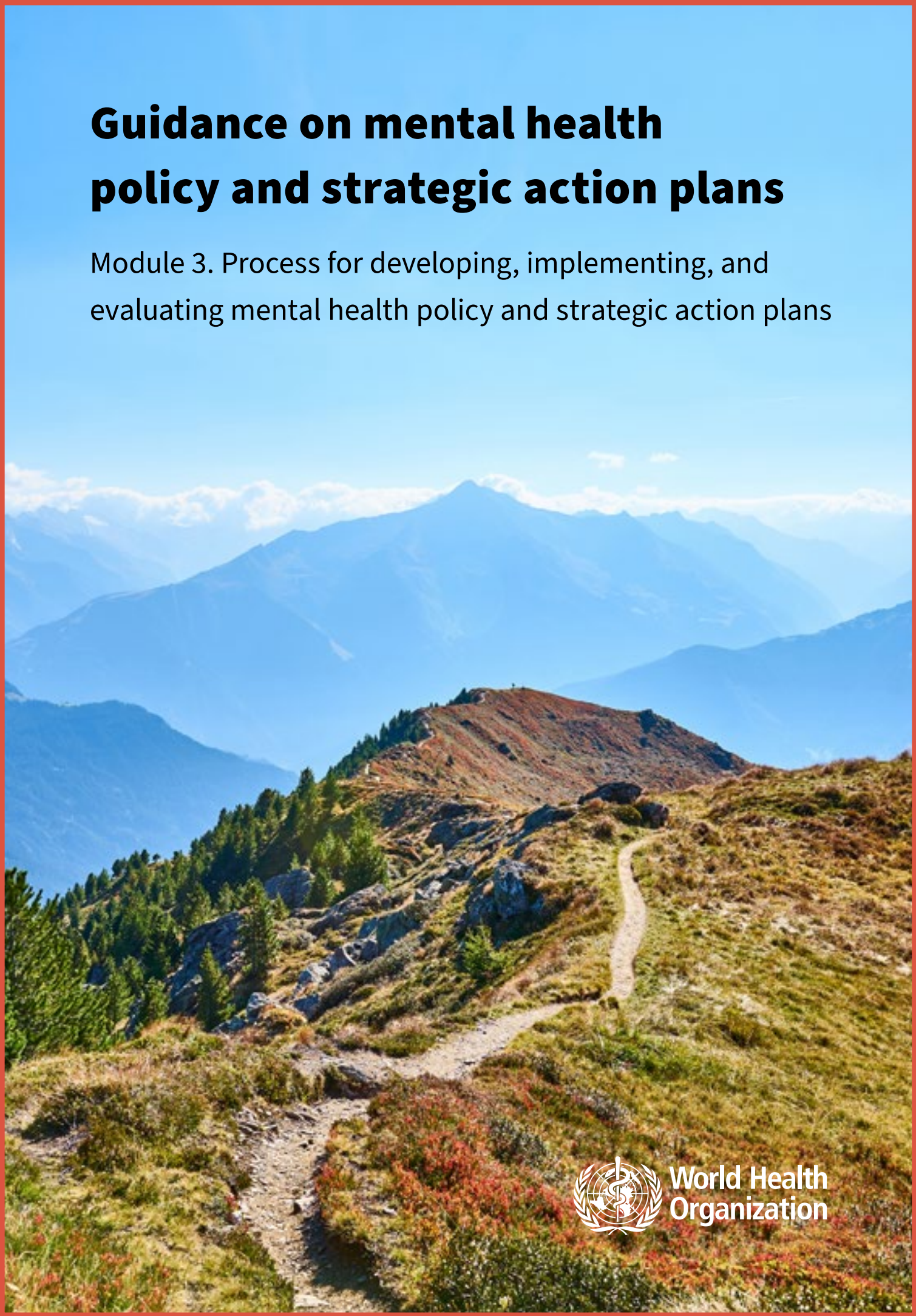
Guidance on mental health policy and strategic action plans

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



World Health Organization

Guidance on mental health policy and strategic action plans

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

World Health Organization

Guidance on mental health policy and strategic action plans. Module 3. Process for developing, implementing, and evaluating 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 978-92-4-010683-3 (electronic version)
ISBN 978-92-4-010684-0 (print version)

Suggested citation. Guidance on mental health policy and strategic action plans. Module 3. Process for developing, implementing, and evaluating 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/.

Design and layout: Jennifer Rose Fivefold Studio
Cover photo: Paths, peaks and lakes in Zillertal, Austria. ©istock marako85

Contents

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).

Writing team

This publication was written by **Michelle Funk**, **Natalie Drew Bold**, **Maria Francesca Moro**, and **Celline Cole** (Unit of Policy, Law and Human Rights in the Department of Mental Health, Brain Health and Substance Use, WHO); and **Peter McGovern** (Modum Bad, Vikersund, Norway). WHO would like to thank the following individuals and organizations for their valuable contributions, feedback and inputs:

External contributors and reviewers

Aminath Ula Ahmed (Mental Health Support Group, Malé, Maldives); **Tsuyoshi Akiyama** (World Federation for Mental Health, Japan); **Ammar Humaid Albanna** (Al Amal Psychiatric Hospital, Emirates Health Services, Dubai, United Arab Emirates); **Abdulhameed Alhabeeb** (National Center for Mental Health Promotion, Ministry of Health, Riyadh, Saudi Arabia); **Michaela Amering** (World Association for Psychosocial Rehabilitation (WAPR) and Medical University of Vienna, Austria); **Caroline Amissah** (Ministry of Health, Accra, Ghana); **Action Amos** (Pan African Network of Persons with Psychosocial Disabilities (PANPPD), Blantyre, Malawi); **Ghida Anani** (ABAAD MENA - Resource Center for Gender Equality, Beirut, Lebanon); **Jordi Blanch Andreu** (Department of Health, Catalonia, Spain); **Victor Aparicio Basauri** (Public University of Lanús, Buenos Aires Province, Argentina); **Steven Appleton** (Global Leadership Exchange, United Kingdom of Great Britain and Northern Ireland); **Maria Magdalena Archila** (Ministry of Health, San Salvador, El Salvador); **Gregory Armstrong** (Nossal Institute for Global Health, University of Melbourne, Victoria, Australia); **Emmanuel Asampong** (University of Ghana, Accra, Ghana); **Toshiaki Baba** (Ministry of Health, Labour and Welfare, Tokyo, Japan); **Radmila Stojanović Babić** (Susret, Zagreb, Croatia); **Jo Badcock** (Ending Loneliness Together, Pyrmont, New South Wales, Australia); **Stojan Bajraktarov** (University Ss. Cyril and Methodius, Skopje, North Macedonia); **Julia Bartuschka** (Federal Ministry of Social Affairs, Health, Care and Consumer Protection, Vienna, Austria); **Rimma Belikova** (Ministry of Health, Riga, Latvia); **Eleanor Bennett** (Mental Health Unit, Ministry of Health and Wellness, Belmopan, Belize); **Simona Bieliune** (Ministry of Health, Vilnius, Lithuania); **Johann Böhmann** (Delmenhorst Institute for Health Promotion (DIG), Delmenhorst, Germany); **Marit Borg** (World Association for Psychosocial Rehabilitation (WAPR) and University of South-Eastern Norway (USN), Drammen, Norway); **Lisa Brophy** (La Trobe University, Bundoora, Victoria, Australia); **Todd Buchanan** (Loyalist College/ Peer Support South East Ontario (PSSEO), Kingston, Ontario, Canada); **Ernest Burés** (Support Girona, Catalonia, Spain); **Rochelle Burgess** (UCL Centre for Global Non-Communicable Diseases, London, the United Kingdom); **Cristina Carreno** (Médecins sans Frontiers (MSF), Barcelona, Spain); **Catherine Carty** (Munster Technological University, Tralee, Ireland); **Magda Casamitjana i Aguilà** (National Mental Health Pact of Catalonia, Catalonia, Spain); **Marika Cencelli** (NHS England, London, the United Kingdom); **Francesca Centola** (Mental Health Europe, Brussels, Belgium); **Odille Chang** (College of Medicine, Nursing and Health Sciences, Fiji National University, Suva, Republic of Fiji); **Fatma Charfi** (Department of Child Psychiatry, Mongi-Slim Hospital, University of Tunis El-Manar, Tunis, Tunisia); **Andreas Chatzittofis** (Medical School, University of Cyprus, Nicosia, Cyprus); **Roman Chestnov** (HIV/ Health and Development Team, United Nations Development Programme (UNDP), Geneva, Switzerland); **Iva Cheung** (Health Justice, Vancouver, British Columbia, Canada); **Dixon Chibanda** (The Friendship Bench, Harare, Zimbabwe); **Jana Chihai** (Nicolae Testemitanu State Medical and Pharmaceutical University, and Trimbos Institute, Chisinau, Republic of Moldova); **Kalaba Mulutula Chilufya** (Resident Doctors Association of Zambia, Lusaka, Zambia); **Teodora Ciolompea** (Mental Health Program, Drug Addiction Evaluation and Treatment Center, Bucharest, Romania); **Susan Clelland** (National Mental Health Program, Ministry of Public Health, Doha, Qatar); **Jarrod Clyne** (International Disability Alliance (IDA), Geneva, Switzerland); **Pamela Collins** (Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland, the United States); **Sarah Collinson** (Sightsavers, London, the United Kingdom); **Souleymane dit Papa Coulibaly** (Centre Hospitalier Universitaire (CHR), Le Ministre de la Santé et du Developpement Social, Bamako, Mali); **Cécile Crozet** (Institutional Affairs, Support Girona, Catalonia, Spain); **Anderson da Silva Dalcin** (CAPS III – Brasilândia, São Paulo, Brazil); **Pere Bonet Dalmau** (Special Adviser, Ministry of Health, Andorra La Vella, Andorra); **Evans Danso** (Mental Health Authority, Ministry of Health, Accra, Ghana); **Maria-Luisa de la Puente** (Mental Health Pact, Barcelona, Spain); **Shelley de la Vega** (Institute on Aging, National Institutes of Health, Manila, Philippines); **Linda Dervishaj** (Delmenhorst Institute for Health Promotion (DIG), Delmenhorst, Germany); **Matrika Devkota** (KOSHISH - National Mental Health Self-Help Organization, Kathmandu, Nepal); **Hervita Diatri** (Cipto Mangunkusumo General Hospital, Department of Psychiatry, University of Indonesia, Jakarta, Indonesia); **Prianto Djatmiko** (Adult Mental Health Division, Ministry of Health, Jakarta, Indonesia); **Reine Dope Koumou** (Centre National de Santé Mentale, Ministère de la Santé et des Affaires Sociales, Libreville, Gabon);

S. Benedict Dossen (Mental Health Program, Ministry of Health, Monrovia, Liberia); **Marianna Duarte** (Médecins sans Frontiers (MSF), Paris, France); **Julian Eaton** (CBM Global, London, the United Kingdom); **Rabih El Chammay** (National Mental Health Programme, Ministry of Health, Beirut, Lebanon); **Javiera Paz Erazo Leiva** (Disease Prevention and Control Division, Ministry of Health, Santiago, Chile); **Carla Fadlallah** (Support Girona, Catalonia, Spain); **John Farrelly** (Mental Health Commission, Dublin, Ireland); **Julia Faure** (WHO QualityRights Program, Etablissement Public de Santé Mentale (EPSM) Lille Métropole - Centre collaborateur de l'OMS pour la Recherche et la Formation en Santé mentale, Lille, France); **Emma Ferguson** (United Nations Children's Fund (UNICEF), New York, New York, the United States); **Katherine Ford** (University of Oxford, Oxford, the United Kingdom); **Arianne Foret** (Support Girona, Catalonia, Spain); **Melvyn Freeman** (University of Stellenbosch, Stellenbosch, South Africa); **Harumi Fuentes** (Office of the United Nations High Commissioner for Human Rights (OHCHR), Geneva, Switzerland); **Silvana Galderisi** (University of Campania "Luigi Vanvitelli", Naples, Italy); **Carlos Enrique Garavito Ariza** (Non-Communicable Diseases Department, Ministry of Health and Social Protection, Bogotá, Distrito Capital, Colombia); **Neha Garg** (Mental Health, Ministry of Health and Family Welfare, New Delhi, India); **Gladwell Gathecha** (Division of Noncommunicable Diseases, Ministry of Health, Nairobi, Kenya); **Lynn Gentile** (Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland); **Nariman Ali Ghader** (Emirates Health Services, Dubai, United Arab Emirates); **Neeraj Gill** (School of Medicine and Dentistry, Griffith University, Southport, Queensland, Australia); **Ketevan Goginashvili** (Health Policy Division, Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, Tbilisi, Georgia); **Ximena Goldberg** (Barcelona Institute for Global Health (ISGlobal), Barcelona, Spain); **Kristijan Grđan** (Mental Health Europe (MHE), Zagreb, Croatia); **Anne Guy** (Beyond Pills Alliance, London, the United Kingdom); **Bill Gye** (Community Mental Health Australia (CMHA), Rozelle, New South Wales, Australia); **Ahmed Hankir** (Western University, London, Ontario, Canada); **Muhammad Ali Hasnain** (United for Global Mental Health, London, the United Kingdom); **Karin Hechenleitner Schacht** (Office of the United Nations High Commissioner for Human Rights (OHCHR), Geneva, Switzerland); **Vivian Hemmelder** (Mental Health Europe (MHE), Brussels, Belgium); **Helen Herrman** (Orygen Centre for Youth Mental Health, The University of Melbourne, World Psychiatric Association, Melbourne, Victoria, Australia); **Zeinab Hijazi** (United Nations Children's Fund (UNICEF), New York, New York, the United States); **Mark Horowitz** (UCL, London, the United Kingdom); **Ada Hui** (Royal College of Nursing, London, the United Kingdom); **Asma Humayun** (Ministry of Planning, Development and Special Initiatives, Islamabad, Pakistan); **Yoshikazu Ikehara** (Tokyo Advocacy Law, Tokyo, Japan); **Elturan Ismayilov** (Mental Health Center, Baku, Azerbaijan); **Gabriel Ivbijaro** (World Mental Health Federation (WFMH), London, the United Kingdom); **Bernard Jacob** (Federal Public Service Health (FPS Health), Brussels, Belgium); **Florence Jaguga** (Alcohol and Drug Abuse Rehabilitation Unit, Moi Teaching & Referral Hospital, Eldoret, Kenya); **Lucy Clare Johnstone** (Independent Trainer, the United Kingdom); **Nev Jones** (School of Social Work, University of Pittsburgh, Pittsburgh, Pennsylvania, the United States); **Simon Njuguna Kahonge** (Mental Health, Ministry of Health, Nairobi, Kenya); **Olga Kalina** (European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP), Tbilisi, Georgia); **Timo Kallioaho** (European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP), Pentinmäki, Finland); **Gregory Keane** (Médecins Sans Frontières (MSF), Paris, France); **Thomas Kearns** (Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland (RCSI), Dublin, Ireland); **Rene Keet** (GGZ Noord-Holland-Noord, Heerhugowaa, Netherlands (Kingdom of the)); **Tim Kendall** (NHS England, London, the United Kingdom); **Saqui Khandoker** (Shuchona Foundation, Dhaka, Bangladesh); **Gary Kiernan** (Mental Health Commission, Dublin, Ireland); **Nina Kilkku** (European Psychiatric Nurses (Horatio), Faculty of Health Sciences, Institute for Health, VID Specialized University, Oslo, Norway); **Seongsu Kim** (Dawon Mental Health Clinic, Korean Open Dialogue Society, Suwon, Republic of Korea); **Hansuk Kim** (Division of Mental Health Policy, Ministry of Health and Welfare, Sejong-si, Republic of Korea); **Sarah Kline** (United for Global Mental Health, London, the United Kingdom); **Martin Knapp** (NIHR School for Social Care Research, London School of Economics and Political Science, London, the United Kingdom); **Manasi Kumar** (Institute for Excellence in Health Equity, New York University School of Medicine, New York, New York, the United States and Department of Psychology, University of Nairobi, Kenya); **Zrinka Laido** (Mental Health Department, Ministry of Social Affairs, Estonia); **Norman Lamb** (South London and Maudsley NHS Foundation Trust, London, the United Kingdom); **Jennifer Leger** (Humanity and Inclusion, Lyon, France); **Valentina Lemmi** (School of Health and Social Care, University of Essex, Colchester, the United Kingdom); **Yiu-hong Leung** (Health Promotion Branch, Department of Health, Hong Kong Special Administrative Region, China); **Michelle Lim** (Ending Loneliness Together, Pyrmont, New South Wales, Australia); **Jutta Lindert** (University of Applied Sciences, Emden, Germany); **Laura Loli-Dano** (Mood and Anxiety Ambulatory Services, The Centre for Addiction and Mental Health (CAMH), Toronto, Ontario, Canada); **Antonio Lora** (Aziende Socio Sanitarie Territoriali (ASST) Regione Lombardia, Lecco, Italy); **Nasser Loza** (The Behman Hospital, Cairo, Egypt); **Crick Lund** (Centre for Global Mental Health, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, the United Kingdom); **Ma Ning** (National Mental Health Project Office, National Medical Center for Mental Illness, Peking University Sixth Hospital, Beijing, China); **Alicia Malcolm** (Behavioral Health Services Department, Ministry of Health and Human Services, Cockburn Town, Turks and Caicos Islands, British Overseas Territory); **Raj Mariwala** (Mariwala Health Initiative, Mumbai, India); **Michael Marmot** (UCL International Institute for Society and Health, University College London, London, the United Kingdom); **Sergi Martínez** (Support Girona, Baixos, Girona, Spain); **Patience Mavunganidze** (Mental Health Department, Ministry of Health and Child Care, Harare, Zimbabwe); **Felicia Mburu** (Article 48 Initiative, Nairobi, Kenya); **Shari McDaid** (Mental Health Foundation, London, the United Kingdom); **Zul Merali** (Brain and Mind Institute, Aga Khan University, Karachi, Pakistan); **Happiness Mkhatshwa** (World Vision International, Mbabane, Eswatini); **Tlaleng Mofokeng** (Special Rapporteur on the right to physical and mental health, Johannesburg, South Africa); **Cristina Molina Parrilla** (National Mental Health Pact of Catalonia, Spain); **Cristian Montenegro** (Wellcome Centre for Cultures and Environments of Health, University of Exeter, the United Kingdom); **Guadalupe Morales Cano** (Fundación Mundo Bipolar, Madrid, Spain and European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP), Spain); **Alejandra Moreira** (Mental Health Care Program, Ministry of Public Health, Montevideo, Uruguay); **Natalia Muffel** (United Nations Children's Fund (UNICEF), New York, New York, the United States); **Fabian Musoro** (Ministry of Health and Child Care, Harare, Zimbabwe); **Charity Muturi** (Representative of service users and caregivers, Tunawiri, Kenya); **Takuya Nakamura** (Ministry of Health, Labour and Welfare, Tokyo, Japan); **Byambadorj Ninj** (Ministry of Health, Ulaanbaatar, Mongolia); **Michael Njenga** (CBM Global, Nairobi, Kenya); **Aikaterini Nomidou** (Greek Association of Families/Carers and Friends for Mental Health, Athens, Greece); **Zuzana Novakova** (Ministry of Health, Bratislava, Slovakia); **Nurashikin binti Ibrahim** (National Centre of Excellence for Mental Health (NCEMH), Ministry of Health, Malaysia); **Hauwa Ojeifo** (She Writes Woman, Abuja, Nigeria); **Nasri Omar** (Ministry of Health, Nairobi, Kenya); **Bouram Omar** (Mental Health Office, Ministry of Health and Social Protection, Rabat, Morocco); **Olivia Marie Angèle Awa Ouedraogo** (Ministry of Health, Ouagadougou, Burkina Faso); **Aldemar Parra Espitia**

(Non-Communicable Diseases Department, Ministry of Health and Social Protection, Bogotá DC, Colombia); **Soumitra Pathare** (Centre for Mental Health Law and Policy, Pune, India); **Marline Elizabeth Paz Castillo** (Ministerio de Salud Pública y Asistencia Social, Ciudad de Guatemala, Guatemala); **Claudia Pellegrini Braga** (Faculty of Medicine, University of São Paulo, Brazil); **Lorena López Pérez** (Comisión Nacional de Salud Mental y Adicciones, Secretaría de Salud, Mexico DF, Mexico); **Núria Pi** (Support Girona, Baixos, Girona, Spain); **Kathleen Pike** (Global Mental Health Program, Columbia University, New York, New York, the United States); **Mohammad Reza Pirmoradi** (School of Behavioral Sciences and Mental Health, Iran University of Medical Sciences, Tehran, Iran (Islamic Republic of)); **Andrea Pregel** (Sightsavers, Chippenham, the United Kingdom); **Marek Procházka** (Psychiatric Hospital of Horni Berkovice, Czechia); **Benjamas Prukkanone** (Department of Mental Health, Ministry of Public Health, Nonthaburi, Thailand); **Dainius Pūras** (Department of Psychiatry, Faculty of Medicine, Vilnius University, Vilnius, Lithuania); **Jorge Quílez Jover** (Department of Health, Catalonia, Spain); **Gerard Quinn** (Centre for Disability Law and Policy, National University of Ireland, Galway, Ireland; **Anne Randväli** (Ministry of Social Affairs, Tallinn, Estonia); **Solomon Rataemane** (World Association of Psychosocial Rehabilitation (WAPR), and University of Limpopo (MEDUNSA), South Africa); **John Read** (University of East London, London, the United Kingdom); **Greg Roberts** (Nossal Institute for Global Health, the University of Melbourne, Victoria, Australia); **Ignas Rubikas** (Mental Health Division, Ministry of Health, Vilnius, Lithuania); **Maria Rubio-Valera** (Mental Health Pact, Parc Sanitari Sant Joan de Déu, Barcelona, Spain); **Oleg Salagay** (Ministry of Health of the Russian Federation, Moscow, Russian Federation); **James Sale** (United for Global Mental Health, London, the United Kingdom); **Liuska Sanna** (Mental Health Europe, Brussels, Belgium); **Martha Savage** (School of Geography, Environment and Earth Sciences, Victoria University, Wellington, New Zealand); **Aminath Shahuza** (National Mental Health Department, Ministry of Health, Malé, Maldives); **Michael Shannon** (Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland (RCSI), University of Medicine and Health Sciences, Dublin, Ireland); **Dudu Shiba** (Directorate of Mental Health and Substance Abuse Policy, Department of Health, Pretoria, South Africa); **Laura Shields-Zeeman** (Trimbos Institute, Utrecht, Netherlands (Kingdom of the)); **Sarah Simpson** (Nossal Institute for Global Health, the University of Melbourne, Victoria, Australia); **Laura Smart Richman** (Population Health Sciences, Duke University, Durham, North Carolina, the United States); **Josep Maria Solé** (Support Girona, Catalonia, Spain); **Chhit Sophal** (Department of Mental Health and Substance Abuse, Ministry of Public Health, Nonthaburi, Thailand); **Priti Sridhar** (Mariwala Health Initiative, Mumbai, India); **Fabrizio Starace** (Department of Mental Health and Drug Abuse, Azienda Unità Sanitaria Locale di Modena, Italy); **Charlene Sunkel** (Global Mental Health Peer Network, Johannesburg, South Africa); **Kota Suzuki** (Department of Health and Welfare for Persons with Disabilities, Mental Health and Disability Health Division, Ministry of Health, Labour and Welfare, Tokyo, Japan); **Ingibjörg Sveinsdóttir** (Ministry of Health, Reykjavik, Iceland); **Angie Tarr-Nyakoon** (Mental Health Program, Ministry of Health and Social Welfare, Monrovia, Liberia); **Dilorom Tashmukhamedova** (Committee on Youth, Culture and Sports, Senate of the Republic of Uzbekistan, Tashkent, Uzbekistan); **Aracely Téllez Orellana** (Programa de Salud Mental, Ministerio de Salud Pública y Asistencia Social, Ciudad de Guatemala, Guatemala); **Murali Thyloth** (World Association for Psychosocial Rehabilitation (WAPR), India); **Tor Helge Tjelta** (Centre for Development Mental Health and Addiction, the Norwegian Association for Mental Health and Addiction Care, and the European Community-based Mental Health Service Providers Network (EUCOMS), Norway); **Emanuela Tollozhina** (Ministry of Health and Social Protection, Tirana, Albania); **Catherine Townsend** (Ford Foundation, New York, New York, the United States); Joy Ubong (She Writes Woman, Abuja, Nigeria); **Michael Udedi** (Ministry of Health and Population, Lilongwe, Malawi); **Carmen Valle Trabadelo** (IFRC Reference Centre for Psychosocial Support, Copenhagen, Denmark); **Chantelle van Straaten** (Booysen); (Independent Consultant and Advocate for Mental Health, South Africa); **Javier Vasquez** (Washington College of Law, American University, Washington, District of Columbia, the United States); **Sahar Vasquez** (Global Mental Health Peer Network, Belize); **Alberto Vasquez Encalada** (Center for Inclusive Policy (CIP), Peru); **Simon Vasseur-Bacle** (Ministère de la Santé et de la Prevention, France et Service de recherche et de formation en santé mentale, Etablissement Public de Santé Mentale (EPSM) Lille Métropole/Centre collaborateur de l'OMS pour la Recherche et la Formation en Santé mentale, Lille, France); **Joan Vegué** (Mental Health and Addictions Master Plan of Catalonia, Spain); **Matej Vinko** (National Mental Health Programme, National Institute of Public Health, Ljubljana, Slovenia); **Andrej Vršanský** (League for Mental Health, Bratislava, Slovakia); **Ann Watts** (International Union of Psychological Science, Durban, South Africa); **Douglas Webb** (United Nations Development Programme, New York, New York, the United States); **Rick Peter Fritz Wolthusen** (Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina, the United States); **Stephanie Wooley** (European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP), Paris, France); **Miguel Xavier** (National Coordination of Mental Health Policies, Ministry of Health, Lisbon, Portugal); **Peter Yaro** (BasicNeeds, Accra, Ghana); Constantin Zieger (Competence Center Psychosocial Health, Federal Ministry for Social Affairs, Health, Care and Consumer Protection, Vienna, Austria); **Martin Zinkler** (Department of Psychiatry and Psychotherapy, Gesundheit Nord gGmbH - Klinikverbund, Bremen, Germany); **Thurayya Zreik** (Public Health and Development Researcher, Beirut, Lebanon). WHO would also like to acknowledge the coordinated input received from the **Australian Government Department of Health and Aged Care**, to this publication.

WHO contributors and reviewers

WHO headquarters staff and consultants

Ben Adams; Mirna Amaya; Annabel Baddeley; Rachel Baggaley; Nicholas Banatvala; Daryl Barrett; Kenneth Carswell; Sudipto Chatterjee; Daniel Chisholm; Nicholas James John Corby; Catarina Magalhães Dahl; Anne-Marijn De Graaff; Tarun Dua; Alexandra Fleischmann; Brandon Gray; Rachel Mary Hammonds; Fahmy Hanna; Ernesto Jaramillo; Dzmitry Krupchanka; Aiysha Malik; Gergana Manolova; Farai Mavhunga; Pauliina Nykanen-Rettaroli; Miriam Orcutt; Barango Prebo; Giovanni Sala; Alison Schafer; Katrin Seeher; Chiara Servili; Tova Tampe; Tamitza Toroyan; Nicole Valentine; Mark Van Ommeren; Benoit Varenne; Kerri Viney; and Inka Weissbecker.

WHO review and coordination at regional level

Florence Kamayonza Baingana (former, WHO Regional Office for Africa); **Andrea Bruni** (WHO Regional Office for South-East Asia); **Claudina Cayetano** (WHO Regional Office for the Americas); **Eric Domingo** (WHO Regional Office for the Western Pacific); **Jennifer Hall** (WHO Regional Office for Europe); **Matias Irarrazaval** (WHO Regional Office for the Americas); **Ledia Lazeri** (WHO Regional Office for Europe); **Carmen Martinez** (WHO Regional Office for the Americas); **Jason Maurer** (WHO Regional Office for Europe); **Melita Murko** (WHO Regional Office for Europe); **Renato Oliveira e Souza** (WHO Regional Office for the Americas); **Cassie Redlich** (WHO Regional Office for Europe); **Chido Ratidzai Rwafa Madzvamutse** (WHO Regional Office for Africa); **Khalid Saeed** (WHO Regional Office for the Eastern Mediterranean); **Ana Maria Tijerino Inestroza** (WHO Regional Office for Europe); **Martin Vandendyck** (former, WHO Regional Office for the Western Pacific); **Cherian V. Varghese** (former, WHO Regional Office for South-East Asia); **Jasmine Vergara** (WHO Regional Office for the Western Pacific).

WHO staff and consultants in regions and countries

Issifou Alassani (WHO Country Office for Togo); **Ambroise Ané** (WHO Country Office for Cote d'Ivoire); **Murat Can Birand Apaydin** (WHO Regional Office for Europe); **Naye Bah** (WHO Country Office for Gabon); **Sadhana Bhagwat** (WHO Country Office for Bangladesh); **Rayan Butaita** (WHO Country Office for Bahrain); **Ashra Daswin** (WHO Country Office for Indonesia); **Cheick Bady Diallo** (WHO Regional Office for Africa); **Issimouha Dille Mahamadou** (WHO Regional Office for Africa); **Barkon Dwah** (WHO Country Office for Liberia); **Imane El Menchawy** (WHO Country Office for Morocco); **Dalia Elasi** (WHO Regional Office for the Eastern Mediterranean); **Wafaa Elsawy** (WHO Regional Office for the Eastern Mediterranean); **Rut Erdelyiova** (WHO Country Office for Slovakia); **Melania Angue Essiene Obono** (WHO Country Office for Equitorial Guinea); **Katoen Faromuzova** (WHO Country Office for Tajikistan); **Atreyi Ganguli** (WHO Country Office for India); **Momodou Gassama** (WHO Country Office for Gambia); **Augustin Gatera** (WHO Country Office for Rwanda); **Leveana Gyimah** (WHO Country Office for Ghana); **Ishakul Kabir** (WHO Country Office for Bangladesh); **Hafisa Kasule** (WHO Country Office for Uganda); **Nazokat Kasymova** (WHO Country Office for Uzbekistan); **Olga Khan** (WHO Country Office for Poland); **Shabana Khan** (WHO Regional Office for South-East Asia); **Rusudan Klimiashvili** (WHO Country Office for Georgia); **Aye Moe Moe Lwin** (WHO Country Office for Myanmar); **Debra Machando** (WHO Country Office for Zimbabwe); **Tebogo Madidimalo** (WHO Country Office for Botswana); Raquel Dulce **Mahoque Maguele** (WHO Country Office for Mozambique); **Kedar Marahatta** (WHO Country Office for Nepal); **Joseph Lou Kenyi Mogga** (WHO Country Office for South Sudan); **Hasina Momotaz** (WHO Country Office for Bangladesh); **Laurent Moyenga** (WHO Country Office for Burkina Faso); **Siddharth Maitreyee Mukherjee** (WHO Country Office for India); **Julius Muron** (WHO Country Office for Ethiopia); **Christine Chiedza Musanhu** (WHO Country Office for Uganda); **Joseph Muiruri Kibachio Mwangi** (Country Office for South Africa); **Thato Mxakaza** (WHO Country Office for Lesotho); **Alphoncina Nanai** (WHO Country Office for Tanzania); **Jérôme Ndaruhutse** (WHO Country Office for Burundi); **Nikolay Negay** (WHO Country Office for Kazakhstan); **Olivia Nieveras** (WHO Country Office for Thailand); **Ishmael Nyasulu** (WHO Country Office for Malawi); **Brian Ogallo** (WHO Country Office for Sudan); **Milena Oikonomou** (WHO European Office for Investment for Health and Development); **Edith Pereira** (WHO Country Office for Cape Verde); **Hanitra Rahantarisoa** (WHO Country Office for Madagascar); **Mamitahiana Rakotoson Ramanamahefa** (WHO Country Office for Madagascar); **Sajeeva Ranaweera** (WHO Regional Office for South-East Asia); **Vageesha Rao** (WHO Regional Office for South-East Asia); **Maura Reap** (WHO Country Office for the Republic of Moldova); **Raoul Saizonou** (WHO Country Office for Benin); **Yasara Samarakoon** (WHO Country Office for Sri Lanka); **Nabil Samarji** (WHO Country Office for the Syrian Arab Republic); **Reynold Burkrie George Senesi** (WHO Country Office for Sierra Leone); **Yutaro Setoya** (WHO Country Office for India); **Mahmoud Ahmed Mohamed Farah Shadoul** (WHO Country Office for Sudan); **Elena Shevkun** (WHO Regional Office for Europe); **Mekhri Shoismatuloeva** (WHO Country Office for Tajikistan); **Tsitsi Siwela** (WHO Country Office for Zimbabwe); **Thirupathy Suveendran** (WHO Country Office for Sri Lanka); **Rita Tayeh** (WHO Country Office for Yemen); **Win Moh Moh Thit** (WHO Country Office for Myanmar); **Papy Tshimanga Manji** (WHO Country Office for Congo); **Andrew Vernon** (WHO Regional Office for the Americas); **Asmamaw Bezabeh Workneh** (WHO Country Office for Ethiopia); **Eyad Yanes** (WHO Country Office for Libya); **Edwina Zoghbi** (WHO Country Office for Lebanon).

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

his 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 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 document)

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 time frames, 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

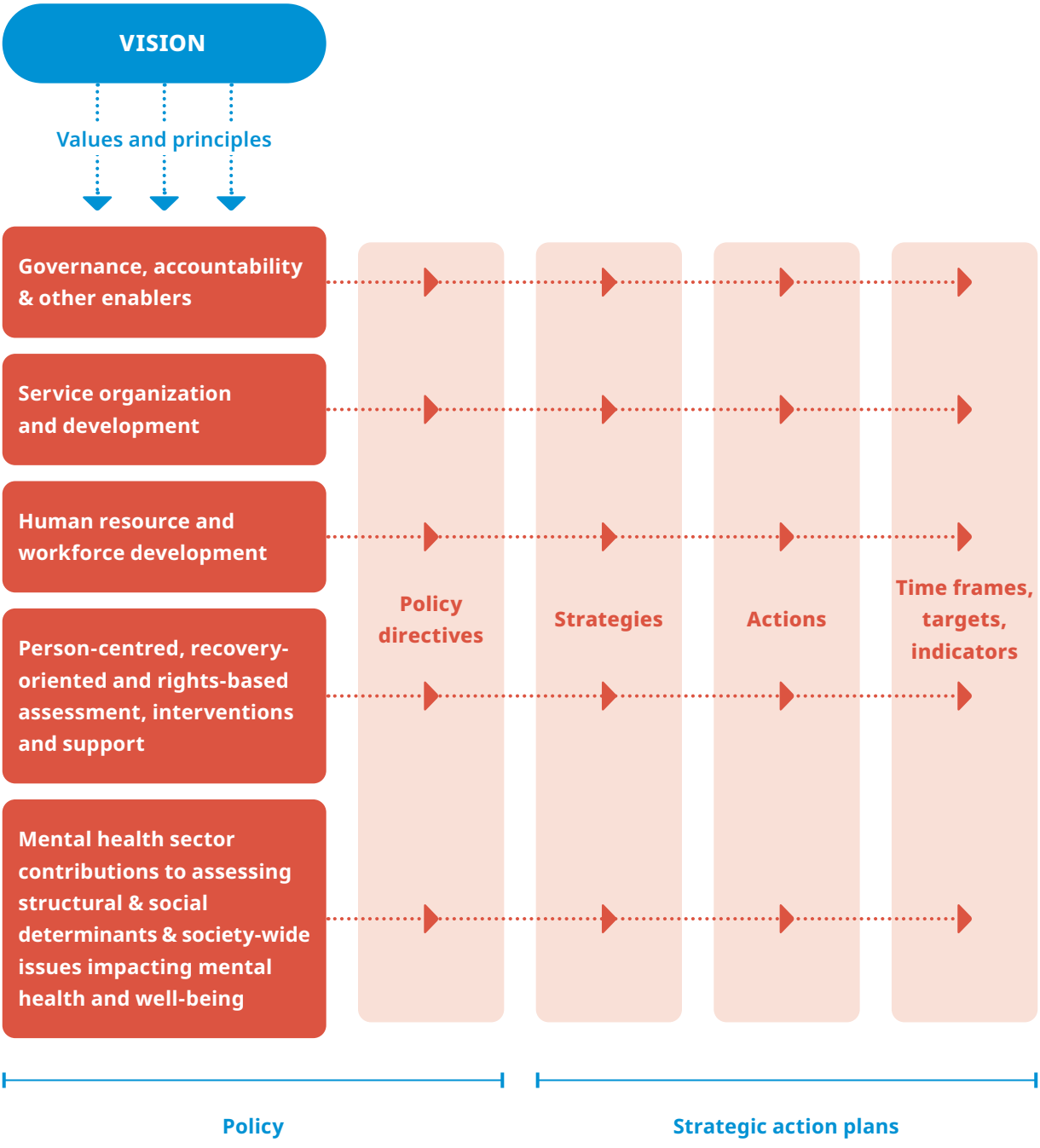
This Guidance offers a comprehensive blueprint and framework for developing national mental health policies and strategic action plans and aligning them with international human rights standards. It outlines key policy areas for reform, including policy directives, associated strategies and actions that 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

Mental health policies and strategic action plans are essential tools for coordinating actions across all levels, from national to sub-district. They encompass and enable a shared vision, specific policy directives, strategies, and actions with defined time frames, targets, and indicators (see Fig. 1).

Fig. 1 **The mental health policy and strategic action plan: a conceptual framework**



Establishing a comprehensive, inclusive, and rights-aligned process for developing and then implementing and evaluating mental health policies and strategic action plans is crucial (see Module 1 of this Guidance for a full discussion). Module 3 (this document) outlines nine key steps for this process and should be used in conjunction with *Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans*. The nine steps are flexible and do not need to be completed in a strict, linear order. For example, steps may need to be revisited and updated periodically as circumstances change or as gaps are identified during the policy drafting process.

Module 3 also provides template checklists that planners can use or adapt to assess and evaluate policies and strategic action plans, whether these are pre-existing or newly drafted. The checklists help ensure that policies are person-centred, recovery-oriented, and rights-based, and that they cover all essential elements.

Additionally, Module 4 provides three country case scenarios to illustrate the varied approaches countries can take when reforming their mental health policy. Module 5 provides a quick access directory to the directives, strategies and actions discussed in Module 2.

It is important to note that countries will have varying starting points. Before starting the process of policy development and implementation, each country should assess what has already been done and identify any gaps. For instance, if a situational analysis has been completed or is in progress, there would be no need to restart this process. Instead, countries should review the analysis to ensure the findings are still relevant, identify any gaps or omissions, and address them accordingly.

However, it is also important to recognize that many policies and strategies remain unimplemented or ineffective, due to factors such as lack of political commitment, insufficient stakeholder engagement and consensus, poor awareness and understanding of policy directives, unrealistic planning without sufficient funding, and an under-appreciation how social and structural determinants (see Box 1) affect mental health. Appreciating this can help planners and implementers avoid common pitfalls and surmount hurdles. See the *Spotlight* section for approaches that will help mitigate and manage many of the likely challenges.

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.

The responsibility for developing and implementing a mental health policy and strategic action plan varies by country. While Ministries of Health often lead the process, other national public health and mental health bodies may also play key roles, and many government sectors should be involved (see Box 2). In some cases, the head of state may oversee the reform. Regardless of the approach, it is crucial to involve a diverse range of stakeholders from various government sectors and civil society (see Box 3), including people with lived experience and their organizations.

SPOTLIGHT on avoiding common challenges and pitfalls in policy development. Following these pointers from the outset will help mitigate many common policy development challenges.

Strive for internal consistency. Policy documents and strategic action plans often lack coherence. Inconsistent directives, strategies, and actions may conflict with each other or with the overall vision and values, leading to ambiguity and uncertainty. This inconsistency can weaken the document and may indicate a lack of commitment, a tokenistic approach to values, or insufficient consensus about policy directions. Ensuring consistency throughout the document is crucial for its effectiveness.

Define a realistic scope and time frame. The policy and plan should be challenging but also realistic and aligned with the specific context and available human and financial resources. Avoid unrealistic goals that are overly ambitious, go beyond the intended scope, or exceed realistic resources.

Set a clear direction. Clarity and simplicity in policy and plans enhance understanding and effectiveness. A good policy doesn't have to be sophisticated or overly complex. A well organized, straightforward and understandable document increases the likelihood of successful implementation.

Ensure the strategic action plan is clear and well-documented. This includes developing a coherent set of strategies linked to the realistic time frame and budget. Within the strategies, emphasize specific, achievable and financed actions and incorporate monitoring and evaluation (M&E) mechanisms to track progress, assess outcomes, and provide opportunities to adjust strategies and actions.

Step 1: Conduct high-level policy dialogue to establish commitment and to engage wide-ranging government sectors

The first step in planning a mental health policy is to initiate a high-level policy dialogue among ministers or their representatives across various sectors, including: culture, art, and sports; defence and veterans; education; employment; environment, conservation and climate protection; finance and treasury; health; interior; justice; social protection; urban and rural development (see Box 2) *(22)*. The political cycle, including elections and the appointment of key personnel in ministries, should be considered, as these may influence policy momentum.

Civil society organizations should also be actively engaged in the dialogue to ensure their perspectives are incorporated, as they play a crucial role in representing community voices and promoting accountability.

This dialogue should review wide-ranging national policies and plans beyond just the mental health sector to assess how well they protect and promote mental health and align with the rights-based approach in the CRPD. Key outcomes of this dialogue can include:

- clarification of each sector's role in developing and implementing a rights-based mental health policy, including potential changes to better support mental health;
- mechanisms for interaction and collaboration between sectors and the mental health sector to ensure effective policy implementation;
- financing mechanisms and/or shared budgets for joint initiatives; and
- identification of sectors interested in joining the multistakeholder advisory committee (see Step 2) to oversee the policy development process.

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.

Step 2: Establish a multistakeholder advisory committee to develop and oversee policy and strategic action planning

A well-functioning advisory committee itself requires careful planning, broad representation, and ongoing support. The committee should have clear terms of reference outlining its roles, responsibilities, activities, expected outcomes, and time frame for completing the different components of its work.

Committee members should bring a mix of skills, such as management, problem-solving, networking, and political influence. Some members should have technical expertise, but the committee must also be able to identify technical tasks and delegate them to subgroups, such as drafting teams. At least some committee members should have experience of implementing policy, even if not directly related to mental health.

The committee plays a critical role in securing stakeholder buy-in for reform, thereby supporting effective implementation. To enable this, membership should be diverse, representing stakeholders from government and non-government sectors (see Box 3). It may be helpful to develop an outreach plan, including calls for diverse applications to join the advisory group.

In selecting committee members, it is important to consider inclusivity and diversity. As far as feasible, engage expertise from groups facing discrimination related to age, gender, sexual orientation, disability, immigration or refugee status, race, ethnicity, indigeneity, or houselessness.

Directly engaging with organizations representing people with lived experience of mental health conditions and psychosocial disabilities is essential. These groups provide first hand insights into challenges and solutions and make recommendations for inclusive and effective policies *(23)*. If organizations are unavailable, outreach should directly engage individuals, with support from regional and international disability organizations to ensure representation *(24)*. It is vital to avoid tokenistic participation, to recognize the diversity within lived experience groups, and create safe spaces for participation.

Simply appointing people is insufficient. Committee members will require support, including resources for meetings, such as logistical assistance and technology. Accessibility measures should accommodate people with disabilities so they can to participate actively. Capacity building and financial support should be provided to enable meaningful involvement. Training opportunities should be provided to address gaps in expertise. Remote meeting options can reduce costs and facilitate more frequent interactions. Participants should be paid for their time if their role is not part of their job.

To maintain integrity in policy development, committees should integrate mechanisms to address potential conflicts of interest. This includes establishing clear guidelines for disclosure, ensuring transparency in decision-making processes, and mitigating undue influence from any individual or group.

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.

Step 3. Build understanding and new mindsets on person-centred and rights-based approaches

Stigma and discrimination against people with mental health conditions and psychosocial disabilities remain widespread, creating resistance to rights-based approaches in mental health and hindering implementation of rights-based policies and strategic action plans. Addressing and transforming societal misconceptions, fears, and ableist views and improving understanding of human rights is crucial for the success of any new mental health policy *(25)*.

Investing resources and time to shift mindsets and attitudes among all stakeholders, including the broader community, is essential from the outset. The high-level policy dialogues in Step 1 should start discussions on implementing community-wide capacity building initiatives and the multistakeholder advisory committee established in Step 2 should receive targeted information and training on rights-based approaches. Sustained efforts to build capacity, within the advisory group, the community, and across broader stakeholder constituencies, are critical throughout the policy development and planning stages.

The *WHO QualityRights face-to-face training modules* *(26)* as well as the *WHO QualityRights e-training* *(27)* on mental health, recovery and community inclusion, are effective tools for fostering positive and lasting changes in attitudes and practices. These resources can be widely disseminated among stakeholders and communities, having already achieved significant change in practice, attitudes and mindsets in many countries *(28, 29)*.

Step 4: Review international human rights obligations and commitments

The multistakeholder advisory committee members should carefully study their country's obligations under international human rights law. Countries that have ratified human rights treaties are committed to protect, respect, and fulfill the rights these outline through legislation, policy, advocacy and other measures. It is crucial that everyone involved in policy development is aware of the treaties their country has ratified and the corresponding obligations. The rights-based training initiated as part of Step 3 will enhance understanding.

Even countries that have not ratified key international human rights treaties should review treaty provisions before developing new policies and plans, as these offer valuable guidance for implementing good practices and promoting human rights in mental health. Regional human rights instruments should also be considered. Additionally, countries need to consider further commitments made through UN and Human Rights Council resolutions *(30–33)* as well as their endorsement of WHO's *Comprehensive mental health action plan 2013–2030 (20)*.

There are nine core international human rights treaties (see Box 4), including the International Covenants on Civil and Political Rights, and on Economic, Social and Cultural Rights, and seven thematic treaties. The CRPD, ratified by 188 State Parties, is particularly important, as it enshrines the human rights model of disability and is essential for rethinking and reforming mental health systems and service provision.

Box 4. Resources for understanding human rights in mental health

Core international United Nations human rights instruments

- International Covenant on Civil and Political Rights https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights *(34)*
- International Covenant on Economic, Social and Cultural Rights https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights *(35)*
- Convention on the Elimination of All Forms of Racial Discrimination https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial *(36)*
- Convention on the Elimination of All Forms of Discrimination against Women https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women *(37)*
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading *(38)*
- Convention on the Rights of the Child https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child *(39)*
- Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-protection-rights-all-migrant-workers *(40)*
- Convention for the Protection of All Persons from Enforced Disappearance https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-protection-all-persons-enforced *(41)*
- Convention on the Rights of Persons with Disabilities https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities *(15)*

United Nations Human Rights Council resolutions

- Resolution A/HRC/32/18, mental health and human rights, adopted by the Human Rights Council on 1 July 2016 https://undocs.org/A/HRC/RES/32/18 *(30)*
- Resolution A/HRC/RES/36/13, mental health and human rights, adopted by the Human Rights Council on 28 September 2017 https://undocs.org/A/HRC/RES/36/13 *(31)*
- Resolution A/HRC/RES/43/13, mental health and human rights, adopted by the Human Rights Council on 19 June 2020 https://undocs.org/A/HRC/RES/43/13 *(32)*
- Resolution A/HRC/52/L.15 Mental health and human rights; adopted by the Human Rights Council on 24 March 2023 https://digitallibrary.un.org/record/4007595 *(33)*

Step 5: Undertake a situational analysis of the context, priorities, challenges and opportunities

The multistakeholder advisory committee should conduct a situational analysis in order to understand the mental health context, and to identify priorities and challenges. The stages are as follows.

5.1 Define content and issues for the situational analysis

Strategy 5.1.1

Social and structural determinants of mental health.

Social and structural determinants encompass a wide range of factors (social, economic, and environmental) that impact population mental health (see Box 1). Not all segments or groups of the population are affected by these determinants equally or in the same way *(42, 43)*.

The situational analysis should identify the key social and structural determinants and other issues affecting the country, along with existing initiatives addressing these in various settings and sectors, including workplaces, education, communities, and humanitarian settings.

Strategy 5.1.2

Mental health policy/plan and legal framework.

National mental health policies, plans, and legal frameworks should be reviewed to assess their alignment with international human rights and other commitments (see Step 3). It is important to identify elements that are lacking, contradictory, or in need of reform *(44)*.

Attention should be given to how current frameworks support rights-based community mental health services and whether they incentivize or challenge institutionalization, involuntary admission, and other coercive practices.

The analysis should also evaluate the implementation of each policy, plan, and rights-aligned legal provision, describing the key challenges and barriers to implementation, opportunities, and successes.

Strategy 5.1.3

Information on people with mental health conditions, psychosocial disabilities, groups facing discrimination or at risk of discrimination and other key mental health issues.

The situational analysis should include data on the prevalence of mental health conditions, psychosocial disabilities, and other significant mental health concerns in the country. It should encompass information on specific categories of mental health conditions, as well as data related to alcohol and other psychoactive substance use, cognitive and intellectual disabilities and neurological conditions including dementia, and epilepsy (if these are typically managed within the mental health system). Additionally, data collection efforts should aim to identify groups at increased risk of mental health conditions, psychosocial disabilities, and other significant mental health concerns. Disaggregating data by relevant characteristics (for example by gender, age, and socio-economic status) can enhance this understanding. It is also important to describe local understanding of mental health, including indigenous understanding. Understanding suicide rates, contributing factors, and the most common and lethal means of suicide and suicide attempts is crucial. This stage complements Step 5.1.1, which focuses on social and structural determinants of mental health.

Strategy 5.1.4

Mental health services, and their delivery.

Mental health services should be reviewed and mapped to determine what is available and to identify any gaps. Each type of service (see Box 5) should be assessed to ensure compliance with human rights standards, including those outlined in Box 6. This assessment should cover both publicly and privately funded services and supports.

Box 5. Types of mental health services to include in situational analyses

Types of mental health services include:

- community mental health centres;
- crisis response services;
- hospital-based services;
- community outreach services;
- peer support services;
- supported living services;
- mental health in primary healthcare;
- any other services providing mental health support in the community, including therapists in private practice.

Modes of service delivery

- **In-person services**. Face-to-face support and care, including therapy sessions, group support meetings, and community-based mental health programmes.
- **Online services**. Virtual support communities, mental health apps, and self-guided therapy programmes accessible through the internet, offering remote access to resources and peer support.

- **Phone-based services**. Consultations and support delivered via phone calls, including crisis hotlines, mental health check-ins, and phone counselling.
- **Digital services**. Technology-driven mental health tools, such as mobile apps, self-help platforms, and online therapy resources that can be accessed independently or as supplements to traditional care.
- **Hybrid services**. A blend of in-person, online, digital, and/or phone-based options, such as therapy that includes both face-to-face sessions and digital follow-ups, or virtual care supplemented by in-person support groups.

Box 6. Key human rights issues to be assessed within services

- **Respect for legal capacity**. Can people exercise choice and make decisions about their treatment, care and support?
- **Non-coercive practices**. Are strategies in place to end coercion (seclusion, restraint, physical, sexual and emotional abuse)?
- **Participation**. Are people with lived experience involved in running services?
- **Community inclusion**. Do services link people to relevant community services and supports, such as social protection and disability benefits, housing, employment opportunities etc.?
- **Recovery approach**. Is care person-centred and holistic, addressing relationships, work, family, and education? A recovery approach is not just diagnosis, medication and symptom reduction.

Adapted from: *Guidance on community mental health services: promoting person-centred and rights-based approaches (45).*

Other key data to collect include the number of services available in each category and the number or percentage of people with mental health conditions and psychosocial disabilities receiving treatment and support from these services annually. If available, data on the characteristics of people using each type of service (such as gender, age, origin, socio-economic status, etc.) should also be included.

By using the information already gathered on the prevalence of mental health conditions, distress, and contributing factors (see Step 5.1.3), gaps in treatment and support, whether in quantity or type, can be identified. It is also crucial to collect data to determine if any groups within the population disproportionately lack access to mental health services and supports, along with identifying the reasons and barriers for this.

For each type of service, it is useful to assess accessibility, including geographical distribution, the percentage of public versus private services, and whether health insurance covers users' costs. Gaps should be documented, and the information fed into policy discussions concerning new or scaled-up services.

Strategy 5.1.5

Housing, education, employment, and social protection for people with mental health conditions and psychosocial disabilities.

The situational analysis should describe and assess the services available for housing, education, employment, and social protection (see Box 7). For each type of service, it is crucial to assess whether delivery aligns with the human rights principles outlined in Box 6. If available, data on the number of people who might need each service and those who actually use it should be included. Where possible, the analysis should also describe how each service links to the mental health system.

Box 7. Assessing housing, education, employment and social protection services in a mental health context

Housing

The country's housing approach for people with mental health conditions or psychosocial disabilities should be evaluated, with a focus on ensuring that access to housing does not depend on treatment acceptance or compliance. It is important to assess diverse housing options based on individual needs, including support levels (from minimal to live-in), support staff location (on-site or off-site), housing structure (individual or group), and housing permanence (transitional or permanent with limited emphasis on moving out) *(46)*.

Education

The assessment should determine whether schools, colleges, and universities adopt inclusive approaches by adapting curricula and settings for learners with mental health conditions and psychosocial disabilities (47, 48). It should also evaluate the availability of health and social support systems at all education levels (primary, secondary, and higher education including apprenticeships, colleges and universities), as well as accommodations like online classes, lighter schedules, individual assistance, peer support or assistance in navigating the school system. The assessment should consider whether supported education services assist adults with mental health conditions to return to school *(49, 50)*.

Employment

The assessment should describe how people with mental health conditions or psychosocial disabilities are supported in entering, re-entering or remaining in employment, through options such as sheltered approaches, vocational training, transitional employment, opportunities with social enterprises, individual placements and support, small businesses and livelihood programmes and others *(51)*.

Social protection

The assessment should explore whether people with mental health conditions and psychosocial disabilities have equal access to disability-related benefits, as well as non-disability-related social protection schemes, such as pensions and housing benefits, and whether support mechanisms exist to help them access these benefits *(45)*.

Justice sector

The assessment should examine the country's legal frameworks to determine whether they adequately address the rights and needs of people with mental health conditions or psychosocial disabilities. This includes identifying whether legal frameworks align with international human rights standards like the CRPD, covering legal capacity laws, non-discrimination policies, access to justice, and ensuring procedural accommodations are available. In addition, the assessment should identify where laws may allow for coercive practices, such as involuntary treatment, detention, or substitute decision-making. Furthermore, it should review alternatives to incarceration in prisons or forensic facilities, such as diversion programmes and mental health courts that support a rights-based approach within the justice system.

See *Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors* for further guidance on each of these sectors (forthcoming) *(22)*.

Strategy 5.1.6

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

International human rights standards emphasize the right to evidence-based and human rights-based interventions, including lifestyle, psychological, social, economic interventions, and psychotropic drugs. The assessment should identify the types of interventions (Box 8) offered in each service category (Box 5). It should describe whether the assessment of support needs meets the requirements of full and informed consent (see Policy directive 4.1 in Module 2) and how services ensure that interventions, including psychotropic drugs, align with the individual's will and preferences.

Box 8. Flexible and non-exhaustive menu of physical health and lifestyle, psychological, social and economic mental health 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 *(52, 53)*;
- nutrition and healthy diet *(54, 55)*;
- sleep *(56, 57)*;
- sexual and reproductive health *(58, 59)*;
- stress management and relaxation techniques (for example, mindfulness-based interventions, yoga) *(3, 60, 61)*;
- art and culture-based therapy *(62–64)*;
- nature-based green and blue interventions *(3, 65, 66)*;
- harm reduction interventions (for example, needle and syringe programmes) *(67, 68)*;
- screening, brief interventions, and referral to treatment for hazardous substance use and substance use disorders *(67)*;
- tobacco cessation *(69, 70)*;
- collaboration/referral for screening and treatment of physical health conditions as appropriate (for example, diabetes, CVD, cancer, HIV/AIDS) *(71–73)*.

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 *(74, 75)*;
- eye movement desensitization and reprocessing (EMDR) *(76)*;
- family therapy (for example, parenting programmes including home visits for pregnant or postpartum mothers, their partner, and their children, couples therapy, family-focused interventions) *(3, 77–79)*;
- family and other care giver interventions (for example, support interventions, education and guidance) *(74, 80–81)*;
- problem-solving therapy and skills training *(74, 82, 83)*;
- psychoeducation *(3, 84)*;
- interpersonal and social skills, cognitive and organizational skills and self-regulation-based interventions *(74, 75)*;
- cognitive stimulation therapy and cognitive training *(74, 75)*, mainly in relation to dementia;
- beginning-to-read interventions, early communication interventions and specialized instructional techniques *(74, 75)*, mainly for children and adolescents;
- recovery, advance, and crisis response plans *(85–88)*.

Social interventions:

- social prescribing *(63, 89, 90)*;
- housing assistance (for example, Housing First, other supported social housing programmes) *(3, 91)*;
- personal assistance (for example, supported decision-making, assistance for daily activities) *(92–94)*;
- peer support and mutual help groups (1:1, group, and online) *(95–97)*;
- social support and community reinforcement approaches (including to build meaningful social connection and combat isolation and loneliness) *(3, 98, 99)*;
- occupational therapy *(3, 100, 101)*;
- community-led interventions and bottom-up interventions *(102–105)*.

Economic interventions:

- access to income generation and employment (for example, individual placement and support, supported employment and other employment schemes) (*3, 45, 106, 107)*;
- housing assistance (for example, rental assistance programmes) *(108, 109)*;
- cash transfer *(3, 110, 111)*;
- personal budget *(3, 112, 113)*;
- disability allowances and concessions, (for example, disability pensions, living allowances, tax exemptions, discounts) *(94, 114, 115)*.

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 *(116)*.

Strategy 5.1.7

Workforce mapping and training.

The organization and development of the workforce are crucial for delivering responsive, high-quality services. Key factors include effective recruitment, fostering motivation, ensuring retention, designing appropriate educational curricula, providing training, and supporting ongoing professional development *(117, 118)*.

The assessment should evaluate the number of professionals in each role listed in Box 9, how these map onto services as well as the geographical distribution of mental health professionals. It should consider staffing levels (including number and distribution), roles, tasks, and the competencies needed to transform and scale up services as outlined in Box 5.

It is important to examine recruitment practices and whether the workforce includes diverse disciplines beyond traditional medical roles. The analysis should also consider working conditions, pay and incentive strategies for each profession, and the extent of migration to other countries by specialized staff.

The situational analysis should review whether training curricula for each professional group are person-centred, recovery-oriented, and rights-based. Educational curricula shape practice, so it is crucial to identify gaps and areas for improvement and priority areas for the new policy (see Policy directive 3.3). Curricula and competencies need to align with international human rights standards, shifting towards rights- and recovery-focused approaches.

Curriculum assessment for each profession should include:

- core competencies in human rights, community inclusion, and recovery approaches;
- comprehensive support needs assessment and treatment approaches, public health issues, and social and structural determinants of mental health (see Box 9 in Module 2 for mental health curriculum topics);
- identification of gaps and strengths;
- teaching methods;
- how well stakeholder groups, including people with lived experience, are involved in curriculum development and delivery; and
- modes of assessment.

Opportunities for continuing professional development should also be assessed, particularly regarding training in rights-based, recovery-oriented, and person-centred approaches. It is also useful to examine mental health workforce attitudes towards these approaches, including views on coercive practices, legal capacity, participation, community inclusion, and recovery-oriented practices.

Box 9. Mental health workforce roles to assess

When assessing the mental health workforce, include:

- psychiatrists;
- nurses;
- medical doctors;
- psychologists;
- peer supporters;
- social workers;
- community health workers;
- occupational therapists;
- counsellors;
- clinical staff; and
- community volunteers.

Additionally, consider other roles that are important to link with, such as:

- nutritionists;
- physiotherapists;
- dentists;
- neurologists;
- pharmacists;
- employment and education specialists;
- physical activity trainers and sports coaches;
- art and music therapists;
- speech therapists;
- legal advisers; and
- traditional and faith-based leaders or healers.

Families and other caregivers, while not part of formal health and social care systems, play a vital role in supporting individuals with mental health conditions and psychosocial disabilities. Assessing whether they receive adequate training and support to fulfil this role effectively is essential.

Strategy 5.1.8

Financing.

Many countries underinvest in mental health, leading to limited access and poor-quality services. In low- and middle-income countries, mental health services are often minimally included or absent from public health service packages or health insurance coverage. Psychiatric hospitals typically receive the majority of mental health funding, with WHO's *Mental health atlas 2020* reporting that 70% of mental health budgets in low- and middle-income countries and 35% in high-income countries are allocated to psychiatric hospitals *(119)*. Moreover, many financing and insurance systems incentivize hospital-based care over community-based care, reinforcing harmful practices like institutionalization and overprescribing psychotropic drugs *(45)*.

To eliminate coercive practices and prioritize person-centred, recovery-oriented, and human rights-based approaches in community settings, it is essential to assess how the country invests in mental health, the sources of funding, and the key issues that need to change. The situational analysis should also indicate how much of the total health budget is allocated to mental health, who makes these allocation decisions, and how they are made.

The analysis should list and describe the major areas of mental health expenditure, identifying which types of services receive the greatest proportion of the national mental health expenditure. If available, the proportion of the mental health budget allocated to community-based services should be compared with the budget for psychiatric hospitals and beds.

Additionally, the analysis should include data on the actual costs of service delivery for each type of service and how health insurers incorporate mental health into their reimbursement schemes.

Strategy 5.1.9

Information systems and data.

Mental health information systems are crucial for an effective mental health system, enabling policy-makers and planners to understand the mental health landscape, monitor progress, assess whether goals and objectives are being met, and inform decisions for improvements and future courses of action.

The situational assessment should determine if the country has a standardized health information system that collects data, and, if so, describe whether it includes data from mental health services in both the public and private sectors. It should document the data collected at population, service, and individual levels, noting the indicators used. Additionally, it should identify any relevant data being collected by information systems in other sectors and whether this directly feeds into a monitoring and evaluation system that interprets the data being collected.

Significant data collection gaps should be highlighted. See Box 6 in Strategy 1.3.1 of Module 2 for examples of key indicators.

The assessment should detail how data are collected (manually or digitally), how they are collated from facility to national levels, and how they are used and disseminated. It should also evaluate the information system, including whether it is being used consistently across different levels and categories of mental health service, its reliability, comprehensiveness, constraints, and opportunities for improvement.

Strategy 5.1.10

Research.

Effective mental health policy should be grounded in research, making it crucial for countries to increase investment and capacity in this area. Historically, research has been dominated by a focus on neuroscience, genetics, and psychopharmacology. Research on services and human rights-based approaches in mental health remains limited and needs greater emphasis *(120)*.

The situational analysis can assess and describe the funding allocated to mental health research in the country, identifying the main public and private donors and funders. It should also evaluate the types of research being conducted and funded, including the number of projects, funding amounts, and research focus. This includes assessing the balance between biomedical research and studies on human rights-based approaches, such as preventing coercive practices, realizing legal capacity, and implementing recovery-oriented practices, peer support, and community-based mental health services. Additionally, it is important to assess how many research projects are led independently by people with lived experience and how many have been co-produced with their involvement.

Strategy 5.1.11

Rights-based policy directions and strategic actions adopted by other countries.

Reviewing mental health policies from other countries can offer valuable insights for policy development. The situational analysis should identify rights-based mental health policies and plans from the region or globally, assessing their relevance to domestic priorities and needs. However, focus should be on countries with progressive policies and plans aligned with international human rights standards, noting that re-alignment is needed in many countries. Additionally, social, economic, and cultural differences may mean certain provisions are not transferable or may require modifying and adapting, while ensuring that human rights are not compromised in the process.

Strategy 5.1.12

Barriers to, and opportunities for, rights-based mental health care.

Identifying barriers and opportunities is crucial. Barriers may include financial constraints, resistance from stakeholders, frequent government changes, rapid turnover of personnel within the mental health or health sector, and other factors that hinder progress. Opportunities, however, may arise through increased attention to mental health issues, emerging support for human rights-based approaches, and partnerships with civil society. Addressing these barriers and leveraging these opportunities can help create a supportive environment for sustainable, rights-based mental health care.

5.2 Set clear time frames and choose data gathering and analysis methods

A thorough situational analysis that identifies key issues, strengths, and shortcomings will guide prioritization of mental health policy areas. However, in-depth studies on each issue can be resource- and time-intensive. In many cases, useful information might already exist within health information systems, academic research, or international surveys like the *Mental health atlas 2020* *(119)*. It is important to review existing data before initiating new research projects.

It is important to recognize that trend data can sometimes show significant and misleading changes due to factors like the introduction of new definitions, gaps in data collection, or increased focus on a particular issue. For instance, heightened awareness of Attention Deficit and Hyperactivity Disorder (ADHD) in many countries has led to a rise in reporting and diagnoses of this condition in recent decades *(121)*. Any significant changes should be noted with potential explanations.

The situational analysis should be carefully planned based on the issues identified in Step 3. Depending on the context, one or more experts could be appointed to conduct the analysis, or sub-committees or working groups could be created to focus on specific issues.

A clear time frame with milestones for completing the analysis should be established. The methods for gathering and/or accessing information should be chosen based on the resources and time available, and these can vary between countries. Three main approaches are outlined in Box 10.

Once the situational analysis is completed, the multistakeholder committee should summarize the main findings and identify key priority areas and recommendations for mental health policy development.

Box 10. Three main approaches to gathering data, and examples of their use

Quantitative research, including epidemiological studies

Quantitative research can be used to collect new data or analyze existing data *(122)*. For example, analyzing existing service-level data can reveal the number of mental health or other professionals in the service, the annual number of people accessing different types of services, and trends over time. This data can also be used to determine rates of involuntary admissions and other coercive practices in services in each region and year.

Epidemiological studies provide insights into key issues such as prevalence and incidence of mental health conditions, psychosocial disabilities, and distress, as well as any associated mortality rates. When national or local epidemiological data is lacking, estimates from similar countries, international studies, or international organizations can be used, with clear acknowledgment and explanation of any estimates.

Qualitative research, including focus groups and individual interviews

Qualitative research methods *(123)*, such as focus groups and individual interviews, offer in-depth insights into specific issues, concepts, or experiences.

Focus group interviews are moderated interviews with a group of people who share similar characteristics, common interests and/or areas of expertise. Focus groups help understand subjective perspectives, attitudes, experiences, and beliefs among stakeholders on topics like staff attitudes or experiences with coercive practices. They can also explore barriers and facilitators for implementing rights-based approaches.

Individual interviews can be structured variously, ranging from informal conversational interviews to semi-structured and completely standardized interviews. Individual interviews, particularly with high-level stakeholders like ministers, heads of government, professional organizations or advocacy leaders within the service user's rights movement, provide detailed information that might not be suitable for group settings and can help avoid the influence of group dynamics.

Questionnaires and surveys

Questionnaires and surveys can be either quantitative and qualitative in format and can use closed-ended questions with predetermined answer options or open-ended questions allowing the respondent to answer in their own words *(124)*. They can be particularly suitable where it is useful to gather anonymous information, or information from many people, or in situations where resources are limited.

Step 6: Draft the mental health policy

6.1 Establish a drafting team

The multistakeholder committee (see Step 2) should select members for the mental health policy drafting team. It is important to ensure that all stakeholder groups, including people with lived experience, who are often marginalized in policy-making, are well-represented and meaningfully involved. The team should work collaboratively to achieve consensus on the vision, principles, areas of action, and policy directives for the new mental health policy, guided by the priorities identified in the situational analysis (Step 5).

Depending on the expertise and knowledge of team members, it may be helpful to form working groups within the drafting team (see Box 11).

Box 11. Sub-committees and working groups

When drafting the policy and strategic action plan, forming specific sub-committees or working groups can be beneficial. These groups might include stakeholders with expertise in various policy areas, such as policy-makers and managers from health and social sectors, people with lived experience and their organizations, family members and other caregivers, representatives from marginalized groups, general health and mental health practitioners, legal and human rights experts, NGOs, OPDs, academic researchers, and community leaders such as traditional and faith-based healers or leaders.

For example, a working group focused on transforming or creating new services could organize consultations with the managers and providers of best-practice services identified in the situational analysis. This would provide valuable insights into the steps required to establish similar services, the resources needed, potential barriers, challenges, and strategies to overcome them.

6.2 Schedule and conduct consultations with wider stakeholder groups

From the outset, the policy drafting team should engage closely with a broad array of stakeholder groups and communities to gather ideas and expertise. Regular consultations offer a valuable opportunity to understand stakeholders' suggestions, address concerns, and work through challenging issues or resistance. These discussions aim to build a shared understanding and consensus, which can significantly inform and shape the draft policy. Effective planning and execution of these consultations will help build broad support, enhancing the likelihood of successful implementation.

6.3 Define the policy's vision

Defining a common vision for the new rights-based mental health policy is a crucial early step in the drafting process, as it will guide all major policy actions. The vision should be a concise statement that reflects the overall goal for mental health, aligning with international human rights instruments, as outlined in Box 4, particularly the CRPD. The vision should be ambitious, setting high expectations for what the policy aims to achieve. It is important to agree on a vision that is both inspiring and easy to communicate, ensuring that all stakeholders can identify with, support, and commit to it. For example: "**High quality community-based mental health services that include everyone, that encourage recovery, are fair for all, free from coercion, and that respect diversity, dignity and human rights**."

6.4 Define the policy's values and principles

The next step is to develop a set of guiding values and principles. These core statements support the vision and steer the policy solutions and directives. While the specific values and principles guiding mental health policy may vary depending on cultural, social, and economic contexts, they are often based on international human rights instruments, particularly the CRPD, and the *Comprehensive mental health action plan 2013–2030 (20)*. See Box 12 for examples of guiding values and principles.

Box 12. Values and principles related to mental health policy

Human rights

- Respect people's inherent dignity and individual autonomy, including the freedom to make one's own choices.
- Promote full and effective participation and community inclusion.
- Actively integrate the expertise of people with lived experience in all relevant actions and processes.
- Adopt recovery-oriented and person-centred approaches.
- Eliminate coercive practices.
- Treat people equally and without discrimination.
- Uphold accessibility and equity.

A life course approach

- Health and social needs are considered at all stages of the life course from childhood to older age.

Groups that face discrimination

- The specific needs of groups that face or are at risk of discrimination are considered and addressed.

Evidence-based practice

- Policy development is guided by scientific evidence and/or good practice, taking cost and cost-effectiveness, as well as cultural considerations, into account.

Universal health coverage

- Policy development aims for universal health coverage. All people with mental health conditions and psychosocial disabilities should be able to access good quality rights-based general health, mental health and social services that enable them to recover and reach the highest attainable standard of health without suffering financial hardship.

Multisectoral approach

- Coordinate, collaborate and partner with the education, social welfare, justice, employment, gender, youth, and other relevant sectors, as well as with other programmes within the health sector.

6.5 Determine policy areas for action

Policy areas for action are key to achieving the mental health policy's vision. These areas should be chosen based on the vision and principles, and informed by priorities and gaps identified in the situational analysis (Step 5). The specific areas and their details will vary depending on the context and requirements, however, the key policy areas for countries to consider are the five discussed in detail in Module 2.

Policy area 1. Leadership, governance and other enablers presents solutions for strengthening good governance and leadership in mental health, including coordination, monitoring mechanisms, information systems, research and legal frameworks.

Policy area 2. Service organization and development covers issues including accessibility and affordability of services; stigma and discrimination; developing and implementing rights-based community mental health services; and deinstitutionalization.

Policy area 3. Human resource and workforce development addresses pressing issues like the general shortage of healthcare workers; unequitable distribution of staff; lack of skills in rights-based approaches to mental health, and the narrow focus on diagnosis, drug treatment and symptom reduction in education and training.

Policy area 4. Person-centred, recovery-oriented and rights-based assessment, interventions and support includes myriad issues around developing and delivering physical health and lifestyle, psychological, social and economic interventions, as well as issues around accessing and prescribing psychotropic drugs.

Policy area 5. Mental health sector contributions to addressing social and structural determinants and society-wide issues impacting mental health and well-being addresses the underlying factors driving mental ill-health in society.

6.6 Determine policy directives for each policy area for action

Policy directives should be mapped out for each policy area for action. These directives identify specific issues to be addressed within each area. Fig. 2 provides options for policy directives to consider for each key area of action. For more detailed information, refer to Module 2, which offers a menu of potential policy directives.

Fig. 2 Options for policy directives

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

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

6.7 Conduct final reviews and consultations

After drafting the vision, principles, policy areas, and directives, the policy should be reviewed by the multistakeholder advisory committee. Following this internal review, the draft can be presented to wider stakeholder groups and the public for further consultation before finalization.

Although inclusive involvement has been part of the process, the final consultation remains crucial. It provides an opportunity for suggestions, concerns, and objections to be addressed, and it also raises public awareness about mental health issues, rights, and community-based approaches: all key factors to ensuring effective policy implementation.

Final reviews and consultations can take various forms to encourage broad participation. For instance, the draft policy could be shared publicly on a dedicated website for comments. National or regional meetings and workshops could be held to bring stakeholders together for discussion and to negotiate their most important concerns and suggestions. All feedback, objections, and the drafting team's responses should be meticulously documented and later shared with the public. This documentation will serve as an important record to help the public understand the policy's background and rationale.

Step 7: Draft the mental health strategic plan

Building on the mental health policy developed in Step 6, the next step is to draft a national mental health strategic plan. This plan should outline the strategies needed to implement each policy directive, with clearly defined time frames, targets, indicators, specific actions, outputs, and costs. The implementation time frame for a mental health strategic plan typically ranges from three to ten years, depending on the country's context and circumstances.

7.1 Establish a drafting team and hold consultations

From the outset, the drafting team should schedule consultations with broader stakeholder groups and communities, similar to those conducted during the policy drafting process (see Step 6.2). These consultations are critical for exchanging ideas and building consensus on the strategic plan's content. Discussions should cover all aspects of the plan, including strategies, actions, targets, indicators, time frames, and resources.

7.2 Formulate strategies to achieve policy directives

The mental health strategic plan should include component strategies for implementing each policy directive. These strategies should outline specific, feasible, and measurable actions to achieve the policy directives effectively. Prioritizing strategies (see Box 13) requires a deep understanding of the issues and evidence base, but also direct experience. The drafting committee may need to consult with both domestic and international experts.

- For a quick overview of potential strategies for the suggested policy directives see *Module 5. Comprehensive directory of policy areas, directives, strategies, and actions for mental health*.
- For more detailed information and discussion on these potential strategies see *Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans*.

Box 13. Tips for prioritizing strategies

Limited resources mean that not all strategies and actions can be implemented at once, making prioritization essential.

The process should achieve a mix of quick and easy-to-implement outcomes (so-called low hanging fruit), alongside medium- and long-term outcomes that require more time and investment, but that are crucial for long-term success.

It is important to regularly revisit and re-evaluate the implementation plan to ensure medium- and long-term goals are not neglected and to identify any critical issues hindering the overall implementation process.

Questions to guide the prioritization process

- Which strategies and actions are critical? Look particularly for those that prevent risks to people's health and lives.
- What strategies offer quick wins, and will implementing them have the desired impact?
- Which strategies or actions have a cumulative impact and should be initiated from the start?
- Which strategies and actions can be phased in later, building on earlier successes?
- What is essential for creating a strong foundation?
- What is a good time frame for strategies and actions being implemented? For example, it takes more than a couple of cohorts of undergraduates to bring about a workforce change. Highlighting this might help planners think about what is doable within a 5–10 year strategic action plan.

7.3 Define actions for each strategy

Each strategy should consist of a set of carefully planned actions. These break down the strategy into specific steps that, if implemented successfully, will deliver the strategy. Prioritizing actions requires the drafting group and consulted experts to draw on research evidence, national experience, as well as experience from other countries.

- For a quick overview of potential actions under the different strategies see *Module 5. Comprehensive directory of policy areas, directives, strategies, and actions for mental health*.
- For more detailed information and discussion on these actions see *Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans*.

7.4 Define, targets indicators and time frames

Clear targets, indicators, and time frames are essential for effective planning, budgeting, monitoring and evaluation. Targets and indicators should be established for each strategy. Targets specify what will be achieved numerically, while indicators measure the success of the strategy's implementation.

Each strategy should have a clear and realistic time frame, specifying the start year and duration. Some strategies may be ongoing, while others are time limited. It is important to define what will be achieved, and by when, considering contextual factors and available human and financial resources. Individual actions should be set within clear, realistic, and sequenced time frames, allowing planners to determine which need to be sequential and which can be done concurrently. See Table 1 for an example of a strategy's time frame with associated targets and indicators.

7.5 Identify roles and responsibilities for sectors and stakeholders

When drafting the mental health strategic plan, it is important to determine who will take action and what needs to be done. The drafting team should identify the sectors, organizations, or individuals best suited to implement these actions, for example based on their leadership, expertise, or funding capacity. Clearly defining roles and responsibilities early on helps avoid unnecessary competition, duplication, and oversights. Certain strategies and actions may require building strong collaborations between various sectors and stakeholders.

Once roles and responsibilities have been discussed and agreed, they should be clearly documented at either the strategy or action level, depending on what makes the most sense. Allocating roles and planning collaborations may require multiple rounds of meetings with the relevant sectors and stakeholder groups to ensure alignment and commitment.

7.6 Determine the costs, resources and budget

The total cost of implementing the strategic plan, including each policy directive, should be calculated using a bottom-up approach, starting with the cost of each action, then aggregating the costs within each strategy, and finally summing up the costs for all policy directives and the entire plan. Costs should be broken down by year and across the full implementation period (see Table 1 for an example). Costs should be adjusted for inflation to ensure accuracy over the implementation period.

Both recurrent and capital costs need consideration. Healthcare costs typically include recurrent expenses like human resources, consumables, equipment, and supplies (for example, drugs and laboratory investigations). Capital costs cover infrastructure and equipment (such as buildings and vehicles), which are not annual expenses but require periodic renewal because they deteriorate and depreciate over time. In many countries, human resource costs account for two-thirds or more of total recurrent health expenditures.

The strategic plan should clearly outline its funding sources, whether from state funds (from general taxation), social insurance, donors, private insurance, or out-of-pocket payments from individuals. Sectors like education, employment, social protection, or housing, responsible for implementing actions, may need to allocate budgets towards the plan.

Once resource needs are estimated and their availability confirmed, it may be necessary to reassess the feasibility of strategies based on the available budget. If needed, strategies, actions, and timelines can be adjusted to fit available resources.

7.7 Conduct a final review and consultation

A final review and consultation, similar to Step 6.7, should be conducted. The multistakeholder advisory committee should review the draft strategic plan before sharing it with the public and other stakeholders. All final feedback should be recorded and addressed, with necessary adjustments made, such as revising cost estimates and budgets, before the plan is finalized and published.

Table 1 Drafting the mental health strategic plan

An example template for formulating targets and indicators and activities, responsible people/organizations, budget and costing.

Policy area for action: Service organization and development
Policy directive: Coordinated rights-based community mental health services and support at all levels of care
Strategy: Create and expand rights-based crisis response services
Target(s): Over a five-year period, one accident and emergency unit equipped to provide rights-based support to people experiencing a mental health crisis in each of five regional hospitals; one national mental health crisis line established and functioning; one functioning mobile crisis team in 10 of 50 districts; one crisis house in three of 20 districts.
Indicator(s): Numbers of people accessing each crisis service

Actions	Responsible person(s)/ organization(s)	Time frame for implementation (years)						Cost of activity (per year)						Available total budget for activity	Additional resources required
		1	2	3	4	5	X	1	2	3	4	5	X		
Establish rights-based crisis telephone line(s) and their operational protocols	Contracted NGOs with oversight by national dept of mental health	x	x												
Establish rights-based crisis mobile team(s), their functions and operational protocols	District health authorities		x	x	x	x									
Establish mental health-friendly environment and rights-based responses to mental health crisis in accident and emergency units of general hospitals	Regional health authorities			x	x	x									
Establish rights-based crisis house(s), their functions and operational protocols	Contracted NGOs with oversight by national department of mental health			x	x	x									

Step 8: Implement the policy and strategic action plan

Good planning and thorough thinking are essential for lasting change. Without them, a mental health policy and strategic plan may fail to achieve their goals. After finalizing the policy and plan, ongoing implementation needs to be planned.

8.1 Awareness-raising, dissemination and communication of the new mental health policy and plan

Weak dissemination and communication often lead to limited stakeholder engagement and political commitment. Effective dissemination is crucial. The Ministry of Health or other responsible bodies should communicate the policy and plan to all relevant government sectors and ministries (including social affairs, education, employment, finance amongst others), regional and local governments, health authorities, and partner agencies and stakeholders. Dissemination strategies could involve press conferences, public events, printed materials, and meetings with relevant teams, consumers, families, advocacy groups and other stakeholders to present the policy and discuss implementation.

But dissemination should do more than share information: it should build engagement and commitment. It should make implementation a priority for regional and local stakeholders. These stakeholders need sufficient support from federal or regional governments to effectively implement the policy in their communities.

Stigma, myths, and misconceptions about mental health and psychosocial disabilities can hinder policy implementation. Changing public attitudes is crucial, and disseminating information on rights-based approaches can help achieve this. The media plays a vital role in highlighting new mental healthcare practices, especially the importance of rights-based community approaches.

It is essential to inform and engage advocacy groups, NGOs, OPDs, and organizations of persons with lived experience of mental health conditions and psychosocial disabilities about the new policy. While these groups should have been involved in drafting, not everyone will have participated. People not previously involved need to be informed through different channels.

Following initial dissemination, implementing agencies should plan regular meetings and events to sustain commitment.

8.2 Incremental and scaled up implementation processes

In some countries and situations, it is helpful to scale up implementation incrementally. For instance, the implementation process might start in dedicated demonstration areas (for example, a geographical region or a sector of a large city) where policy, plans and programmes can be implemented more rapidly and evaluated more thoroughly than elsewhere in the country. This initial implementation phase can be used to identify the successes and barriers. Based on these lessons learned, implementation can then be scaled up.

8.3 Fundraising

While the budget for implementing the mental health policy should be determined during the development of the strategic plan, ongoing fundraising should be undertaken throughout implementation. Regularly monitoring whether confirmed funding is received as planned and securing continued commitments from funding agencies is also essential.

In addition to established funding streams, there are practical options to diversify and expand the funding base. Domestic resources can be mobilized from various sources, such as government budget allocations or tax-based national health insurance schemes. Mental health can also be integrated into other funded programmes. Public–private partnerships may offer sustained support.

External funding opportunities should also be pursued, including grants or donations from international agencies, philanthropic foundations, and innovative financing models that attract private sector participation. See also Module 2, Policy directive 1.2 on financing and budgeting.

8.4 Programme of work

A realistic implementation plan should detail the specific steps needed to execute the actions and achieve the targets. The plan should cover all years of the strategic plan, with priorities reviewed annually. Tasks should be mapped out on a monthly basis and updated regularly based on lessons learned, including successes and challenges. Table 2 provides an example template for outlining tasks, time frames, budget, and resources for one action over a year of implementation.

Table 2. Programme of work

An example for one action within one strategy over one year, including time frame, budget and resources

Area for action: Service organization and development
Policy directive: Coordinated rights-based community mental health services and support at all levels of care
Strategy: Create and expand rights-based crisis response services
Action: Establish rights-based crisis telephone line(s) and their operational protocols.
Time frame: 1 year

Action 1: Establish rights-based crisis telephone line(s) and their operational protocols.	**Responsible person(s)/ organization(s)**	**Time frame for implementation (months)**												**Cost per year**	**Available budget per year**	**Additional resources required**
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**			
Task 1: Based on the situational analysis, determine how many new crisis telephone lines need to be set up including their locations and the human and other resources needed	Dedicated person or team within mental health department of ministry of health	x	x	x												
Task 2: Explore rights-based good practices that may exist within the country, region and across the world	As above				x	x	x									
Task 3: Identify rights-based services to which people can be referred and develop a collaboration with these services	As above							x	x	x						
Task 4: Prepare the operational protocol for the telephone lines	As above							x	x							
Task 5: Recruit and train staff for crisis telephone lines	As above									x	x	x	x			

Step 9: Monitor and evaluate implementation of the mental health policy and strategic action plan

Regular monitoring is essential to ensure that implementation actions are being carried out, targets are being met, and timelines are on track. Early identification of barriers, such as insufficient budget, staffing shortages, high staff turnover, lack of management support, loss of a policy champion, or negative staff attitudes, allows for timely solutions, conserving time and resources.

Evaluating the impact of the policy and strategic plan is equally crucial. It is not enough to confirm that strategies and actions are implemented; it is also necessary to assess whether they are achieving the desired outcomes. If progress is lacking, efforts should be made to adjust the approach or strategies. Sometimes unintended impacts may arise. Early identification is key to taking corrective action.

REFLECTION on evaluation. Evaluation is essential for avoiding unintended consequences. For example, the global push to deinstitutionalize mental health care and support individuals to transition into the community aims to improve health outcomes and social inclusion. However, in some countries, inadequate resources for community-based services has resulted in hospital closures without proper alternatives: leading to homelessness, incarceration, and increased stigma. Ongoing evaluation could have ensured that institutions closed only when robust, rights-based, and recovery-oriented community services were in place. Achieving better health and social integration requires comprehensive deinstitutionalization programmes that fully engage communities. Simply discharging people is insufficient.

An evaluation schedule should be set for the entire policy period, with evaluations after one year, ongoing evaluations, and a final evaluation at the end of the policy period. The frequency and type of evaluation depend on the implementation plan and available resources. For example, if the plan involves actions and annual targets, evaluation will need to be annual.

Evaluations can be conducted in various ways (see Table 3), with the best approach depending on available resources, the specific questions to be answered, and the time frame. Both quantitative and qualitative research may be needed to evaluate the policy and plan. Rapid appraisals may be suitable in some cases, while in-depth research, such as in-depth interviews, may be required in others.

While evaluations are typically led by the Ministry of Health and other collaborating sectors, independent evaluations by concerned individuals or organizations are also valuable. By consistently asking, "How well have we done? How well are we doing? How can we do better?" progress can be significantly enhanced. Table 3 provides an example of planning the monitoring and evaluation of all actions within one strategy with a time frame of five-years.

Table 3 Monitoring and evaluating actions within a strategy

Area for action: Service organization and development
Policy directive: Coordinated rights-based community mental health services and supports
Strategy: Create and expand rights-based community mental health centres
Time frame: 5 years

Actions	Target	Research/evaluation required	Sources/methods of data collection
Action 1: Establish functions and operational protocols	Written service policy and operational protocols developed	• Review of policy and operational protocol by experts for alignment with evidence and human rights	• Expert review report • Mechanisms in place to provide interventions and support • System in place to provide documentation required by policy and operational protocols
Action 2: Deploy trained staff to work in the community mental health centre	One functioning community mental health centre	• Number of people accessing the service • Extent to which the centre provides evidence- and rights-based support • Compliance by centre staff with the policy and operational protocols	• Observations of staff providing treatment, care and support • Periodic satisfaction surveys • Qualitative interviews with people using the service

Checklists

1. Introduction

These checklists provide straightforward, practical guidance for stakeholders involved in drafting a rights-based mental health policy and strategic action plans. They are also a tool for assessing and evaluating whether existing policies and plans align with a rights-based, person-centered and recovery-oriented approach to mental health and well-being. The checklists can be extracted and saved in an electronic format that can be expanded and adapted as needed.

When using the checklists to assess policies or strategic action plans, please note that the items and questions are not exhaustive. It is essential to also refer to the main content of Module 2 of the Guidance, which includes proposed policy directives, strategies, actions, and process steps for developing a mental health policy and strategic action plan.

Depending on the purpose and specific country context, you may choose to add new policy directives and strategies, adapt existing ones, or omit others as needed. The key is to follow the outlined drafting process and to document a clear rationale for any additions, modifications, or omissions.

2. Policy and strategic action plan drafting process checklist

Question	Yes/ No	Notes
Is/was a high-level policy dialogue undertaken between all relevant government sectors and civil society actors?		
Is/was a multistakeholder advisory committee established to oversee the development of the policy and strategic action plan, actively involving all stakeholders including people with mental health conditions and psychosocial disabilities?		
Does/did the committee have clearly defined terms of reference outlining its roles, responsibilities, expected outcomes and time frame for completing the different components of its work?		
Does/did the committee have adequate support to carry out its work effectively (such as resources for meetings, logistics, technology, and accommodations?).		
Are/were there capacity-building efforts to build understanding and new mindsets to facilitate person-centered and rights-based approaches among key stakeholders and the broader community?		

Question	Yes/ No	Notes
Are/were international human rights obligations and commitments reviewed?		
Is/was a situational analysis conducted to understand the mental health context, priorities, challenges and opportunities in the country and did it cover the following areas?		
Social and structural determinants of mental health		
Review of existing national mental health policies, plans and legal frameworks		
Prevalence of mental health conditions, psychosocial disabilities, groups at risk of or facing and other key mental health issues		
Information on existing mental health services and service delivery		
Housing, education, employment, and social protection for persons with mental health conditions or psychosocial disabilities		
Person-centered, recovery-oriented, and rights-based assessment, interventions, and support, including lifestyle, psychological, social, economic, and drug interventions		
Workforce and training in mental health		
Financing		
Information systems and data		
Research		
Relevant rights-based policy directions and strategic actions from other countries		
Barriers and opportunities for rights-based mental health care		

Question	Yes/ No	Notes
Is/was a drafting team for the policy or combined policy and plan established representing all relevant stakeholder groups including people with mental health conditions or psychosocial disabilities?		
Are/were consultations scheduled and conducted with wider stakeholder groups?		
Are/were targets, indicators and time frames defined for the strategic action plan?		
Are/were implementation roles and responsibilities of sectors and stakeholders for defined and documented for each of the selected strategies and actions?		
Are/were costs, resources and budgets defined for the strategic action plan?		

3. Policy and strategic action plan content checklists

Vision and principles

Question	Yes/No	Notes
Does the policy have a well-defined aspirational vision aligned with human rights?		
Does the policy include rights-based values and principles regarding the following areas:		
Respect for inherent dignity and individual autonomy including the freedom to make one's own decisions and choices		
Full and effective participation and community inclusion		
Active integration of the expertise of persons with lived experience in all relevant actions and processes		
Recovery-orientation and person-centered approach in services		
Freedom from coercive practices		
Non-discrimination		
Accessibility and equity		
Is there a consideration of health and social needs at all stages of the life course from childhood to older age?		
Is there a consideration of specific needs of groups that face or are at risk of discrimination and their protection through? policy		
Is policy development guided by scientific evidence and/or good practice, taking cost and cost-effectiveness as well as cultural considerations into account?		
Is policy development guided by the goal of achieving universal health coverage?		
Is policy development guided by a multisectoral approach?		

Policy areas, directives and strategies

Are the following aspects included? If no, the notes column can be used to record the reason. If yes, please document any specific actions that will be taken.

Policy area 1. Leadership, governance, and other enablers	Yes/No	Notes
Policy directive 1.1. Coordination, leadership and accountability		
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		
Strategy 1.1.2 Strengthen mental health sector leadership aligned with the rights-based, recovery-oriented and person-centred approach		
Strategy 1.1.3 Monitor service quality and rights protection, including via an independent monitoring committee and complaints mechanism		
Policy directive 1.2. Financing and budget		
Strategy 1.2.1 Build a sustainable funding base for mental health, including within universal health coverage		
Strategy 1.2.2 Reorient funding and insurance schemes towards person-centred, recovery-oriented and rights-based services and initiatives for mental health		
Strategy 1.2.3 Allocate sectoral budgets and financing to protect and promote mental health according to both joint and sector-specific responsibilities		
Policy directive 1.3. Information systems and research		
Strategy 1.3.1 Establish indicators and information systems to track progress for mental health and well-being		
Strategy 1.3.2 Set a prioritized research and evaluation agenda in collaboration with stakeholder groups		

Policy area 1. Leadership, governance, and other enablers	Yes/No	Notes
Policy directive 1.4. People with lived experience, civil society, and communities		
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 board and working groups on policy, law, strategy and evaluation		
Strategy 1.4.2 Implement standards so that people with lived experience can participate meaningfully in policy, law, service delivery, training and research		
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		
Policy directive 1.5. Rights-based law reform		
Strategy 1.5.1 Conduct training for wide-reaching mindset change and advocacy for law reform		
Strategy 1.5.2 Reform legislation related to mental health to align it with human rights standards, including the CRPD		
Strategy 1.5.3 Set up implementation mechanisms and actions including training		

Policy area 2. Service organization and development	Yes/No	Notes
Policy directive 2.1. Coordinated rights-based community mental health services and support at all levels of care		
Strategy 2.1.1 Create and expand rights-based, short-term inpatient units, outpatient, and community outreach services in general hospitals		
Strategy 2.1.2 Create and expand rights-based crisis response services		
Strategy 2.1.3 Create and expand rights-based community mental health centres and outreach services		
Strategy 2.1.4 Create and expand rights-based peer support services		
Strategy 2.1.5 Integrate rights-based mental health approaches into primary care and other health services		
Strategy 2.1.6 Implement an integrated, comprehensive and sustainable approach in and across services		
Policy directive 2.2. Integrated mechanisms that respond to social and structural factors and incorporate rights-based approaches in mental health		
Strategy 2.2.1 Operationalize mechanisms within services to address the social and structural determinants of mental health		
Strategy 2.2.2 Uphold human rights, eliminate coercion, and promote recovery while continuously improving service quality		

Policy area 2. Service organization and development	Yes/No	Notes
Policy directive 2.3. Partnerships for community inclusion, socio-economic development, and for protecting and promoting rights		
Strategy 2.3.1 Improve meaningful social connection for people using mental health services		
Strategy 2.3.2 Strengthen partnerships between mental health services and other sector services, including housing, education, employment, justice, and social protection		
Strategy 2.3.3 Establish accessible disability and social protection benefits and schemes for people with mental health conditions and psychosocial disabilities		
Strategy 2.3.4 Develop tailored services for people with long term needs and support requirements		
Strategy 2.3.5 Engage with families and other informal care providers in local communities, including religious centres, family homes, schools, and villages		
Policy directive 2.4. Deinstitutionalization		
Strategy 2.4.1 Establish the foundation and enabling environment for successful deinstitutionalization		
Strategy 2.4.2 Develop and implement a deinstitutionalization plan for each institution that immediately improves rights and quality for all residents		
Strategy 2.4.3 Create individualized support plans for each resident transitioning 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		

Policy area 3. Human resources and workforce development	Yes/No	Notes
Policy directive 3.1. A multi-disciplinary workforce with task sharing, training and support		
Strategy 3.1.1 Leverage regulatory and administrative processes to introduce role and task sharing		
Strategy 3.1.2 Implement staff training initiatives across and within services		
Strategy 3.1.3 Establish supervision and support for staff working within the mental health and other health services		
Policy directive 3.2. Recruitment, retention and staff well-being		
Strategy 3.2.1 Recruit staff from a broad array of disciplines and ensure diversity		
Strategy 3.2.2 Distribute staff equitably across the country		
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		
Policy directive 3.3. Competency-based curricula for mental health		
Strategy 3.3.1 Develop or adapt core competency-based curricula for mental health		
Strategy 3.3.2 Implement competency-based curricula for mental health		

Policy area 4. Person-centred, recovery-oriented and rights-based assessment interventions and support	Yes/No	Notes
Policy directive 4.1. Assessment of mental health and support needs by multidisciplinary team		
Strategy 4.1.1 Develop a person-centred, recovery-oriented and rights-based framework and guidelines for assessing mental health and support needs		
Strategy 4.1.2 Implement the newly developed framework and guidelines for assessing mental health and support needs		
Policy directive 4.2. Physical health and lifestyle, psychological, social and economic interventions		
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		
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		
Policy directive 4.3. Psychotropic drug interventions		
Strategy 4.3.1 Identify psychotropic drug interventions and develop guidelines for their safe prescribing, use and discontinuation, including managing adverse effects and withdrawal		
Strategy 4.3.2 Implement the guidelines for safe prescribing, use and discontinuation from psychotropic drugs		

Policy area 5. Mental health sector contributions to addressing social and structural determinants and society-wide issues impacting mental health and well-being	Yes/No	Notes
Policy directive 5.1. Improved literacy and transformed mindsets to promote mental health and well-being and combat stigma, discrimination and exclusion		
Strategy 5.1.1 Implement awareness strategies for staff of all government sectors to transform mindsets, improve understanding to mental health, and to combat stigma and discrimination		
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		
Policy directive 5.2. Joint actions on social and structural determinants and society-wide issues		
Strategy 5.2.1 Advocate for policy changes in government sectors outside mental health to address key social and structural determinants of mental health		
Strategy 5.2.2 Collaborate to agree on, and implement changes to, government sector policies that address social and structural determinants of mental health		

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. 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.

23. Increasingly consulted, but not yet participating: IDA global survey report on participation of organisations of persons with disabilities. New York: International Disability Alliance; 2020 (https://www.internationaldisabilityalliance.org/blog/increasingly-consulted-not-yet-participating-ida-global-survey-report-participation, accessed 10 December 2024).
24. United Nations Disability Inclusion Strategy. Guidelines on consulting persons with disabilities. Indicator 5. Geneva: United Nations; 2021 (https://www.un.org/sites/un2.un.org/files/un_disability-inclusive_consultation_guidelines.pdf, accessed 10 December 2024).
25. Mental health, human rights and legislation: guidance and practice; pp. 117–118. 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).
26. 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).
27. 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).
28. Harden B, Gyimah L, Funk M, Drew-Bold N, Orrell M, Moro MF et al. Attitudes towards persons with mental health conditions and psychosocial disabilities as rights holders in Ghana: a World Health Organization study. BMC Psychiatry. 2023;23 (https://doi.org/10.1186/s12888-023-04620-3).
29. Morrissey FE. An evaluation of attitudinal change towards CRPD rights following delivery of the WHO QualityRights training programme. Ethics, Medicine and Public Health. 2020;13 (https://doi.org/10.1016/j.jemep.2019.100410).
30. Resolution A/HRC/32/18, mental health and human rights, adopted by the Human Rights Council on 1 July 2016. Geneva: United Nations, Human Rights Council; 2016 (https://undocs.org/A/HRC/RES/32/18, accessed 10 December 2024).
31. Resolution A/HRC/RES/36/13, mental health and human rights, adopted by the Human Rights Council on 28 September, 2017. Geneva: United Nations, Human Rights Council; 2017 (https://undocs.org/A/HRC/RES/36/13, accessed 10 December 2024).
32. Resolution A/HRC/RES/43/13, mental health and human rights, adopted by the Human Rights Council on 19 June 2020. Geneva: United Nations, Human Rights Council; 2020 (https://undocs.org/A/HRC/RES/43/13, accessed 10 December 2024).
33. Resolution A/HRC/52/L.15, mental health and human rights, adopted by the Human Rights Council on 24 March 2023. Geneva: United Nations, Human Rights Council; 2023 (https://digitallibrary.un.org/record/4007595, accessed 10 December 2024).
34. International Covenant on Civil and Political Rights. Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966. Geneva: United Nations, General Assembly; 1976 (https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights, accessed 10 December 2024).
35. International Covenant on Economic, Social and Cultural Rights, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. Geneva: United Nations, General Assembly; 1976 (https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights, accessed 10 December 2024).
36. International Convention on the Elimination of All Forms of Racial Discrimination, resolution 2106 (XX). New York: United Nations, General Assembly; 1966 (https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial, accessed 10 December 2024).
37. Convention on the Elimination of All Forms of Discrimination against Women (A/RES/34/180). New York: United Nations, General Assembly; 1981 (https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women, accessed 10 December 2024).
38. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (A/RES/39/46). New York: United Nations, General Assembly; 1987 (https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading, accessed 10 December 2024).
39. Convention on the Rights of the Child (A/RES/44/25). New York: United Nations, General Assembly; 1990 (https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child, accessed 10 December 2024).
40. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (A/RES/45/158). New York: United Nations, General Assembly; 2003 (https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-protection-rights-all-migrant-workers, accessed 10 December 2024).
41. International Convention for the Protection of All Persons from Enforced Disappearance (A/RES/47/133). New York: United Nations, General Assembly; 2010 (https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-protection-all-persons-enforced, accessed 10 December 2024).
42. 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).
43. Compton MT, Shim RS. The social determinants of mental health. FOCUS. 2015;13:419–25 (https://doi.org/10.1176/appi.focus.20150017).
44. Mental health, human rights and legislation: guidance and practice; p. 113. 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).
45. 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).
46. McPherson P, Krotofil J, Killaspy H. What works? Toward a new classification system for mental health supported accommodation services: the simple taxonomy for supported accommodation (STAX-SA). Int J Environ Res Public Health. 2018;15:190 (https://doi.org/10.3390/ijerph15020190).
47. Okyere C, Aldersey HM, Lysaght R, Sulaiman SK. Implementation of inclusive education for children with intellectual and developmental disabilities in African countries: a scoping review. Disabil Rehabil. 2019;41:2578–95 (https://doi.org/10.1080/09638288.2018.1465132).

48. My right is our future: the transformative power of disability-inclusive education. Bensheim: CBM; 2018 (https://www.cbm.org/fileadmin/user_upload/Publications/DID_Series_-_Book_3.pdf, accessed 10 December 2024).
49. Killackey E, Allott K, Woodhead G, Connor S, Dragon S, Ring J. Individual placement and support, supported education in young people with mental illness: An exploratory feasibility study. Early Interv Psychiatry. 2016;11:526–31 (https://doi.org/10.1111/eip.12344).
50. Ringeisen H, Langer Ellison M, Ryder-Burge A, Biebel K, Alikhan S, Jones E. Supported education for individuals with psychiatric disabilities: state of the practice and policy implications. Psychiatr Rehabil J. 2017;40:197–206 (https://doi.org/10.1037/prj0000233).
51. Grove B. International employment schemes for people with mental health problems. BJPsych International. 2015;12:97–9. doi: https://doi.org/10.1192/s2056474000000672.
52. 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).
53. WHO guidelines on physical activity and sedentary behaviour. Geneva: World Health Organization & United Nations Development Programme; 2020 (https://iris.who.int/handle/10665/336656).
54. 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).
55. 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).
56. 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).
57. 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).
58. 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).
59. 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. doi: https://doi.org/10.1136/bmjgh-2020-002903.
60. 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).
61. 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).
62. 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, accessed 10 December 2024).
63. A toolkit on how to implement social prescribing. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/354456).
64. 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).
65. Cuthbert S, Kellas A, Page LA. Green care in psychiatry. Br J Psychiatry. 2021;218:73–4 (https://doi.org/10.1192/bjp.2020).
66. 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).
67. 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).
68. Guide to starting and managing needle and syringe programmes. Geneva: World Health Organization, UNAIDS & UNODC; 2007 (https://iris.who.int/handle/10665/43816).
69. 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).
70. WHO clinical treatment guideline for tobacco cessation in adults. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/377825).
71. 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).
72. 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. doi: https://doi.org/10.3390/ijerph20010126.
73. 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).
74. Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. Geneva: World Health Organization; 2024 (https://iris.who.int/handle/10665/376208).
75. 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).
76. 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).
77. 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).

78. 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).

79. 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).

80. 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).

81. 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).

82. 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).

83. 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).

84. 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).

85. 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/10665/32959).

86. 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).

87. Supported decision-making and advance planning: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329609).

88. 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).

89. 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).

90. 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).

91. 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 metaanalysis of randomised controlled trials. J Epidemiol Community Health. 2019;73:379–87 (https://doi.org/10.1136/jech-2018-210981).

92. 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).

93. 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).

94. Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/364834).

95. 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).

96. 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).

97. Shalaby RAH, Agyapong VIO. Peer support in mental health: literature review. JMIR Ment Health. 2020;7:e15572 (https://doi.org/10.2196/15572).

98. 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).

99. 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).

100. 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).

101. 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).

102. 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).

103. 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).

104. 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).

105. 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).

106. 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).

107. 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.

108. 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).

109. 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).

110. 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).

111. 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).

112. 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).

113. 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).

114. 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).

115. 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).

116. 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).

117. Global strategy on human resources for health: workforce 2030. Geneva: World Health Organization; 2016 (https://iris.who.int/handle/10665/250368).

118. Working for health and growth: investing in the health workforce. Geneva: World Health Organization; 2016 (https://iris.who.int/handle/10665/250047).

119. Mental health atlas 2020. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/345946).

120. Porsdam Mann S, Bradley VJ, Sahakian BJ. Human rights-based approaches to mental health: a review of programs. Health Hum Rights. 2016;18:263–76. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5070696/, accessed 10 December 2024).

121. Abdelnour E, Jansen MO, Gold JA. ADHD diagnostic trends: increased recognition or overdiagnosis? Mo Med. 2022;119:467–73. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9616454/, accessed 10 December 2024).

122. Analyzing quantitative data for evaluation, evaluation briefs no. 20. Atlanta: United States Department of Health and Human Services – Centers for Disease Control and Prevention; 2018 (https://www.cdc.gov/healthyyouth/evaluation/pdf/brief20.pdf, accessed 10 December 2024).

123. Analyzing quantitative data for evaluation, evaluation briefs no. 19. Atlanta: United States Department of Health and Human Services – Centers for Disease Control and Prevention; 2018 (https://www.cdc.gov/healthyyouth/evaluation/pdf/brief19.pdf, accessed 10 December 2024).

124. Data collection methods for program evaluation: questionnaires, evaluation briefs no. 14. Atlanta: United States Department of Health and Human Services – Centers for Disease Control and Prevention; 2018 (https://www.cdc.gov/healthyyouth/evaluation/pdf/brief14.pdf, accessed 10 December 2024).

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