2016;387:1123–32 (https://doi.org/10.1016/S0140-6736(15)00298-6).
319. Meddings S, McGregor J, Roeg W, Shepherd G. Recovery colleges: quality and outcomes. Mental Health and Social Inclusion. 2015;19 (https://doi.org/10.1108/MHSI-08-2015-0035).
320. Thompson H, Simonds L, Barr S, Meddings S. Recovery colleges: long-term impact and mechanisms of change. Mental Health and Social Inclusion. 2021;25 (https://doi.org/10.1108/MHSI-01-2021-0002).
321. Creating an age-advantaged community: a toolkit for building intergenerational communities that recognize, engage, and support all ages. New York: MetLife Foundation and Generations United 2016 (https://www.gu.org/app/uploads/2018/06/Intergenerational-Toolkit-CreatingAgeAdvantagedCommunities.pdf, accessed 10 December 2024).
322. National Research Council and Institute of Medicine. Community programs to promote youth development. Washington, DC: The National Academies Press; 2002.
323. World youth report: youth civic engagement. New York: United Nations Department of Economic and Social Affairs; 2019 (https://www.un.org/development/desa/youth/wp-content/uploads/sites/21/2018/12/un_world_youth_report_youth_civic_engagement.pdf, accessed 10 December 2024).
324. Thomson H, Thomas S, Sellstrom E, Petticrew M. Housing improvements for health and associated socio-economic outcomes. Cochrane Database Syst Rev. 2013;2:CD008657 (https://doi.org/10.1002/14651858).
325. Savannah SB, Estes LJ. Catalyzing community action for mental health and wellbeing. Community Dev Innov Rev. 2018;13:21–32. (https://www.frbsf.org/community-development/publications/community-development-investment-review/2018/october/catalyzing-community-action-for-mental-health-and-wellbeing/, accessed 10 December 2024).
326. Nelson CA, Scott RD, Bhutta ZA, Harris NB, Danese A, Samara M. Adversity in childhood is linked to mental and physical health throughout life. BMJ. 2020;371:m3048 (https://doi.org/10.1136/bmj.m3048).
327. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health. 2017;2:e356–e66 (https://doi.org/10.1016/S2468-2667(17)30118-4).
328. Dohrenwend BP. The role of adversity and stress in psychopathology: some evidence and its implications for theory and research. J Health Soc Behav. 2000;41:1–19 (https://doi.org/10.2307/2676357).
329. Violence prevention at CDC. In: Violence Prevention [website]. Atlanta: Centers for Disease Control and Prevention; n.d. (https://www.cdc.gov/violenceprevention/about/index.html, accessed 10 December 2024).
330. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Perspect Psychol Sci. 2015;10:227–37 (https://doi.org/10.1177/1745691614568352).
331. Saeri AK, Cruwys T, Barlow FK, Stronge S, Sibley CG. Social connectedness improves public mental health: investigating bidirectional relationships in the New Zealand attitudes and values survey. Aust N Z J Psychiatry. 2018;52:365–74 (https://doi.org/10.1177/0004867417723990.
332. Perkins JM, Subramanian SV, Christakis NA. Social networks and health: a systematic review of sociocentric network studies in low- and middle-income countries. Soc Sci Med. 2015;125:60–78 (https://doi.org/10.1016/j.socscimed.2014.08.019).
333. Policy brief: digital strategies to address loneliness and social isolation amongst older adults in rural districts. Lancaster: MobileAge; 2016 (https://joinup.ec.europa.eu/sites/default/files/document/2018-11/Policy-Brief-loneliness%26social%20inclusion.pdf, accessed 10 December 2024).
334. WHO Commission on Social Connection. In: World Health Organization [website]. Geneva: World Health Organization; n.d. (https://www.who.int/groups/commission-on-social-connection, accessed 10 December 2024).

ANNEX: Practical resources for policy review, reform and implementation

Practical resources for Policy directive 1.1 Improving coordination, leadership and accountability

- Civil society organizations to promote human rights in mental health and related areas: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329589).
- Transforming services and promoting human rights: WHO QualityRights training and guidance: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329611).
- WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities. Geneva: World Health Organization; 2012 (https://iris.who.int/handle/10665/70927).

Practical resources for Policy directive 1.2 Financing and budgeting

- Cuijpers P, Chisholm D, Sweeny K, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. Lancet Psychiatry. 2016;3 (https://doi.org/10.1016/S2215-0366(16)30024-4).
- Financing mental health: the current situation and ways forward. London: United for Global Mental Health; 2023 (https://unitedgmh.org/app/uploads/2023/10/Financing-of-mental-health-V2.pdf, accessed 10 December 2024).
- Global cost-benefit analysis on mental health and psychosocial support (MHPSS) interventions in education settings across the humanitarian development nexus. New York: UNICEF; 2023 (https://www.unicef.org/reports/benefits-investing-school-based-mental-health-support, accessed 10 December 2024).
- Investing in mental health. Geneva: World Health Organization; 2003 (https://iris.who.int/handle/10665/42823).
- Mental health investment case: a guidance note. Geneva: World Health Organization & United Nations Development Programme; 2021 (https://iris.who.int/handle/10665/340246).

Practical resources for Policy directive 1.3 Information systems and research

- A systematic approach for undertaking a research priority-setting exercise: guidance for WHO staff. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/334408).
- Atlas on substance use (2010): resources for the prevention and treatment of substance use disorders. Geneva: World Health Organization; 2009 (https://iris.who.int/handle/10665/4445).
- Atlas: country resources for neurological disorders, 2nd ed. Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/258947).
- LIVE LIFE: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341726).
- Mental health atlas 2020. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/345946).
- Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. Geneva: World Health Organization; 2016 (https://iris.who.int/handle/10665/208895).
- Preventing suicide: a resource for suicide case registration. Geneva: World Health Organization; 2011 (https://iris.who.int/handle/10665/44757).

Practical resources for Policy directive 1.4 People with lived experience, civil society, and communities

- Advocacy for mental health, disability and human rights: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329587).
- Civil society organizations to promote human rights in mental health and related areas: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329589).
- Freedom from coercion, violence and abuse: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329582).
- Guiding principles and recommendations for effective lived experience youth engagement practices. London: Global Mental Health Action Network; 2024 (https://gmhan.org/news/youth-engagement-guidelines, accessed 10 December 2024).
- Human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329538).
- Legal capacity and the right to decide: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329539).
- Mental health, disability and human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329546).
- Preventing suicide: a resource for filmmakers and others working on stage and screen. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/328774).
- Preventing suicide: a resource for media professionals. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/372691).
- Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329577).
- Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329602).
- Strategies to end seclusion and restraint: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329605).
- Supported decision-making and advance planning: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329609).
- Voice, agency, empowerment: handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/342704).
- WHO framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/367340).
- WHO QualityRights e-training on mental health, WHO Academy. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training; https://whoacademy.org/ accessed 10 December 2024).

Practical resources for Policy directive 1.5 Rights-based law reform

- Convention on the Rights of Persons with Disabilities (A/RES/61/106). New York: United Nations, General Assembly; 2006 (https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html, accessed 10 December 2024).
- 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 10 December 2024).
- 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 10 December 2024).
- 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 (https://iris.who.int/handle/10665/373126).
- 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 10 December 2024).
- WHO policy brief on the health aspects of decriminalization of suicide and suicide attempts. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/372848).

Practical resources for Policy directive 2.1 Coordinated rights-based community mental health services and support at all levels of care

WHO guidance and technical packages on community mental health services

Overall guidance

- Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341648).

Seven technical packages

- Community mental health centres: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341642).
- Community outreach mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341644).
- Comprehensive mental health service networks: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341646).
- Hospital-based mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341647).
- Mental health crisis services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341637).
- Peer support mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341643).
- Supported living services for mental health: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341645).

Other resources

- Framework and case study —Mental health crisis support rooted in community and human rights. In: Mental health and human rights [website]. Toronto: Gerstein Crisis Centre; n.d. (https://gersteincentre.org/about-us/mental-health-and-human-rights/, accessed 10 December 2024).
- IASC handbook, mental health and psychosocial support coordination. New York: Inter-Agency Standing Committee; 2023 (https://reliefweb.int/report/world/iasc-handbook-mental-health-and-psychosocial-support-coordination, accessed 10 December 2024).
- Integrating mental health into primary care: a global perspective. Geneva: World Health Organization; 2008 (https://iris.who.int/handle/10665/43935).
- Integration of mental health and HIV interventions: key considerations. Geneva: World Health Organization and UNAIDS; 2022 (https://iris.who.int/handle/10665/353571).
- Mental health crisis support rooted in community and human rights. New York: Human Rights Watch; 2023 (https://gersteincentre.org/wordpress/wp-content/uploads/2023/11/drd1123_brochure_LOWRES_WEBSPREADS-1.pdf, accessed 10 December 2024).
- mhGAP humanitarian intervention guide (mhGAP-HIG) training of health-care providers: training manual. Geneva: World Health Organization & United Nations High Commissioner for Refugees; 2022 (https://iris.who.int/handle/10665/352581).
- mhGAP operations manual. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/275386).
- One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329591).
- Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization & United Nations Children's Fund; 2020 (https://iris.who.int/handle/10665/337641).
- 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.
- Preventing suicide: a resource for establishing a crisis line. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/311295).
- Preventing suicide: a resource for primary health care workers. Geneva: World Health Organization; 2000 (https://iris.who.int/handle/10665/67603).
- Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/376208).
- The mental health and psychosocial support minimum services package (MHPSS MSP). New York: United Nations Inter-Agency Standing Committee; 2022 (https://www.mhpssmsp.org/sites/default/files/2021-10/MHPSS%20MSP%20Field%20Test%20Version_1.pdf, accessed 10 December 2024).
- Tuberculosis and mental health. In: Courses [website]. Geneva: World Health Organization; 2023 (https://openwho.org/courses/TB-mental-health, accessed 10 December 2024).
- What are crisis support services? Essex: LifeLine International; 2024 (https://lifeline-international.com/app/uploads/2024/07/What-Are-Crisis-Support-Services-LifeLine-International-2024.pdf, accessed 10 December 2024).
- WHO operational handbook on tuberculosis: module 6: tuberculosis and comorbidities: mental health conditions. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/373829).

Practical resources for Policy directive 2.2 Integrated mechanisms that respond to social and structural factors and incorporate rights-based approaches in mental health

- Communicating on climate change and health: toolkit for health professionals. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/376283).
- Freedom from coercion, violence and abuse: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329582).
- Human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329538).
- Legal capacity and the right to decide: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329539).
- Mental health, disability and human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329546).
- 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 (https://iris.who.int/handle/10665/373126).
- Operational framework for building climate resilient and low carbon health systems. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/373837).
- Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329577).
- Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329602).
- Signed, sealed and 212 steps towards delivering the world's first net zero health service. In: Blog [website]. Geneva: NHS England; 2022 (https://www.england.nhs.uk/blog/signed-sealed-and-212-steps-towards-delivering-the-worlds-first-net-zero-health-service/, accessed 10 December 2024).
- Strategies to end seclusion and restraint: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329605).
- Supported decision-making and advance planning: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329609).
- Transforming services and promoting human rights: WHO QualityRights training and guidance: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329611).
- WHO global strategy on health, environment and climate change: the transformation needed to improve lives and wellbeing sustainably through healthy environments. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/331959).
- WHO QualityRights e-training on mental health, WHO Academy. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training; https://whoacademy.org/ accessed 10 December 2024).
- WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities. Geneva: World Health Organization; 2012 (https://iris.who.int/handle/10665/70927).
- WHO commission on social connection. Geneva: World Health Organization; (https://www.who.int/groups/commission-on-social-connection)
- WHO world report on the social determinants of health equity. Geneva: World Health Organization; forthcoming 2025.

Practical resources for Policy directive 2.3 Partnerships for community inclusion, socioeconomic development, and for protecting and promoting rights

- Comprehensive mental health service networks: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341646).
- Field test version: mhGAP community toolkit: Mental Health Gap Action Programme (mhGAP). Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/328742).
- Preventing suicide: a resource for police, firefighters and other first line responders. Geneva: World Health Organization; 2009 (https://iris.who.int/handle/10665/44175).
- Preventing suicide: a resource for teachers and other school staff. Geneva: World Health Organization; 2000 (https://iris.who.int/handle/10665/66801).
- Social isolation and loneliness among older people: advocacy brief. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/343206).
- WHO commission on social connection. Geneva: World Health Organization; (https://www.who.int/groups/commission-on-social-connection)

Practical resources for Policy directive 2.4 Deinstitutionalization

- Deinstitutionalization of people with mental health conditions in the WHO South-East Asia Region. New Delhi: World Health Organization. Regional Office for South-East Asia; 2024 (https://iris.who.int/handle/10665/376123).
- 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/crpdc5-guidelines-deinstitutionalization-including, accessed 10 December 2024).
- Innovation in deinstitutionalization: a WHO expert survey. Geneva: World Health Organization; 2014 (https://iris.who.int/handle/10665/112829).
- Promoting rights and community living for children with psychosocial disabilities. Geneva: World Health Organization; 2015 (https://iris.who.int/handle/10665/184033).
- Šiška J, Beadle-Brown J. Transition from institutional care to community-based services in 27 EU Member States: Final report. Research report for the European Expert Group on Transition from Institutional to Community-based Care. 2020 (https://deinstitutionalisationdotcom.files.wordpress.com/2020/05/eeg-di-report-2020-1.pdf, accessed 10 December 2024).

Practical resources for Policy directive 3.1. A multidisciplinary workforce with task sharing, training and support

- EQUIP - ensuring quality in psychological support. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/equip-ensuring-quality-in-psychological-support, accessed 10 December 2024).
- Freedom from coercion, violence and abuse: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329582).
- Human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329538).
- Legal capacity and the right to decide: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329539).
- Mental health, disability and human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329546).

- mhGAP training manuals for the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0 (for field testing). Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/259161).
- Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/376208).
- Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329577).
- Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329602).
- Strategies to end seclusion and restraint: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329605).
- Supported decision-making and advance planning: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329609).
- mhGAP e-training on integrating mental health into primary care, WHO Academy (https://whoacademy.org/.
- WHO pre-service education in care for mental, neurological and substance use conditions (PSE-MNS). Geneva: World Health Organization; forthcoming 2025.
- WHO QualityRights e-training on mental health, WHO Academy. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training; https://whoacademy.org/ accessed 10 December 2024).

Practical resources for Policy directive 3.2 Recruitment, retention and staff well-being

- Fair share for health and care: gender and the undervaluation of health and care work. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/376191).
- Frontline workers and COVID-19: coping with stress. Geneva: World Health Organization; 2020 (https://www.emro.who.int/images/stories/mnh/documents/1_flyer_flws_covid_coping_with_stress.pdf, accessed 10 December 2024).
- What is stress? In: Mental health and psychosocial support [website]. Geneva: World Health Organization; n.d. (https://www.emro.who.int/mhps/frontline_worker.html, accessed 10 December 2024).
- WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341139).

Practical resources for Policy directive 3.3 Competency-based curricula for mental health

- ENhancing Assessment of Common Therapeutic Factors (ENACT). Geneva: World Health Organization; 2022 (https://equipcompetency.org/sites/default/files/downloads/2022-07/ENACT_inperson_published_220321.pdf, accessed 10 December 2024).
- EQUIP - ensuring quality in psychological support. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/equip-ensuring-quality-in-psychological-support, accessed 10 December 2024).
- Global competency and outcomes framework for universal health coverage. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/352711).
- WHO pre-service education in care for mental, neurological and substance use conditions (PSE-MNS). Geneva: World Health Organization; forthcoming 2025.

Practical resources for Policy directive 4.1 Assessment of mental health and support needs by multidisciplinary teams

- Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/375767).
- International classification of functioning, disability and health: ICF. Geneva: World Health Organization; 2001 (https://iris.who.int/handle/10665/42407).
- Pack on support needs assessment. Dublin: TopHouse – Irish Council for Social Housing; 2020 (https://supportgirona.cat/sites/default/files/wp/2020/02/IO4-Pack-on-Support-Needs-Assessment_ENG-1.pdf, accessed 10 December 2024).
- Slade M, Thornicroft G. The Camberwell Assessment of Need, 2nd Edition. Cambridge: Cambridge University Press; 2020 (https://www.researchintorecovery.com/measures/can/downloadcan/, accessed 10 December 2024).
- The Recovery Assessment Scale – Domains and Stages (RAS-DS) Manual. Version 3. Sydney: University of Sydney; 2019 (https://ras-ds.net.au/wp-content/uploads/2019/09/RASDS-Manual-Version-3-2019-FINAL.pdf, accessed 10 December 2024).
- The Supports Intensity Scale - Adult Version® (SIS-A®). Silver Spring: American Association on Intellectual and Developmental Disabilities; 2023 (https://www.aaidd.org/sis/sis-a/sis-a-2nd-edition, accessed 10 December 2024).
- Ustun TB, Kostanjesek N, Chatterji S, et al. Measuring health and disability : manual for WHO Disability Assessment Schedule (WHODAS 2.0)/ edited by T.B. Üstün, N. Kostanjsek, S. Chatterji, J.Rehm. Geneva: World Health Organization; 2010 (https://iris.who.int/handle/10665/43974).

Practical resources for Policy directive 4.2 Physical health and lifestyle, psychological, social and economic interventions

- A toolkit on how to implement social prescribing. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/354456).
- Carswell K, Harper-Shehadeh M, Watts S, Van't Hof E, Abi Ramia J, Heim E et al. Step-by-step: a new WHO digital mental health intervention for depression. Mhealth. 2018;4:415–20 (https://doi.org/10.21037/mhealth.2018.08.01).
- Doing what matters in times of stress: an illustrated guide. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/331901).
- Early Adolescent Skills for Emotions (EASE): group psychological help for young adolescents affected by distress in communities exposed to adversity, generic field-trial version 1.0, 2023. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/374996).
- EQUIP - ensuring quality in psychological support. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/equip-ensuring-quality-in-psychological-support, accessed 10 December 2024).
- Freedom from coercion, violence and abuse: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329582).
- Group interpersonal therapy (IPT) for depression. Geneva: World Health Organization; 2016 (https://iris.who.int/handle/10665/250219).
- Helping adolescents thrive toolkit: strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours. Geneva: World Health Organization and United Nations Children's Fund (UNICEF); 2021 (https://iris.who.int/handle/10665/341327).
- Human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329538).

- Humeniuk R, Henry-Edwards S, Ali R, Poznyak V, Monteiro MG. The alcohol, smoking and substance involvement screening test (ASSIST): manual for use in primary care. Geneva: World Health Organization; 2010 (https://iris.who.int/handle/10665/44320).
- Innovations in scalable psychological interventions. In: Mental health and substance use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/innovations-in-psychological-interventions, accessed 10 December 2024).
- iSupport for dementia: training and support manual for carers of people with dementia. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/324794).
- Legal capacity and the right to decide: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329539).
- Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/374250).
- Mental health, disability and human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329546).
- mhGAP evidence resource centre. In: Mental health and substance use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre, accessed 10 December 2024).
- mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP), version 2.0. Geneva: World Health Organization; 2016 (https://iris.who.int/handle/10665/250239).
- mhGAP training manuals for the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0 (for field testing). Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/259161).
- Person-centred recovery planning for mental health and well-being: self-help tool: WHO QualityRights. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329598).
- Problem Management Plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity, WHO generic field-trial version 1.1. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/375604).
- Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/376208).
- Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329577).
- Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329602).
- Self help plus (SH+): a group-based stress management course for adults, Generic field-trial version 1.0, 2021. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/345349).
- Strategies to end seclusion and restraint: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329605).
- Supported decision-making and advance planning: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329609).
- Thinking healthy: a manual for psychosocial management of perinatal depression, WHO generic field-trial version 1.0, 2015. Geneva: World Health Organization; 2015 (https://iris.who.int/handle/10665/152936).
- Training for caregivers of children with developmental disabilities, including autism. In: Mental health and substance use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/who-caregivers-skills-training-for-families-of-children-with-developmental-delays-and-disorders, accessed 10 December 2024).

- WHO QualityRights e-training on mental health, WHO Academy. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training; https://whoacademy.org/ accessed 10 December 2024).

Practical resources for Policy directive 4.3 Psychotropic drug interventions

- Horowitz M, Taylor DM. The maudsley deprescribing guidelines: antidepressants, benzodiazepines, gabapentinoids and Z-drugs. London: Wiley-Blackwell; 2024.
- Horowitz MA, J. M, de Haan L, Bogers JPAM, Gangadin SS, Kikkert M. Tapering antipsychotic medication: practical considerations. Psychol Med. 2022;52:32–5 (https://doi.org/10.1017/S0033291721003299).
- Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/374250).
- mhGAP evidence resource centre. In: Mental health and substance use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre, accessed 10 December 2024).
- mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) forthcoming 2025.
- mhGAP e-training on integrating mental health into primary care, WHO Academy (https://whoacademy.org/, accessed 10 December 2024).
- mhGAP training manuals for the IG forthcoming 2025.
- The selection and use of essential medicines 2023: web annex A: World Health Organization model list of essential medicines: 23rd list (2023). Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/371090).

Practical resources for Policy directive 5.1 Improved literacy and transformed mindsets to promote mental health and well-being and combat stigma, discrimination and exclusion

- Advocacy for mental health, disability and human rights: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329587).
- Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO. Geneva: World Health Organization; 2014 (https://iris.who.int/handle/10665/112848).
- Intersectionality resource guide and toolkit: an intersectional approach to leave no one behind. New York: UN Women; 2022 (https://www.unwomen.org/sites/default/files/2022-01/Intersectionality-resource-guide-and-toolkit-en.pdf, accessed 10 December 2024).
- Joint United Nations statement on ending discrimination in health care settings. Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/259622).
- LIVE LIFE: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341726).
- Mental health and psychosocial support for marginalized and underrepresented groups toolkit. Washington, D.C.: USAID/YouthPower2; 2024 (https://www.youthpower.org/sites/default/files/YouthPower/files/resources/MHPSS%20for%20Marginalized%20People%20and%20Underrepresented%20Groups.pdf, accessed 10 December 2024).
- Mental health, disability and human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329546).

- Mosaic toolkit to end stigma and discrimination in mental health. Geneva: World Health Organization. Regional Office for Europe; 2014 (https://iris.who.int/handle/10665/379124).
- Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329577).
- Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329602).
- WHO QualityRights e-training on mental health, WHO Academy. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training; https://whoacademy.org/ accessed 10 December 2024).

Practical resources for Policy directive 5.2 Joint actions on social and structural determinants and society-wide issues

- Advocacy for mental health, disability and human rights: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329587).
- Community engagement: a health promotion guide for universal health coverage in the hands of the people. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/334379).
- IASC guidelines on mental health and psychosocial support in emergency settings, 2007. Geneva: Inter-Agency Standing Committee; 2007 (https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007, accessed 10 December 2024).
- IASC handbook, mental health and psychosocial support coordination. New York: Inter-Agency Standing Committee; 2023 (https://reliefweb.int/report/world/iasc-handbook-mental-health-and-psychosocial-support-coordination, accessed 10 December 2024).
- Implementing health in all policies: a pilot toolkit. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/366435).
- Improving the health and wellbeing of children and adolescents: guidance on scheduled child and adolescent well-care visits. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/376159).
- Key learning on health in all policies implementation from around the world: information brochure. Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/272711).
- LIVE LIFE: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341726).
- Mental health and climate change: policy brief. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/354104)
- Mental health at work: policy brief. Geneva: World Health Organization and International Labour Organization; 2022 (https://iris.who.int/handle/10665/362983).
- Mental health in schools training package. In: Mental health and substance use [website]. Geneva: World Health Organization; n.d. (https://www.emro.who.int/mnh/publications/mental-health-in-schools-training-package.html, accessed 10 December 2024).
- Mental health, disability and human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329546).
- Optimizing brain health across the life course: WHO position paper. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/361251).
- Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329577).

- Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329602).
- Social isolation and loneliness among older people: advocacy brief. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/343206).
- The mental health and psychosocial support minimum services package (MHPSS MSP). New York: United Nations Inter-Agency Standing Committee; 2022 (https://www.mhpssmsp.org/sites/default/files/2021-10/MHPSS%20MSP%20Field%20Test%20Version_1.pdf, accessed 10 December 2024).
- WHO guidelines on mental health at work. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/363177).
- WHO QualityRights e-training on mental health, WHO Academy. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training; https://whoacademy.org/ accessed 10 December 2024).
- WHO commission on social connection. Geneva: World Health Organization; (https://www.who.int/groups/commission-on-social-connection).
- WHO world report on the social determinants of health equity. Geneva: World Health Organization; forthcoming 2025.

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