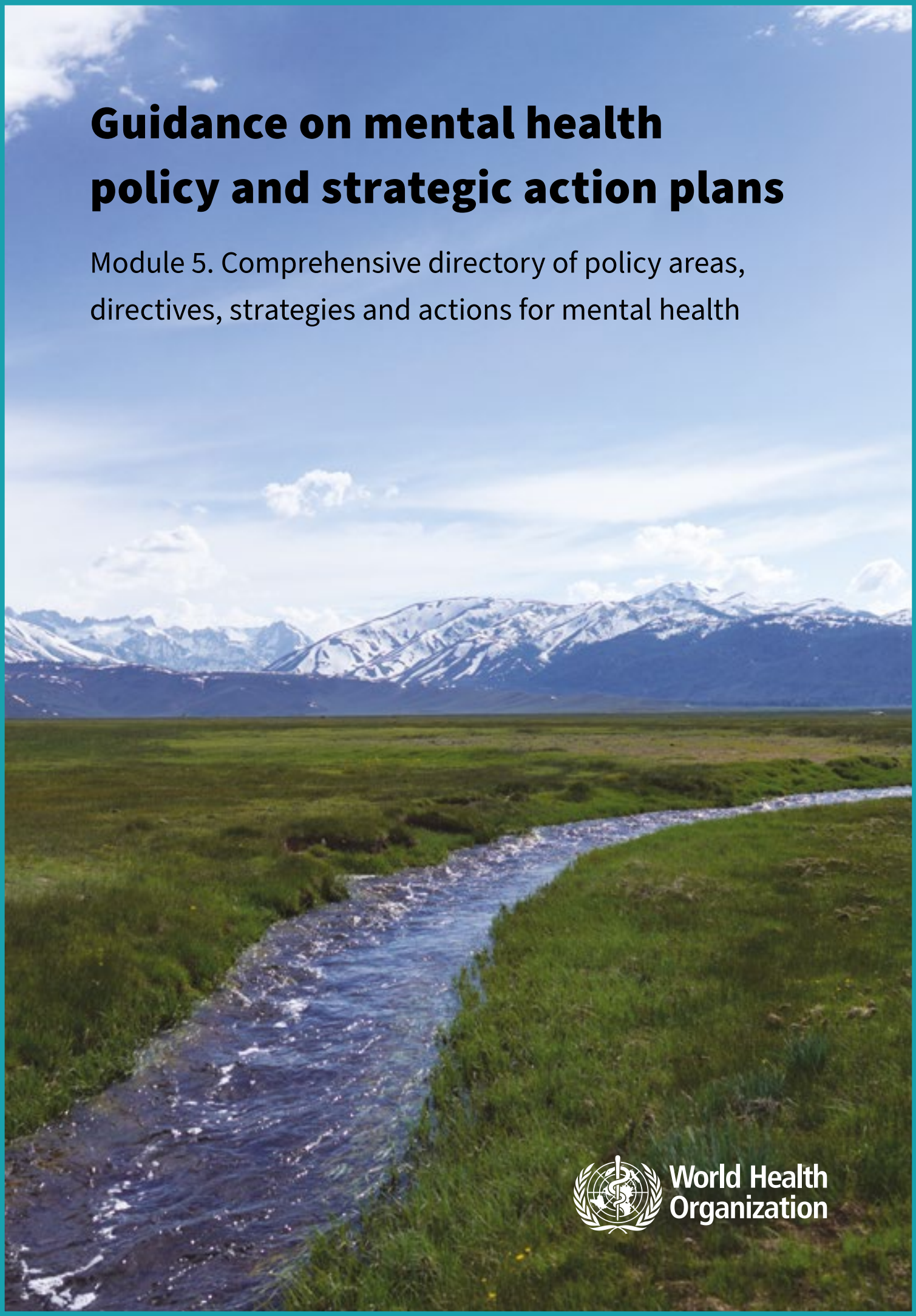
Guidance on mental health policy and strategic action plans

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



World Health Organization

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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

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Glossary

Biomedical model

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

Community mental health care

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

Deinstitutionalization

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

Disability

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

Groups that face discrimination

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

Human rights-based approach

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

Legal capacity

The CRPD defines legal capacity as "...the capacity to be both a holder of rights and an actor under the law. Legal capacity to be a holder of rights entitles persons to full protection of their rights by the legal system. Legal capacity to act under the law recognizes the person as an agent with the power to engage in transactions, and create, modify or end legal relationships" *(7)*. Legal capacity is an inherent and inalienable right, distinct from 'mental capacity' (which refers to people's decision-making abilities) since, regardless of a person's perceived abilities to make decisions, under the CRPD they nevertheless retain their right to exercise their legal capacity on an equal basis with others.

LGBTIQ+

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

Lived experience

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

Mental health and psychosocial support (MHPSS)

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

Procedural accommodation

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

Person-centred care

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

Psychiatric and social care institutions

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

Psychosocial disability

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

Reasonable accommodation

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

Recovery

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

Substitute decision-making

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

Supported decision-making

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

Executive summary

Mental health policy reform is urgent

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

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

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

A comprehensive framework for reform

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

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

Structure of the Guidance

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

Module 1. Introduction, purpose and use of the guidance

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

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

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

Key policy areas for reform

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

Policy area 1. Leadership, governance, and other enablers

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

Policy directives

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

Policy area 2. Service organization and development

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

Policy directives

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

Policy area 3. Human resource and workforce development

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

Policy directives

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

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

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

Policy directives

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

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

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

Policy directives

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

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

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

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

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

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

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

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

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

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

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

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

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

Module 4. Country case scenarios

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

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

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

Module 5 of this Guidance provides a comprehensive directory of key policy areas, directives, strategies, and actions. It serves as a quick and easy, at-a-glance reference for stakeholders involved in mental health policy reform and implementation. This directory helps stakeholders efficiently navigate through policy areas, directives, and their corresponding strategies and actions, making it a practical tool for facilitating discussions on policy reform and planning with staff and key stakeholder groups.

The first diagram presents an overview of the five Policy areas and their associated policy directives, as discussed in Module 2 of the Guidance.

The subsequent diagrams delve deeper, linking each policy directive to its specific strategies, which are further broken down into actions. This structure provides a clear overarching view of how policy directives and strategies can be implemented effectively within each policy area.

Using this directory as a starting point, policy-makers can quickly identify which key elements are relevant, already in place, missing, or require improvement within their mental health systems, policies, and strategic action plans.

See *Module 2. Key policy areas, directives, strategies, and actions for mental health policy and strategic action plans* for more detailed discussion of policy areas and their key challenges, and for more in-depth information on each policy directive, and associated strategies and actions.

Module 4 offers three country case scenarios, illustrating how situations might influence the choice of policy directives strategies and actions, and how these might also be modified to fit the context.

Refer to *Module 1. Introduction, purpose and use of the guidance* for an introductory discussion of the challenges related to mental health policy and the need for reform in line with the international human rights framework.

Module 3. Process for developing, implementing, and evaluating mental health policy and strategic action plans outlines key principles for reforming mental health policy and nine discrete non-linear steps for achieving this.

Policy areas and associated policy directives, strategies and actions

Policy areas for action

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

1 **Policy Area 1.** Leadership, governance and other enablers

1.1 **Policy directive 1.1** Coordination, leadership and accountability

Strategies

Actions

Strategy 1.1.1 Establish coordination structures and mechanisms within the mental health sector and across sectors to strengthen leadership and governance for mental health

Actions

Create a mental health department or smaller unit within the ministry and/or clarify responsibilities and authority, while improving communication channels through to community-level mental health staff.

Establish a national advisory board for mental health and convene working groups to advise on policy, legislative, strategic and evaluation issues.

Hold regular coordination meetings along the chain of responsibility linking the national mental health department and regional, district, and community-level units or focal staff.

Establish a regular forum to gather stakeholder views.

Create an accessible information source for navigating services, support and treatments.

Strategy 1.1.2 Strengthen mental health sector leadership aligned with the rights-based, recovery-oriented and person-centred approach

Actions

Provide leadership training for managers and members of advisory boards and committees.

Celebrate successes and reward good leadership towards transformative change.

Create a coaching and mentoring system that supports aspiring managers and stakeholders.

Strategy 1.1.3 Monitor service quality and rights protection, including via an independent monitoring committee and complaints mechanism

Actions

Identify or create an independent committee or mechanism for monitoring service quality and human rights protections.

Establish a service monitoring framework with a centralized reporting mechanism linked to the appropriate accrediting organization.

Define and implement an independent complaints mechanism.

Policy Area 1. Leadership, governance and other enablers

1.2

Policy directive 1.2 Financing and budget

Strategies

Actions

Strategy 1.2.1 Build a sustainable funding base for mental health, including within universal health coverage

Actions

Analyse, formulate and report the budget and multi-year expenditure plan for mental health.

Make the investment case for mental health, highlighting both short- and long-term returns to the sector and wider society.

Explore all opportunities to secure the funding base for mental health.

Create budget lines for mental health interventions and support within the health sector.

Strategy 1.2.2 Reorient funding and insurance schemes towards person-centred, recovery-oriented and rights-based services and initiatives for mental health

Actions

Negotiate with government financing authorities to fund mental health services through publicly financed health protection schemes.

Explicitly include mental health distress and conditions, as well as treatments, support, and services, in essential care packages and financial protection schemes, and remove discriminatory practices that limit access.

Review financial incentives and disincentives to providing, using, and paying for rights-based and evidence-based community mental health services and interventions.

Negotiate and adjust financial incentives and disincentives in order to promote and prioritize access to rights-based community mental health services.

Strategy 1.2.3 Allocate sectoral budgets and financing to protect and promote mental health according to both joint and sector-specific responsibilities

Actions

Make sector-specific cases for investing in rights-based mental health interventions, estimating costs of inaction and potential benefits.

Talk with government sectors at local, regional, and national levels to discuss budget allocations for mental health, and advocate for more resources.

Establish intersectoral funding mechanisms, including joint budgets, to facilitate collaboration.

Policy Area 1. Leadership, governance and other enablers

1.3 **Policy directive 1.3** Information systems and research

Strategies

Actions

Strategy 1.3.1 Establish indicators and information systems to track progress for mental health and well-being

Actions

Identify and rank indicators that can track progress.

Identify appropriate information systems to store and manage data.

Identify which data will be collected as well as where and how.

Improve mental health data collection with walk-through analyses, reviews, and revised procedures.

Transform manual information systems into electronic systems where feasible.

Collate, routinely report and use mental health data to improve outcomes.

Strategy 1.3.2 Set a prioritized research and evaluation agenda in collaboration with stakeholder groups

Actions

Establish a research and evaluation agenda that is grounded in the human rights-based approach to mental health.

Establish commitment and consensus to include human rights criteria in research projects.

Create centres of research excellence that employ and engage a multidisciplinary workforce using participatory approaches.

Strengthen collaboration around research and evaluation.

Policy Area 1. Leadership, governance and other enablers

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

Strategies

Actions

Strategy 1.4.1 Build and invest in a network of people with lived experience, and representatives from other stakeholder groups, to contribute to high-level decision-making as part of advisory boards and working groups on policy, law, strategy and evaluation

Actions

Employ people with lived experience in the government department responsible for mental health.

Engage people with lived experience, and other stakeholder groups, on the main government-led advisory board and working groups and build their capacity to participate.

Establish mechanism(s) to maintain the independence and autonomy of organizations of people with lived experience.

Strategy 1.4.2 Implement standards so that people with lived experience can participate meaningfully in policy, law, service delivery, training and research

Actions

Draft standards collaboratively with organizations and individuals with lived experience to broaden their representation and participation.

Incentivize increased representation of people with lived experience within policy development, service delivery, training initiatives, 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

Actions

Prepare campaigns and advocacy efforts focused on pressing mental health issues.

Work with traditional and social media to promote responsible coverage of mental health issues and actively educate against stereotypes and human rights violations.

Policy Area 1. Leadership, governance and other enablers

1.5

Policy directive 1.5 Rights-based law reform

Strategies

Actions

Strategy 1.5.1 Conduct training for wide-reaching mindset change and advocacy for law reform

Actions

Implement widescale capacity building with key stakeholders and the community to change mindsets, reduce stigma and discrimination, and promote a rights-based approach in mental health.

Hold dialogues with the key stakeholder groups to discuss the need for, and implications of, legislative reform towards a rights-based approach.

Implement awareness campaigns with the media, highlighting the need for change.

Strategy 1.5.2 Reform legislation related to mental health to align it with human rights standards, including the CRPD

Actions

Undertake a rights-based analysis of current laws, policies, and services related to mental health to understand alignment with international human rights standards.

Repeal, amend and draft laws for alignment with human rights standards using multidisciplinary expertise and inputs from consultations.

Facilitate the legislative process during debate and adoption phases.

Strategy 1.5.3 Set up implementation mechanisms and actions including training

Actions

Establish an oversight agency and bodies for monitoring and implementing the law.

Draft and adopt regulations and codes of practices.

Raise public awareness of the law.

Train stakeholders on rights and the law.

Evaluate whether implementation meets the new legislation's objectives and requirements.

2 **Policy area 2.** Service organization and development

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

Strategies

Actions

Strategy 2.1.1 Create and expand rights-based, short-term inpatient units, outpatient, and community outreach services in general hospitals

Actions

Consult with hospital authorities and stakeholders on creating short-term inpatient unit(s) or beds, outpatient units and community outreach services.

Identify appropriate space and designs for inpatient and outpatient unit(s) in hospitals.

Establish operational protocols for the mental health services within the hospital.

Establish the range of specialized mental health services to be provided in general hospitals, based on the local context.

Recruit and/or deploy trained multidisciplinary staff in hospital mental health services.

Train and supervise other hospital staff on rights-based care and support for mental health.

Strategy 2.1.2 Create and expand rights-based crisis response services

Actions

Establish mental health-friendly environments and rights-based responses in accident and emergency units.

Establish crisis telephone line(s) with rights-based operational protocols.

Establish mobile crisis team(s), their functions and rights-based operational protocols.

Establish crisis accommodation, its functions and rights-based operational protocols.

Strategy 2.1.3 Create and expand rights-based community mental health centres and outreach services

Actions

Establish functions and operational protocols for community mental health centres.

Establish functions and operational protocols for community outreach mental health teams.

Establish the range of specialized services that community mental health centres and outreach services will provide.

Recruit and/or deploy trained multidisciplinary staff to work in rights-based community mental health centre(s) and outreach service(s).

Policy area 2. Service organization and development

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

Strategies

Actions

Strategy 2.1.4 Create and expand rights-based peer support services

Actions

Create or expand one-to-one peer support.

Create or expand group peer support.

Create or expand peer support for family members and caregivers.

Strategy 2.1.5 Integrate rights-based mental health approaches into primary care and other health services

Actions

Identify and integrate mental health functions and operational protocols into primary care.

Identify and integrate mental health functions into specialized health services.

Define tasks, roles and training of staff at primary care and at specialized health services so they can provide rights-based mental health interventions.

Strategy 2.1.6 Implement an integrated, comprehensive and sustainable approach in and across services

Actions

Provide wide access to assessments, interventions and support for service users and caregivers.

Put in place a system and protocols to provide consistent access to psychotropic treatments.

Continue liaison with government authorities and health insurance agencies, even once services are established, in order to secure long-term funding.

Develop high-quality and secure digital infrastructure for delivering online mental health interventions and support.

Implement referral, back referral and other coordination mechanisms.

Continually monitor and evaluate services and publish the findings.

Advocate and promote the service with all stakeholders, and establish ongoing dialogue.

Policy area 2. Service organization and development

2.2

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

Strategies

Actions

Strategy 2.2.1 Operationalize mechanisms within services to address the social and structural determinants of mental health

Actions

Delineate ways to address social and structural determinants of mental health in service policy.

Educate and train staff of all services on addressing the social and structural determinants of mental health.

Ensure that assessment, treatment and support in services directly address individuals' experiences of social and structural determinants.

Task staff of services with supporting individuals to access social and economic interventions, including disability and social protection benefits.

Create safe spaces in services for discussing how social and structural factors influence mental health.

Maintain good knowledge of, and collaboration with, local community and support services.

Build environmentally-friendly and sustainable services that help mitigate climate change and address climate hazards.

Include nature-based interventions in service delivery.

Strategy 2.2.2 Uphold human rights, eliminate coercion, and promote recovery while continuously improving service quality

Actions

Introduce policy guidelines and protocols for improving quality and embedding respect for human rights into the service.

Train service staff on understanding human rights, disability, and recovery in mental health.

Involve people with lived experience in developing, delivering and managing the service, as well as making peer support an integral component.

Introduce holistic recovery plans for people using services.

Set up protocols that integrate supported decision-making into the service and train all staff to understand and follow these.

Introduce advance directives/plans to promote the right to legal capacity within the service.

Set-up comfort and calming spaces within the service.

Train staff on communication and de-escalation procedures.

Set up response teams that can address difficult and conflictual situations.

Put in place comprehensive service assessments, monitoring, improvement/transformation plans and reporting to assess quality and human rights conditions in services.

Develop an anonymous complaints mechanism that feeds into improvement/transformation plans.

Policy area 2. Service organization and development

2.3

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

Strategies

Actions

Strategy 2.3.1 Improve meaningful social connection for people using mental health services

Actions

Map and connect with local opportunities for engagement and participation.

Create or utilize support groups and social communities (both face to face and online) to combat loneliness and reinforce social connectedness.

Mobilize community-based workers or volunteers to assist people at risk of isolation, or who lack support networks.

Support continued access to a range of services and resources that maintain social connectedness.

Strategy 2.3.2 Strengthen partnerships between mental health services and other sector services, including housing, education, employment, justice, and social protection

Actions

Liaise and collaborate with wide-ranging partners, and explore ways to formalize links and to strengthen referral pathways.

Organize joint training with various organizations and sectors so they better understand mental health, and rights-based services, actions and support.

Advocate for increased social sector funding, services and programmes for people with mental health conditions and psychosocial disabilities and for people belonging to groups facing discrimination.

Policy area 2. Service organization and development

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

Strategies

Actions

Strategy 2.3.3 Establish accessible disability and social protection benefits and schemes for people with mental health conditions and psychosocial disabilities

Actions

Establish dialogue with the social protection sector to address gaps in disability benefits and social protection schemes for people with mental health conditions and psychosocial disabilities.

Collaborate with the social protection sector to simplify procedures and establish support mechanisms that help people navigate social protection and disability schemes.

Strategy 2.3.4 Develop tailored services for people with long-term needs and support requirements

Actions

Link to, or create diverse housing options for varying support needs.

Link to, or create, supported education services and resources for varying support needs.

Link to, or create, supported programmes and services for work and income generation.

Link to, or create, programmes and services that provide personal assistance.

Strategy 2.3.5 Engage with families and other informal care providers in local communities, including religious centres, family homes, schools, and villages

Actions

Map and highlight community resources and support to address inclusion, socio-economic development, and rights.

Engaging communities in mental health awareness and dialogue.

Engage with stakeholders embedded in local communities to understand and address the local drivers of poor mental health.

Collaborate with and train families, traditional and faith-based leaders and healers, schools and communities to improve literacy on mental health and human rights, and to support people in distress.

Policy area 2. Service organization and development

2.4

Policy directive 2.4 Deinstitutionalization

Strategies

Actions

Strategy 2.4.1 Establish the foundation and enabling environment for successful deinstitutionalization

Actions

Document the characteristics and location of institutions and discuss deinstitutionalization with staff to bring them on board.

Implement a communication strategy to support deinstitutionalization.

Train service providers and key stakeholders on the human rights-based approach in mental health and tackling stigma and discrimination.

Hold focused discussions in the new community locations where people leaving institutions will be living, in order to assuage community reservations and prepare for deinstitutionalization.

Make person-centred and rights-based community mental health and physical health services available and accessible to people leaving institutions.

Create or link with a variety of services beyond the health sector to facilitate community inclusion and participation.

Budget sufficient funds, including double funding for the first phase of deinstitutionalization and eliminate financial barriers.

Strategy 2.4.2 Develop and implement a deinstitutionalization plan for each institution that immediately improves rights and quality for all residents

Actions

Establish a deinstitutionalization management committee in each institution to develop and implement the deinstitutionalization process.

Develop and implement a deinstitutionalization plan for each institution.

Train staff working in institutions on rights-based and recovery-oriented approaches in mental health.

Train staff to develop individualized plans for people leaving institutions.

Identify community-based mental health services to which staff can apply for work and be deployed as part of deinstitutionalization transitioning.

Policy area 2. Service organization and development

Policy directive 2.4 Deinstitutionalization *continued*

Strategies

Actions

Strategy 2.4.3 Create individualized support plans for each resident transitioning to the community

Actions

Assess each person's need for support.

Provide individuals with accessible and understandable information on all aspects of the deinstitutionalization process.

Develop an individualized plan for each person based on their active participation, support needs and choices.

(Re)establish and support contact with families and other caregivers and general social networks if residents leaving institutions want this.

Assign everyone leaving institutions a focal point person to assist them through the transition process.

Identify, secure and document each person's living arrangements and personalised support needs.

Conduct formal discussions with each individual and their service providers about their care plan before 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

Actions

Identify institutions whose infrastructure, building and land can be repurposed.

Develop a vision and concept paper for repurposing institutions, to ensure that plans align with needs and a human rights-based approach.

Appoint a multidisciplinary management and leadership team with demonstrated expertise, and core values aligned with the centre's goals and a human rights-based approach.

Create close partnerships with academic and research institutions to support research, teaching and training.

Collaborate with innovative services and organizations to develop, provide, and evaluate a person-centred rights-based community service.

3 **Policy area 3.** Human resource and workforce development

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

Strategies

Actions

Strategy 3.1.1 Leverage regulatory and administrative processes to introduce role and task sharing

Actions

Achieve consensus among professional groups, policy-makers and administrators on role changes and task sharing needed to strengthen mental health services and support.

Use current or newly-revised regulatory tools (laws and proclamations, rules and regulations, policies) to enable staff to practice their redefined roles.

Create job descriptions that align with new roles, responsibilities, and tasks.

Create or modify certification/accreditation/licensing mechanisms for newly created staff roles.

Prepare and implement continuing professional development (CPD) schemes.

Strategy 3.1.3 Establish supervision and support for staff working within mental health and other health services

Actions

Identify and enable supervisory staff for each service or group of services.

Train supervisors.

Create one-to-one and group supervision mechanisms.

Use referral pathways to improve staff knowledge and skills.

Strategy 3.1.2 Implement staff training initiatives across and within services

Actions

Identify (re)training requirements for services.

Schedule in-person and online training and assemble a diverse training team.

Set up a training mechanism within each service.

Seek collaborations outside the country to access and provide quality training.

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

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

Families and other caregivers are crucial resources for supporting people, and it is important that they receive appropriate training and support to fulfil this role (see Strategy 1.3.5 on engaging with families and other informal care workers). However, they are not part of the formal support system, unless they have been engaged as family/caregiver peer supporters (see Strategy 2.1.4 on creating and expanding rights-based peer support services).

Policy area 3. Human resource and workforce development

3.2

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

Strategies

Actions

Strategy 3.2.1 Recruit staff from a broad array of disciplines and ensure diversity

Actions

Develop a recruitment strategy and budget to diversify the workforce and fulfil recruitment requirements.

Collaborate with universities, training institutions, government bodies and professional organizations to encourage diverse student enrolment.

Standardize recruitment processes and requirements to ensure quality and accountability.

Strategy 3.2.2 Distribute staff equitably across the country

Actions

Establish dialogues to explore solutions for the challenges in recruiting and retaining staff in less popular and rural areas.

Develop flexible job roles that attract specialist staff to hard-to-fill positions.

Offer professional, personal, and economic incentives for working in under-served regions.

Collaborate with universities and institutes for higher training to develop regional training schemes close to where mental health services are provided.

Strategy 3.2.3 Foster a positive and inclusive work environment, with equitable pay and conditions, and measures to promote staff mental health and well-being

Actions

Create and implement a charter outlining the working conditions and support that staff can expect.

Implement transparent and equitable pay scales as well as career progression pathways for all staff.

Implement transparent and equitable staff performance incentives.

Implement transparent and fair complaints mechanisms to deal with workplace harassment and disputes.

Provide access to mental health care and support for service staff, including frontline workers.

Policy area 3. Human resource and workforce development

3.3

Policy directive 3.3 Competency-based curricula for mental health

Strategies

Actions

Strategy 3.3.1 Develop or adapt core competency-based curricula for mental health

Actions

Convene stakeholders and get consensus for change.

Establish working groups responsible for developing or adapting curricula based on core and on specialist competencies in mental health.

Evaluate, update, or develop curricula for mental health.

Create a framework for assessing students and trainees across various professions.

Regularly convene the working groups to review progress.

Strategy 3.3.2 Implement competency-based curricula for mental health

Actions

Establish an action plan with milestones and timeframes for implementing new curricula for mental health.

Train staff from each academic institution in new curricula.

Launch an information and marketing campaign for new curricula.

Hold an official launch of new mental health curricula well before the academic year in which they will be implemented.

Identify and solve problems in the rollout and implementation.

Topics to cover in curricula on mental health:

- human rights, community inclusion and recovery approaches;
- comprehensive assessment of mental health support needs;
- physical health and lifestyle, psychological, social and economic interventions;
- drug interventions;
- public health issues;
- understanding and responding to the social and structural determinants of mental health in clinical and community settings;
- culturally appropriate approaches;
- responding to the needs of diverse groups including those that face discrimination;
- responding to emergencies;
- mental health and development issues across the lifespan;
- participatory approaches;
- interpersonal skills; and
- leadership and management.

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

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

Strategies

Actions

Strategy 4.1.1 Develop a person-centred, recovery-oriented and rights-based framework and guidelines for assessing mental health and support needs

Actions

Re-evaluate and broaden the approach to assessing mental health.

Identify the areas and items to assess and draft the guidelines.

Consult with all stakeholder groups and conduct pilot studies to finalize the assessment framework and guidelines.

Strategy 4.1.2 Implement the newly-developed framework and guidelines for assessing mental health and support needs

Actions

Develop multidisciplinary training on the new assessment framework and guidelines for all health and social care service staff.

Train staff to use the new assessment framework and guidelines in a phased approach across the health and social care system.

Domains to cover when assessing mental health and support needs.
Assessments should cover:

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

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

4.2

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

Strategies

Actions

Strategy 4.2.1 Identify the physical health and lifestyle, psychological, social and economic interventions for inclusion in Universal Health Care and community initiatives and programmes

Actions

Identify the physical health and lifestyle, psychological, social and economic interventions for integration into all levels of the health and social care system and community initiatives.

Develop a clear and coordinated system for delivering the physical health and lifestyle, psychological, social and economic interventions at all levels of health services and within the community, including the necessary collaborations.

Identify the delivery mode for remote, in-person, and combined delivery interventions.

Strategy 4.2.2 Implement and scale up physical health and lifestyle, psychological, social and economic interventions across all levels of the health system and through community initiatives and programmes

Actions

Prepare and conduct training for delivering physical health and lifestyle, psychological, social, and economic interventions.

Introduce online psychological and self-help interventions accessible through a dedicated website.

Develop comprehensive and accessible information to guide people to interventions and support.

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.

There are many interventions that promote and support mental health, and that provide effective treatment without the use of psychotropic drugs. This list is not exhaustive. For more sources of information, see Box 11 in Module 2.

Physical health and lifestyle interventions:

- physical activity and sport;
- nutrition and healthy diet;
- sleep;
- sexual and reproductive health;
- stress management and relaxation techniques (for example, mindfulness-based interventions, yoga);
- art and culture-based therapy;
- nature-based green and blue interventions;
- harm reduction interventions (for example, needle and syringe programmes in relation to alcohol use or substance use);
- screening, brief interventions, and referral to treatment for hazardous substance use (including alcohol) and substance use disorders;
- tobacco cessation; and
- collaboration/referral for screening and treatment of physical health conditions as appropriate (for example, diabetes, CVD, cancer, HIV/AIDS).

Social interventions:

- social prescribing;
- housing assistance (for example, Housing First, other supported social housing programmes);
- personal assistance (for example, supported decision-making, assistance for daily activities);
- peer support and mutual help groups (1:1, group and online);
- social support and community reinforcement approaches (including to build meaningful social connection and combat isolation and loneliness);
- occupational therapy; and
- community-led interventions and bottom-up interventions.

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 or substance use — contingency management therapy, motivational interviewing and enhancement therapy, positive affect therapy, supportive expressive therapy;
- eye movement desensitization and reprocessing (EMDR);
- family therapy (for example, parenting programmes including home visits for pregnant or postpartum mothers, their partner, and their children, couples therapy, family-focused interventions);
- family and other care giver interventions (for example, support interventions, education and guidance);
- problem-solving therapy and skills training;
- psychoeducation;
- interpersonal and social skills, cognitive and organizational skills and self-regulation-based interventions;
- cognitive stimulation therapy and cognitive training, mainly in relation to dementia;
- beginning-to-read interventions, early communication interventions and specialized instructional techniques, mainly for children and adolescents; and
- recovery, advance, and crisis response plans.

Economic interventions:

- access to income generation and employment (for example, individual placement and support, supported employment and other employment schemes);
- housing assistance (for example, rental assistance programmes);
- cash transfer;
- personal budget; and
- disability allowances and concessions, (for example, disability pensions, living allowances, tax exemptions, discounts).

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

4.3

Policy directive 4.3 Psychotropic drug interventions

Strategies

Actions

Strategy 4.3.1 Identify psychotropic drug interventions and develop guidelines for their safe prescribing, use and discontinuation, including managing adverse effects and withdrawal

Actions

Identify psychotropic drug interventions to be integrated into care across all levels of the health system.

Establish or designate a committee for national guidelines on safely prescribing, using, and discontinuing psychotropic drugs.

Strategy 4.3.2 Implement the guidelines for safe prescribing, use and discontinuation from psychotropic drugs

Actions

Develop and implement training programmes on safe prescribing, use and discontinuation from psychotropic drugs, including managing adverse effects and withdrawal.

Link training programmes on safe drug prescribing, use and discontinuation from psychotropic drugs with professional bodies and professional accreditation processes.

Develop comprehensive and accessible information materials to educate service users, their families and other caregivers about psychotropic drug use, including benefits, adverse effects, and withdrawal.

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

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

Strategies

Actions

Strategy 5.1.1 Implement awareness strategies for staff of all government sectors to transform mindsets, improve understanding on mental health, and to combat stigma and discrimination

Actions

Establish commitment to raising awareness and combating stigma and discrimination by convening senior staff to discuss the benefits.

Support each sector to implement a communication strategy to tackle stigma and discrimination among government employees

Support each sector to implement a training programme for all government employees to improve understanding of mental health and 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

Actions

Collaborate with each sector to develop and implement information campaigns in communities to improve understanding of mental health and change negative attitudes.

Partner with sectors to hold community forums at national, regional and local levels to change mindsets and challenge stigma and discrimination.

Provide opportunities for people with lived experience to participate in and inform all sector initiatives and programmes.

Sectors for joint action include, among others: culture, art, and sports; defence and veterans' services; education; employment; environment, conservation and climate protection; finance and treasury; health; interior; justice; social protection; urban and rural development.

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

5.2

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

Strategies

Actions

Strategy 5.2.1 Advocate for policy changes in government sectors outside mental health to address key social and structural determinants of mental health

Actions

Establish a coalition with civil society groups, professional groups and other community groups.

Prepare position papers on mental health that recommend policy actions for each government sector.

Establish contact with senior politicians and government managers to convey key messages and proposed policy changes.

Engage traditional and social media to disseminate information, evidence, and key messages for change.

Strategy 5.2.2 Collaborate to agree on, and implement changes to, government sector policies that address social and structural determinants of mental health

Actions

Organize planning meetings to discuss the case for change, drawing upon position papers backed by evidence and rights obligations.

Collaborate to review sector-specific policies and strategies, recommending changes that reduce harm to mental health and promote well-being.

Negotiate, obtain consensus on, and implement new or reformed policy.

Strategy 5.2.3 Co-develop and implement community prevention and promotion initiatives with other sectors to tackle social and structural determinants and society-wide issues affecting mental health and well-being

Actions

Hold public discussions and door-to-door conversations to identify and prioritize factors affecting mental health and well-being in the community.

Develop media campaigns to spur community action on society-wide issues.

Develop and implement community-level solutions for the main issues identified, working with a multistakeholder group.

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).

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