Guidance on Mental Health, Human Rights, and Legislation

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**List of abbreviations and acronyms**

To be finalised when the document is completed.

**Glossary of terms**

**Discrimination on the basis of disability:** any distinction, exclusion or restriction on the basis of disability, including mental health conditions, which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation *(1)*.

**Legal capacity:** the capacity to be both a holder of rights and an actor under the law. Legal capacity to be a holder of rights entitles persons to full protection of their rights by the legal system. Legal capacity to act under the law recognizes that person as an agent with the power to engage in transactions and create, modify or end legal relationships *(2)*.

**Recovery:** Gaining new meaning and purpose in life, being empowered and able to live a self-directed life, having hope for their life, and living a life that has meaning for them, despite what a person may have lived through or any emotional distress that may still be a part of a person’s life. The meaning of recovery can be different for each person and thus everyone has the opportunity to define what recovery means for them, and what areas of their life they wish to focus on as part of their own recovery journey. This understanding of recovery moves away from the idea or goal of “being cured” or “being normal again” *(3)*.

**Procedural accommodation:** all necessary and appropriate modifications and adjustments in the context of access to justice, where needed in a particular case, to ensure the participation of persons with disabilities on an equal basis with others. Unlike reasonable accommodations, procedural accommodations are not limited by the concept of “disproportionate or undue burden” *(4)*.

**Reasonable accommodation:** all necessary and appropriate modifications and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms *(1)*.

**Persons with psychosocial disabilities:** persons who, regardless of their self-identification, experience discrimination and societal barriers based on actual or perceived mental health diagnosis or subjective distress. This term aims to reflect a social rather than a medical approach to mental health conditions and experiences, placing the focus on the attitudinal and environmental barriers that restrict their equal participation in society *(5, 6)*.

**Substitute decision-making:** regimes where legal capacity is removed from a person, even if this is in respect of a single decision; or a substitute decision-maker is appointed by someone other than the person concerned, and this can be done against their will; or decisions are made by another person based on what is believed to be in the objective ‘best interests’ of the person concerned, as opposed to being based on the person’s own will and preferences *(7)*.

**Supported decision-making:** regime comprising various support options which allow a person to exercise legal capacity and make decisions with support *(8)*. While supported decision-making regimes can take many forms, under such regimes, legal capacity is never removed or restricted; a supporter cannot be appointed by a third party against the will of the person concerned; and support must be provided based on the will and preferences of the individual *(9)*.

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# INTRODUCTION

## Background

Mental health, human rights and legislation are inextricably linked. Everyone has the right to the highest attainable standard of health (hereinafter “right to health”), which includes both physical and mental health. Countries have corresponding obligations to respect, protect and fulfil this right and its social determinants for all, without discrimination of any kind. Yet, in most parts of the world, access to quality care and support is scarce. Many people with mental health conditions and psychosocial disabilities, in particular, face wide-ranging human rights violations and discrimination, including in mental health care settings. Often, discriminatory practices are underpinned by legal frameworks, which fail to uphold human rights and to acknowledge the pernicious effects of institutionalisation, the over-emphasis on biomedical approaches and treatment options, and the use of involuntary psychiatric interventions.

In recent years, the number of countries that have adopted or are considering adopting legislation on mental health has increased rapidly (see section 1.2). This is the result of multiple factors, including the increasing awareness of the importance of mental health to achieve sustainable development, the expansion of universal health coverage, the substantial impact on mental health of humanitarian crises and emergencies such as the COVID 19 pandemic, and the enhanced attention to human rights challenges in mental health care. Most of these reforms have been passed through stand-alone mental health laws, which have been widely viewed as a progressive feature to advance universal health coverage and service provision *(10)*. However, the primary function of these laws is still to authorise and regulate coercive practices. As a result, legislation continues to condone discrimination. It restricts the exercise of human rights in the mental health system and services and consequently fails to embrace contemporary understandings of international human rights law as they apply to mental health. As the Special Rapporteur on the rights of persons with disabilities has stressed, for too long mental health laws have heavily focused on establishing procedural safeguards to the detriment of rights or liberties rather than ‘breathing life into rights’ *(11)*.

The Convention on the Rights of Persons with Disabilities (CRPD) *(1)*, adopted in 2006, calls for a significant paradigm shift within the mental health field. The CRPD reinforces existing international human rights law protections, such as those provided by the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. It further reaffirms all persons with disabilities, including persons with psychosocial disabilities, as rights holders and equal participants in society. The CRPD fundamentally challenges long-standing practices in mental health systems, such as the denial of legal capacity and the use of coercive practices, and provides instead for a ‘support paradigm’ that underscores the duty and crucial importance of rethinking the objective and role of legislation on mental health to promote personhood, autonomy, full participation, and community inclusion.

The World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR) have underlined the importance of a human rights approach to mental health. The WHO’s Comprehensive Mental Health Action Plan 2013–2030 *(12)*, updated in 2021 at the Seventy-fourth World Health Assembly, stresses the need to adopt mental health-related legislation in line with the CRPD and other international and regional human rights instruments, and to amend or repeal legislation that perpetuates stigmatization, discrimination and human rights violations. Similarly, OHCHR has recommended that States carry out legal reform in line with the CRPD in all sectors relevant to mental health *(13)*.

In 2005, WHO published the highly influential *Resource Book on Mental Health, Human Rights and Legislation (14)*, which aimed to assist countries in drafting, adopting and implementing mental health legislation. At that time, this resource represented a significant advance in recognising the rights of people using mental health services. However, many of the recommendations set therein fall short to the CRPD and the evolving interpretation of the right to health and other related human rights. Therefore, it has since been withdrawn from the WHO catalogue, leaving a gap of information and guidance about what a human rights-based perspective implies for legislation on mental health and its implementation. In parallel, there has been an increase in requests for technical cooperation to support national efforts to adopt or amend mental health-related legislation to adhere to the CRPD and other international and regional human rights instruments. These petitions are likely to increase due to the adoption of more recent technical guidance documents and recommendations by WHO on mental health through the WHO QualityRights initiative *(15, 16)*.

Against this background, WHO and OHCHR aim to provide clear guidance on how to develop legislation on mental health in line with international human rights law.

## Purpose and scope

This Guidance seeks to provide concrete information and serve as a resource for countries when considering adopting, amending or implementing legislation related to mental health systems, care and support. It replaces the WHO Resource Book on Mental Health, Human Rights and Legislation. The aim is to ensure that mental health policies, systems, services and programmes embrace a rights-based approach and provide quality care and support for all in line with international human rights standards, including the CRPD.

This Guidance seeks to encourage reforms to promote, protect, and uphold the rights of all persons interacting with mental health services, regardless of their diagnosis or how they may identify themselves. This includes all persons who may use mental health services, such as persons with psychosocial disabilities; persons with intellectual disabilities; persons with neurological conditions; and persons with alcohol and substance use conditions.

Recognizing that mental health is not exclusive to the health sector, the Guidance highlights cross-sectoral reforms in the social and justice sectors that are also needed to address the social determinants of mental health and move away from biomedical approaches. However, addressing all the different social determinants of mental health requires the transformation of various bodies of law and is a larger, coordinated effort by all government sectors, civil society, and the private sector, which falls beyond the scope of this Guidance. This Guidance focuses specifically on law reform related to mental health care and support as a key aspect of mental health reform.

The Guidance does not intend to promote the adoption of mental health specific laws. Countries without consolidated mental health legislation should consider integrating mental health into general legislation (see section 1.5). At the same time, it is acknowledged that many countries already have stand-alone mental health legislation and need guidance for the progressive transition towards rights-based approaches. In this regard, the Guidance could be used while amending or repealing consolidated mental health laws.

In line with the Comprehensive Mental Health Action Plan 2013–2030 *(12)*, the Guidance is based on the international human rights framework. The Guidance makes multiple references to the CRPD --the highest human rights standard of protection of the rights of persons with disabilities-- given its centrality in changing mental health practice as well as the high level of discrimination and rights violations experienced by persons with psychosocial disabilities. Countries that have not yet fully embraced CRPD standards, can use this Guidance to comply with their obligations under the treaty in relation to mental health care and support. Other countries, that have not yet ratified the CRPD, can also benefit from this guidance to comply with best practice. However, legal harmonization to implement the CRPD and promote, protect, and fulfil all the rights of persons with mental health conditions and psychosocial disabilities goes beyond the scope of this Guidance and legislation on mental health.

Finally, the Guidance serves to encourage codifying into the law the myriad of evidence-based approaches and practices anchored in human rights emerging around the world and whose proliferation continues to spread steadily. Transformation to a rights-based, person-centred, recovery-oriented and community-based mental health paradigm is not only enabled by, but necessitates the accompaniment of the law. In order to do so, the law need shed its worn habits and give room to regeneration and renewal- to enable human rights practice.

## For whom is the guidance intended?

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

This Guidance could also be of interest to any individual or representative of an organization or institution that is involved in mental health or disability rights, including:

* United Nations bodies, entities and experts;
* Government officials;
* Actors working in humanitarian contexts;
* Persons with disabilities and their representative organisations;
* Family members;
* Civil society organisations;
* Community-based organisations;
* Faith-based organisations;
* Professional associations/organisations representing psychiatry and related professions in the mental health sector;
* Professionals and advocates working within the legal and judicial systems;
* Researchers and academics; and
* Media representatives.

## Why is this guidance important?

The Guidance is important for several reasons:

* **A fundamental shift within the mental health field is required.** Stigma, discrimination, and human rights violations continue to exist in mental health care settings. There is an overreliance on biomedical approaches and treatment options and inpatient services, and little attention to social determinants and community-based, person-centred interventions. Legislation can help ensure that human rights underpin all actions in the field of mental health.
* **Most legislation on mental health around the world is outdated and fails to embrace a rights-based approach.** People using mental health services, in particular those belonging to marginalized groups, are not treated equally before and under the law, and are often discriminated against. In many instances, legislation is paternalistic and detrimental to a person’s autonomy and community inclusion. People with mental health conditions or psychosocial disabilities are routinely deemed incapable of making decisions, including whether or not they wish to receive mental health services. There are also no adequate mechanisms to prevent, detect, and remedy these and other human rights violations.
* **International human rights law provides for non-discrimination and respect for all human rights in the implementation of the right to health.** Legislation must ensure a framework for the protection of all human rights in the context of mental health policies, programs, plans and service provision, and to help all persons attain their full potential. The United Nations Human Rights Council has recalled in various resolutions *(17-19)* the importance for States to adopt, implement, update, strengthen or monitor, as appropriate, laws, policies and practices to eradicate any form of discrimination, stigma, violence and abuse in the context of mental health care.
* **The CRPD demands a transformation in the way mental health services are provided.** All persons should be able to exercise their right to provide free and informed consent to accept or reject treatment in mental health systems. Denial of legal capacity, coercive practices and institutionalization must end and be replaced by community-based services and supports that enable the full exercise of human rights. Most countries have ratified the CRPD. To date, [185 States](https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4) and a regional integration organization, the European Union, are parties to the treaty. They have made voluntary, legally binding commitments to implement it across their jurisdictions
* **Legislation can bring out a cultural change and social transformation agenda in relation to mental health**. Legislation plays a fundamental role in framing attitudes and behaviour towards people with mental health conditions and psychosocial disabilities. International guidelines and laws adapted in accordance with them could foster the kind of cultural change advocated by the CRPD, including a transition away from biomedical approaches.
* **The World Health Assembly has called on Member** S**tates to review their mental health legislation in line with human rights.** The Comprehensive Mental Health Action Plan 2013–2020 (extended to 2030) urges member states to strengthen effective leadership and governance for mental health, including by developing, strengthening, keeping up to date and implementing laws and regulations relating to mental health within all relevant sectors, as well as codes of practice and mechanisms to monitor the protection of human rights and implementation of legislation in line with evidence, best practice, the CRPD and other international and regional human rights instruments. Many countries are seeking advice on how to ensure compliance of their legislation on mental health with the CRPD and other international and regional human rights instruments.

## How to use this Guidance?

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

The Guidance is structured to cover both the content and the process for ensuring rights-based legislation on mental health:

* Chapter 1 provides a general overview of the challenges related to legislation on mental health and the need for reform in line with the human rights framework;
* Chapter 2 underlines the key principles and issues that legislation needs to reflect and presents examples of different rights-based provisions; and
* Chapter 3 provides guidance on how to ensure a rights-based process while developing, implementing and evaluating mental health-related legislation.

The Guidance includes, as an appendix, a checklist for assessing legislation, which is designed to assist countries in evaluating whether legislation on mental health adopts a rights-based approach, and which identifies key components which should be reflected in the legal framework. This checklist could also be useful for informing the development of any new legislation related to mental health care.

While the Guidance proposes a set of principles and addresses issues and provisions that could be mirrored in national legislation, users of this guidance should adapt and tailor them to the specific circumstances of each country (national context, languages, cultural sensitivities, legal systems, etc.), but without compromising human rights standards.

For more information on mental health reform and human rights, WHO has developed, through its QualityRights initiative, key guidance and tools that are grounded in a rights-based approach, which complement and support the translation of law into practice. It is recommended to consult the WHO QualityRights materials for training, guidance and transformation *(20)* and the WHO Guidance on community mental health services: Promoting person-centred and rights-based approaches (2021) *(21)*. Additionally, new policy and strategic plan guidance is currently under development. The present guidance on mental health, human rights and legislation should be read in the light of these new resources and pathways for organizing a rights-based mental health system.

**Box 1. QualityRights materials and tools**

* **WHO QualityRights e-training on mental health, recovery and community inclusion** <https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training>
* **WHO QualityRights materials for training, guidance and transformation** <https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools>
* **WHO guidance and technical packages on community mental health services** <https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services>
* **WHO information and resources on promoting rights-based policy & law for mental health** <https://www.who.int/activities/promoting-rights-based-policy-and-law-for-mental-health>

1. A note on language

We acknowledge that language is not neutral and is constantly evolving. Terms commonly used to refer to mental health experiences include ‘mental illness’, ‘mental disorders’, ‘mental health problems’ and ‘mental health conditions’. Some people find some of these terms stigmatizing and reject the medicalisation of these experiences. As a result, they may use different expressions such as ‘persons with lived experience’, ‘consumers’, ‘service users’, or ‘psychiatric survivors’. People must be able to decide on the vocabulary, idioms and descriptions of their experience, situation, or distress. When undertaking legal reforms, the meaningful participation and engagement of lawmakers, parliamentarians and other public officials with the target populations is crucial and necessary to clarify the appropriate use of language in each given context.

Throughout this Guidance, for the sake of inclusiveness, we use the terms ‘persons with psychosocial disabilities’, ‘persons with mental conditions’, ‘persons using mental health services’, ‘service users’ and ‘persons with lived experience’.

The term ‘psychosocial disability’ is the preferred term used by international human rights actors and the disability community to refer to people who, regardless of their self-identification, experience discrimination and societal barriers based on a mental health-related diagnosis or experiences of subjective distress. The use of the term ‘disability’ highlights the significant barriers that hinder the full and effective participation in society of people with actual or perceived impairments and the fact that they are protected under the CRPD.

The term ‘mental health condition’ is used in a similar way as the term physical health condition and refers to all people experiencing or having experienced mental health issues or challenges – this may include people who may or may not identify as having a disability and who may or may not face disabling barriers. The term has been adopted in this guidance in recognition that medical conceptualisations constitute the dominant way of understanding mental distress and experiences in many, if not most, countries in the world, and that healthcare professionals and systems have a crucial role to play in social responses to human distress and suffering. Notwithstanding, this Guidance raises concerns with the over-medicalisation of distress and draws attention to the problems this creates.

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

# CHAPTER 1

# Rethinking legislation on mental health

## Introduction

This chapter provides an overview of the state of mental health and related legislation around the world. It examines important human rights issues in the current mental health context and underscores how most existing legislation on mental health does not align with international human rights obligations, thereby calling for a paradigm shift in legislation on mental health, alongside the broader paradigm shift towards holistic, person-centered, rights based approaches in mental health.

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

## Context and challenges in mental health

Mental health is more than just the absence of mental health conditions. Embracing a holistic view of mental health, WHO defines it as a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to the community *(22)*. The conditions in which people are born, grow, live, work and age shape their lived experience of mental health. As such, mental health issues cannot be addressed in isolation from other non-health sectors such as education, employment, child protection, or humanitarian and disaster responses.

Mental health cannot be considered in isolation of an individual’s multiple and intersecting layers of identity and oppression. A person’s age, sex, sexual orientation, gender identity, disability, caste, racial or ethnic origin, socio-economic status, migrant or refugee status, and other markers of identity and experience cumulate to influence mental health and access to quality mental health care and support. Mental health policies, services and programmes should be responsive to a diversity of needs and seek to overcome the negative impact of multiple and intersecting forms of discrimination experienced by individuals.

Mental health is essential for sustainable development. Without good mental health, people can experience challenges in carrying out daily living activities, playing an active part in their communities or in living a life that has meaning to them. Mental health is relevant to all the Sustainable Development Goals and is explicitly mentioned under Goal 3. Persons with mental conditions and psychosocial disabilities are more likely to fall into poverty, experience poor physical health, and have less access to livelihood opportunities and resources *(23, 24)*. Suicide mortality is a global public health concern that affects all ages, sexes and regions of the world and that disproportionately affects young people *(25, 26)*. The mental health consequences of conflict, humanitarian crisis and other forms of adversity are significant, with elevated rates of post-traumatic stress, depression, and anxiety *(27)*.

The economic case of ignoring mental health to the global economy is substantial. Lost productivity as a result of depression and anxiety, two of the most common mental health conditions, is estimated at US$ 1 trillion each year *(28)*. Investment in quality and rights-based mental health care and support is typically not seen as an investment, but as a cost, and is often scarce. According to the WHO Mental Health Atlas 2020, levels of public expenditure on mental health are low, with a global median of 2.1% of government health expenditure *(29)*. Without enough financial resources, mental health systems struggle to provide adequate support to meet people’s needs. However, the problems of mental health provision cannot be addressed by simply increasing resources; there is an imperative to transform the way mental health care and support are conceived and provided.

While there is growing recognition that mental health and well-being are intimately linked to one’s social, economic, and physical environment, including exposure to poverty, violence and discrimination, most mental health systems fail to embrace a holistic approach. The biomedical model, in which the predominant focus of care is on diagnosis, medication and symptom reduction, continues to be the most prevalent approach across existing mental health systems. As a result, social determinants that impact people’s mental health are overlooked, resulting in persons with mental health conditions and psychosocial disabilities continuing to face higher rates of unemployment, poverty, homelessness, and incarceration *(30-32)*.

Moreover, too many people experience discrimination and human rights violations when they seek to access mental health care and support. Many are denied care due to lack of resources or migrant status. Those receiving care through psychiatric hospitals are often denied general health treatment, including access to life-saving treatment *(33)*. Some are exposed to poor quality services and living conditions, without basic water and sanitation or subjected to dehumanizing, degrading treatment. Rates of involuntary hospitalization and treatment continue to increase around the globe, particularly in high-income countries *(34)*. Seclusion or solitary confinement and the use of restraints, including chemical restraints, are frequently used as a way to enforce compliance to treatment and medication *(35)*. Many people are institutionalised for months, years and even for life in mental health facilities or social care institutions *(36, 37)*; some remain in the community but locked at home or shackled *(38)*.

Women and gender and sexual minorities experience situations of discrimination and violence that are different from others. Gender-related stereotypes may influence the diagnosis of mental health conditions and lead to higher rates of prescription of psychotropic drugs to women *(39)*. Conversely, gender stereotyping may also lead to under-diagnosis of mental health conditions in men *(39)*. Women and girls with mental health conditions and psychosocial disabilities are often deemed incapable of making decisions about their sexual and reproductive health and rights, leading to violence, sexual abuse, forced sterilization, coerced abortion, and forced contraception *(40)*. Lesbian, gay, bisexual, transgender and queer individuals continue to be targeted through so-called ‘conversion therapies’ that aim to change sexual orientation and gender identity *(41)*.

Despite all these challenges, rights-based approaches to mental health remain a neglected part of global efforts to improve mental health. In the last years, mental health care has gained international attention, but there is still limited political commitment and funding for community and person-centred approaches. Public expenditure on mental health services is mostly directed to inpatient care, especially psychiatric hospitals and residential institutions, while community-based and non-coercive psychosocial services are barely funded and portrayed as ‘alternative’ care, instead of being embedded in general health and mental health policies and systems. Hence, most people in the world do not receive quality mental health care or support *(42-44)*.

Legislative reform can help adopt policies and best practices aimed at challenging stigma, discrimination, and segregation, ensuring rights-based approaches, and increasing access to quality health care.

## Mental health and the law

Legislation on mental health has changed considerably in the last 150 years. While the origins of western mental health law can be traced back to the Middle Ages, its expansion was consolidated during the nineteenth and twenty centuries *(45)*. This development has occurred in parallel with the evolution of understandings of ‘mental illness’, treatment perspectives, and human rights standards.

The French mental health law of 1838 and the English and Welsh Lunacy Act of 1890 represent two of the earliest and most influential efforts to regulate mental health admission and treatment in the modern era. These laws consolidated paternalism and notions of ‘dangerousness’ in the mental health field by introducing new procedures authorizing compulsory confinement in a mental health institution on the basis of ‘need for treatment’ or alleged ‘dangerous behaviour’, which continue to be central in justifying involuntary admission and treatment to this day *(46)*. Although these laws are no longer in force, their structures have become the blueprint of ‘modern’ mental health legislation, exported to countries that were under colonial rule and whose legacy remained following their independence *(47)*.

Since the 1970s, legislation on mental health became increasingly influenced by rights-based discourses with a focus on regulating mental health powers. In this vein, the main purpose of the law is to guarantee procedural safeguards to involuntary commitment and treatment, as well as for the use of force. Criteria for compulsory treatment of individuals vary from ‘need for care and treatment’ to ‘danger to self and others’ depending on the country’s practice and legal tradition. This is still the model embedded in most legislation on mental health. The jurisprudence of the European Court of Human Rights *(48)* and the adoption of the Principles for the Protection of Persons with Mental Illness (MI Principles) in 1991 strengthened this approach and prompted a new wave of mental health law reform around the world *(49)*.

A different approach was taken by a few countries, which adopted legislation aiming not at regulating mental health powers, but at expanding community mental health services. This is the case of Italy which in 1978 adopted Law No 180, also known as the Basaglia Law *(50)*. This law placed significant focus on the reorganization of mental health services; it prompted the development of a network of decentralised community-based services, and established a ban on building new mental health hospitals and on admitting new patients to existing ones, which were gradually closed. While coercive measures are still authorised under specific circumstances, this law rejects the notion of dangerousness because of its stigmatizing effects. The Basaglia Law has been highly influential in Latin America where, together with the ‘Caracas Declaration’ of 1990 *(51)*, inspired several laws focused on psychiatric reform, such as in Brazil *(52)*, Argentina *(53)*, Uruguay *(54)*, Peru *(55)*, and Chile *(56)*, which combined the procedural safeguards approach with a reformist drive.

Currently, the overarching trend across countries is the development of stand-alone mental health legislation. The Mental Health Atlas 2020 reports that a total of 111 countries (65% of responding countries, 57% of WHO Member States) have a stand-alone law for mental health *(57)*. More than 70% of responding countries in the Western Pacific, Eastern Mediterranean and European Regions reported the existence of stand-alone laws for mental health. The percentage of countries with stand-alone mental health legislation has increased for almost all regions since the first Mental Health Atlas was published in 2014 *(58)*.

The content of stand-alone mental health legislation often includes provisions on the rights of users of mental health services; diagnostic criteria; voluntary and involuntary admission and treatment; community treatment orders; informed consent for ‘special treatments’ (e.g., electroconvulsive therapy, psychosurgery, sterilization); monitoring and review mechanisms; criminal offenders; and governance and administration of mental health services.

The adoption of the CRPD has prompted new interest for legislation on mental health. While it is too early to understand the real impact of the CRPD in national mental health legislative frameworks, as chapter 2 exemplifies, several countries have begun to integrate CRPD standards into their legislation on mental health (e.g., reasonable accommodation, advance directives, supported decision-making), but without challenging the legitimacy of the denial of legal capacity and compulsory treatment powers, thus falling short of human rights standards.

## Mental health law and human rights

While mental health laws have become the natural response of States to regulate mental health services and ensure the protection of rights within them, they also raise significant human rights concerns that reflect deep and lasting tensions about mental health practice and law *(59)*.

Albeit decreasingly prevalent, legislation inherited from colonial rule can be described as ‘archaic and obsolete’ *(47)*. Language is often stigmatizing and derogatory (‘lunatic’, ‘insane’, ‘mentally ill’, ‘mentally abnormal’, ‘mentally disordered’, ‘unsound mind’), and significant discretion is given to families and mental health professionals to decide on behalf of the individual concerned. Welfare protection and public safety are frequently invoked as criteria for involuntary commitment, with an emphasis on custodial administration.

More recent legislation on mental health continues to place its focus on the restriction of rights and commonly provides lower protection standards to people on the basis of a mental health diagnosis. This entails discrimination in the enjoyment of the rights to informed consent, to privacy, to liberty and security of the person, to access to justice, among others. Moreover, laws fail to challenge harmful stereotypes that these individuals are ‘dangerous’ and ‘incompetent’ and contribute to their perpetuation *(60)*.

An additional concern is the explicit use of a reductionist Western biomedical model in mental health law, which works to the detriment of other holistic and person-centered and rights-based approaches and strategies for understanding and addressing mental health experiences *(61, 62)*. This includes different cultural conceptions of and approaches to mental health, such as those held by indigenous peoples and related understandings of well-being, healing and community, to the detriment of both the individual and the collective. Mental health law often sees mental health conditions as a ‘problem’ for the individual and society, and places little attention to the economic, social and cultural factors that affect the capacities of individuals, families and communities to respond to distress *(63)*. This framing often leads to stigma for those experiencing or expressing distress, an over-emphasis on biomedical treatment options, undue attention to changing the individual rather than changing circumstances in which they live, and a general acceptance of coercive practices *(21)*.

Coercion remains a core component of existing mental health laws across jurisdictions *(34)* and is a major concern (see box 2). Coercion encompasses a broad range of practices in the context of mental health care characterised by the use of force and threats *(64, 65)*. These may include involuntary hospitalization, involuntary medication, involuntary electroconvulsive therapy (ECT), seclusion, and physical, chemical and mechanical restraint. In general, it is deemed to be a legitimate form of ‘patient management’ through clearly specified parameters and safeguards (e.g., as a last resort and for the shortest period) *(66)*.

Criteria for the use of coercion varies across jurisdictions. In most countries, having a mental health condition is the principal requirement for civil commitment, in addition to other variables such as risk to self or to others, or need of treatment *(67)*. A few countries also use lack of capacity or ‘insight’ as a criterion *(68)*. Some countries have further widened their criteria to authorise coercion within the community through community treatment orders. Although several countries have tightened their criteria for involuntary commitment, rates have not reduced *(34)*.

Another pressing concern is institutionalization. Mental health legislation has directly contributed to the practice of institutionalization *(69)*. By allowing for broad criteria for civil commitment based on a biomedical perspective, such legislation has contributed to high rates of people being admitted to and living in institutions, condoned discrimination and human rights abuses, and entrenched barriers and neglected reform towards systemic transformation. Having a clear legal mandate to close psychiatric hospitals, institutions and similar facilities and to provide people with the support they need in the community could boost change in many parts of the world *(70)*.

Mental health legislation also continues to serve as an instrument to reinforce asymmetrical power structures in society and, thus, sustain the exclusion and oppression of specific populations. It has traditionally regulated women and girls and their bodies through explicit provisions that override their free and informed consent to their sexual and reproductive health and rights *(71)*. For example, legislation may mandate sterilization, contraception or abortion -- all on the basis of alleged ‘best interests’, including to prevent harm to a woman or girl’s mental health.

Similarly, with regard to children and adolescents, mental health laws often deny their rights to express their views and be heard, taking into account their evolving capacities or identities *(72)*. Moreover, mental health law has played a key role in enabling the segregation and institutionalization of children in mental health or social care facilities where services wield significant power and operate as gatekeepers to decide on institutionalization of a child, violating their right to family life, among others.

In the Global South, those who are most marginalized – including those from a low socio-economic or educational background, belonging to a minority, or based on their migrant status-- are often denied what few protections mental health legislation may provide for, due to the lack of law enforcement and accountability mechanisms. This leads to the proliferation of harm both within and outside the mental health system. For example, ‘therapeutic communities’ and ‘prayer camps’ often target people from marginalized backgrounds and subject individuals to ill-treatment such as shackling, confinement and punishment in the name of recovery and rehabilitation *(38, 73)*. Although in some countries these practices are prohibited by law, the intersectional discrimination these groups face, together with the lack of state oversight, limits their access to any form of justice.

Widespread human rights violations and harm caused by mental health system enabled by mental health laws has led to a legacy of trauma that inhabits many individuals and communities and transgresses generations. Indeed, the structural violence and harm exercised through and facilitated by mental health laws is, in itself, a form of historical trauma. The process of legislative reform calls for further social examination, research, and meaningful dialogue among all concerned. Legislation that supports a new paradigm for enjoyment of the right to mental health could play a role and have an impact to address this legacy and enable its redress. Above all, this requires the engagement and participation of those who have lived experience, including those who have experienced intergenerational trauma, to shape the law to reflect and respond to their perspectives, in the pursuit of recovery, reparation and healing.

Against this background, there is a need to rethink legislation on mental health, including stand-alone mental health laws, to ensure legislation does not continue to be a vehicle for the violation of rights, but on the contrary, that, where it exists, it serves as a tool to promote the exercise of rights and social inclusion.

**Box 2. The case against coercion**

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

From a human rights perspective, coercive practices in mental health care contradict international human rights law, including the CRPD. They conflict with the right to equal recognition before the law and protection under the law through the denial of the individual’s capacity. Coercive practices also contradict the right to free and informed consent and, more generally, the right to health. They can inflict severe pain and suffering on a person with long-lasting physical and mental health consequences, which can impede recovery and lead to substantial trauma and even death. Moreover, the right to independent living and inclusion in the community is violated when coercive practices result in institutionalization or any other form of marginalization *(74)*.

Furthermore, coercive practices violate the right to be protected from cruel, inhumane and degrading treatment, which is a non-derogable right *(75)*. In 2013, the UN Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment *(76)* called on States to impose an absolute ban on all forced and non-consensual medical interventions, including the involuntary administration of psychosurgery, electroconvulsive therapy, ‘mind-altering drugs’, and the use of restraints and solitary confinement *(77)*.

Defenders of the exceptional use of coercion in mental health services argue that there is no absolute right, and that the principles of autonomy and liberty must be balanced against other rights and interests, including public order and safety. However, many experts have noted that compulsory powers are ineffective in their own terms *(59)*. There is limited evidence to support the success of coercion to reduce the risk of self-harm, facilitate access to treatment, or protect the public. Predicting self-harm or risk of harming others before the fact, apart from being ethically questionable, is extremely difficult *(78, 79)*. Although mental health conditions are associated with both suicidal ideation and attempt, there is little evidence that risk assessment tools and coercive mental health treatment prevent suicide *(80, 81)*.

In addition, evidence suggests that, in general, persons with mental health conditions and psychosocial disabilities are not more likely to be violent than anyone else; in fact, they are much more likely to be the victims of violence *(82)*. Findings on the association between violence and certain mental health diagnoses, namely schizophrenia, are mostly related to substance abuse *(83)*. Even in such cases, there are good and validated policy options for supporting these individuals without coercion. Furthermore, there is no evidence that coercion facilitates access to mental health care and, conversely, it may discourage people to seek support *(84-86)*. Against this background, the reasonableness of the restrictions placed by mental health law on fundamental rights does not hold, especially when there is a growing pool of non-coercive practices that can be implemented in their place *(21)*. There is also a growing body of evidence that indicates that non-coercive practices lead to better mental-health outcomes *(87-89)*.

## The international human rights framework

The Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948 *(90)*, set out for the first time the fundamental human rights to be universally protected. There are nine core human rights treaties which lay out in more detail what these rights entail. These include the two covenants - the International Covenant for Civil and Political Rights *(91)*, and the International Covenant for Economic, Social and Cultural Rights *(92)*– and seven thematic treaties, including the CRPD. All UN Member States have ratified at least one core international human rights treaty, and 80 percent have ratified four or more *(93)*. Other instruments have been adopted at the regional level reflecting specific human rights concerns and providing for specific mechanisms of protection.

Human rights are universal, inalienable, indivisible and interdependent. A human rights-based approach to mental health addresses political, economic, social and cultural barriers while empowering individuals and groups, especially those most disadvantaged. This can make considerable contributions to mental health policies, making them more holistic and responsive to individual needs. Governments and other duty-bearers, including non-State actors, have an obligation to respect, protect and fulfil all human rights in mental health care and support.

The right to health is a fundamental human right indispensable for the exercise of other human rights. Mental health is an integral and essential component of the right to health, which covers physical, mental and social well-being. The arbitrary division between physical and mental health has contributed to a situation of unmet needs and human rights violations in the context of mental health *(94)*. The promotion, protection and realization of mental health should be regarded as a vital human rights concern.

The right to health is an inclusive right which contains freedoms, entitlements and is conditioned by the underlying determinants of health. The right to health also contains essential elements: availability, accessibility, acceptability, and quality (known as the AAAQ framework) *(95)*. The elements of the AAAQ framework are interrelated and must be holistically addressed in the provision of mental health care. In addition, the right to health requires ensuring participation and accountability. A rights-based approach to mental health requires the adoption of a legal and policy framework explicitly shaped by these human rights principles and obligations. This will contribute to advancing reform in mental health policies, programs and practices, and to identifying and challenging human rights violations within the health system.

The CRPD, in force since 2008, reinforces the protections of the international human rights framework in the field of mental health. It reflects the most advanced international human rights standards on the rights of persons with mental health conditions and psychosocial disabilities. The CRPD challenges traditional understandings of disability, equality, and personhood; and supersedes previous ‘soft law’ instruments, such as the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) *(96)*.

Upholding the interdependence and indivisibility of rights, the CRPD, like other group-specific conventions, erases the artificial divide between civil and political rights on the one hand, and economic, social and cultural rights on the other, and appreciates the holistic nature and exercise of rights. It also imposes obligations which are of immediate effect, such as the mandate of non-discrimination, and others which may be realized progressively, such as the right to access individualised support services. Progressive realisation still entails an immediate obligation to take deliberate steps towards the full realization of such rights *(97)*.

The CRPD recognizes that disability, including psychosocial disability, is a social construct that results from the interaction between persons with actual or perceived impairments and attitudinal and environmental barriers. For too long, under a medical approach, disability was understood as a problem residing in the individual and the ultimate aim was to cure or fix the person so they can become ‘normal’. Rather than promoting social change, diversity and inclusion, the medical model implied that persons with disabilities need themselves to change, which has historically led to disempowerment, discrimination and institutionalisation. The CRPD shifts the focus to the social barriers which prevent people from participating in society on an equal basis with others *(98)*. This departure from the medical model does not mean dismissing the importance of access to health care interventions, but questions the role of the medical sector vis-à-vis human rights and inclusion *(99)*.

The CRPD embraces a substantive model of ‘inclusive equality’ relevant to mental health care and support, which extends over four dimensions *(100)*:

* a recognition dimension: combating stigma, stereotyping, prejudice and violence and recognizing intersectionality;
* a redistributive dimension: addressing socioeconomic disadvantages;
* a participative dimension: reaffirming the social nature of people as members of social groups and the full recognition of humanity through inclusion; and
* an accommodating dimension: making space for difference as a matter of human dignity.

The CRPD further expands the understanding of legal personhood in the international human rights system – the ability to hold rights and act freely upon those rights. It shifts the focus away from restrictions towards supports that enable individuals to make decisions for themselves and expand their capacities to do so. The support paradigm of CRPD is built around the recognition of the interdependence of the human experience. Support is a fundamental aspect of that interdependence and does not undermine individual autonomy; on the contrary, support expands it *(101)*.

The values, principles and standards of CRPD, applied to the broader human rights discourse, provide a new perspective for creating an enabling legal and policy environment for the development of rights-based mental health services, which prioritise the person’s empowerment and active participation in their own recovery.

**Box 3. Key CRPD provisions for a rights-based approach to mental health**

The contributions of the CRPD to the mental health field are significant. The CRPD, through its different provisions, has innovated the understanding of the human rights of persons with disabilities and of human rights theory in general. All of its principles and substantive provisions are relevant to mental health systems and services as they demand the application of the principle of equality and discrimination across the board. Persons with mental health conditions or service users who may not self-identify as persons with disabilities or do not face disabling barriers are still protected under the CRPD, because discrimination based on a person’s actual or perceived impairment or mental health condition is prohibited under this treaty.

**Legal capacity**

Legal capacity is a precondition for the exercise of rights and making autonomous healthcare decisions. In most legal systems, the legal capacity of persons with mental health conditions and psychosocial disabilities can be restricted in many areas of life *(102)*. The lack of ‘mental capacity’ is commonly used as the basis for this restriction. Often, a legal representative is appointed to make decisions on their behalf, or decision-making is delegated to medical personnel or a court *(103)*.

Article 12 of the CRPD recognises that all persons with disabilities, including those with psychosocial disabilities, enjoy the right to exercise their legal capacity on an equal basis with others in all areas of life. Accordingly, a person’s ‘mental capacity’ cannot be the basis for denial of legal capacity. Persons with mental health conditions and psychosocial disabilities should have the right to make legally binding decisions and, if wanted, be provided with access to the support they may require in exercising their legal capacity, including formal and informal support *(104)*. States have to replace all forms of substitute decision-making, such as guardianship, curatorship, and conservatorship, with ‘supported decision-making’. For example, a person may choose a trusted person to support them in making healthcare decisions, or choose to adopt ‘advanced plans’ to communicate their will and preference about possible future events (e.g., during mental health crises). They may also find support for other areas of life through peer support or self-advocacy networks.

**Liberty and security of the person**

In most countries, legislation, including mental health laws, authorizes deprivation of liberty based on mental health diagnosis or impairment, or does so in combination with other factors, commonly when the individual presents an alleged risk to self or to others, or is deemed to need care.

Article 14 of the CRPD reaffirms that persons with disabilities enjoy the right to liberty and security on an equal basis with others and, consequently, cannot be deprived of their liberty unlawfully or arbitrarily. Furthermore, it clarifies that ‘the existence of a disability shall in no case justify a deprivation of liberty’. The Committee on the Rights of Persons with Disabilities has stressed that article 14 establishes an absolute ban on deprivation of liberty on the basis of impairment, thereby precluding all forms of involuntary commitment to mental health facilities, including on the basis of dangerousness or need of care (see section 2.3) *(105)*. While there is growing consensus among different human rights experts and mechanisms concerning these standards *(21, 61, 106-112)*, some still maintain that involuntary commitment may be necessary in exceptional circumstances to protect people from serious harm or to protect others *(113, 114)*. This difference in criteria reflects the ongoing transformation in perspectives and attitudes as well as tensions between CRPD standards and previous approaches to mental health law *(115)*.

**Free and informed consent**

Article 25 (d) of the CRPD provides that States must ensure that health care for persons with disabilities is provided on the basis of free and informed consent, and article 15 sets out that no one shall be subjected without his or her free consent to medical or scientific experimentation. The Committee on the Rights of Persons with Disabilities has stressed that involuntary treatment is not only a violation to the right to health, but also to the right to equal recognition before the law (article 12), freedom from torture and ill treatment (article 15), freedom from violence, exploitation and abuse (article 16), and personal integrity (article 17) *(116)*. Today, most mental health laws continue to restrict the right to free and informed consent in the treatment of persons with mental health conditions and with psychosocial disabilities, in favour of substitute decision-making. A fundamental shift is needed to create an enabling legal framework for the developmental of mental health services that respect the rights of persons with mental health conditions and psychosocial with disabilities and base all treatment decisions on the free and informed consent of the individual (see section 2.3).

**Living independently and being included in the community**

Article 19 of the CRPD recognises the right of all persons with disabilities to live independently and be included in the community. This means exercising freedom of choice and control over decisions affecting one’s life with the maximum level of self-determination and interdependence within society *(117)*. Accordingly, persons with mental health conditions and psychosocial disabilities must have the opportunity to choose how, where and with whom to live on an equal basis with others, without being obliged to live in a particular living arrangement, such as institutional settings. This addresses specifically the practice of segregation, institutionalisation and isolation to which persons with mental health conditions and psychosocial disabilities have been historically subjected in mental health and social care. Furthermore, they must also have access to a range of community support services, including individualized disability-specific support and mainstream services and facilities for the general population in the community. All people should have the support necessary to live the way they choose to live.

**Access to justice**

Access to justice for persons with mental health conditions and psychosocial disabilities has commonly been restricted, leaving them without the right to exercise their right to fair trial, avoid arbitrary detention in mental health facilities and contest forced treatment and malpractice in mental health systems. For example, legislation denying their legal standing and thus restricting their right to file a complaint or stand trial diverting them from criminal, civil and administrative processes resulting in deprivation of liberty commonly expressed as forced mental health treatment and institutionalization in mental health facilities; stigma and discrimination leading to lack of credibility; inadequate remedies; inaccessible information and communication; and lack of legal aid. These compounded barriers leave persons with mental health conditions and psychosocial disabilities without effective access to justice, increasing their risk of abuse and neglect within mental health services, and rendering them significantly overrepresented in the criminal justice system. Article 13 of the CRPD sets out the obligation to ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations in order to facilitate their effective role as direct and indirect participants in all legal proceedings (see section 2.8.2). In addition, States Parties are obliged to promote appropriate training for those working in the field of administration of justice, including police and prison staff.

## Applying the human rights framework to legislation on mental health

Throughout history, mental health law has swung, like a pendulum, between periods in which procedural safeguards were expanded to allow greater autonomy, and times when they were severely reduced to favour rapid access to mental health services *(118)*. In practice, however, the situation of persons with mental health conditions and psychosocial disabilities has been a history of constancy encompassing neglect within the community and neglect within institutions *(119)*. At the core of this failure is the inability of mental health policies and systems to fully embrace human rights.

The international human rights framework described in the previous section requires countries to revisit legislation on mental health from a rights-based perspective and move away from regulating the use of compulsory powers. The main goal of legislation on mental health should be to establish a legal framework that enables the development of mental health systems that provide for the right to the highest attainable standard of mental health for all people. Given the context and challenges described arlier, legislation on mental health should also aim at guaranteeing equal rights in mental health systems for people engaging with them, to counter the inertia of standing harmful practices.

There are different objectives that legislation can pursue to advance a human rights approach to mental health:

* Demonstrating political will for and providing a solid foundation for the transformation of mental health systems that benefit the whole of society;
* Enabling rights-based, person-centred, recovery-oriented, community-based mental health systems, which prioritise the person’s empowerment and active participation in their own recovery;
* Explicitly upholding the rights to legal capacity and free and informed consent in mental health services;
* Supporting the eradication of discrimination, stigma, violence, coercion and abuse in mental health service provision;
* Developing and investing in services and support that are respectful of the free and informed consent of the person, and safe from coercion and forced treatment;
* Facilitating the creation of peer-led and peer-run and support networks, both in-service and independently from the health system;
* Promoting the adoption of protocols and training on rights-based approaches for health workers, first responders, police officers and other community actors;
* Promoting the provision of a range of community-based mental health services and support, including non-medical interventions;
* Setting out sustainable deinstitutionalization processes, ensuring the provision of adequate and appropriate economic and social support to live independently in the community;
* Ensuring that the expertise of persons with lived experience, particularly persons with psychosocial disabilities, is recognised and that they are closely consulted and actively involved in the design, development, monitoring and evaluation of mental health services;
* Limiting and preventing the continuation of harmful practices in mental health systems that interfere with the protection and promotion of rights.

These objectives can be met through:

* a cross-sectoral approach to mental health;
* challenging stigma and discrimination;
* ensuring access to quality person-centered, rights-based mental health care and support;
* framing the transition toward mental health services based in the community;
* respecting legal capacity and free and informed consent, and eliminating the use of coercion;
* promoting community inclusion;
* service users’ participation in decision making; and
* the development of robust accountability measures.

The following sections explain these different vehicles and how they align with and support a human rights-based approach to mental health.

### A cross-sectoral approach to mental health

Achieving the highest attainable standard of mental health should be a State strategic objective. This requires a State-wide response that involves the health system and requires cross-sector coordination. Strategic planning towards this objective implies leveraging on the strengths of certain sectors and countering the weaknesses of others. Health systems have a strong transformative potential through its building blocks; organizing quality service delivery, mobilizing the work force, strengthening information systems, providing access to medicines, mobilizing financial resources and structuring governance structures that provide for accountability. Social protection systems are better prepared to address social determinants of mental health, including through the provision of community-based support systems, housing, employment, and the promotion of social structures that increase social recognition of diversity. Legislation can help to integrate mental health as a strategic objective into all policies and promote mental health in all areas. Mainstreaming facilitates the promotion of mental health across the life course and address social determinants.

Legislation on mental health often singles out mental health as a separate regime, either through stand-alone laws or separate ‘mental health’ sections in general health laws. Experience shows that this approach emphasises segregation of mental health, which potentially reinforces mental health-related stigma and a siloed approach. Furthermore, these separate regimes reinforce the idea that mental health is a specialized practice that requires exceptions to the equal exercise of rights, enabling arbitrary restrictions to generally accepted principles of the right to health, such as on the right to free and informed consent.

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

Mainstreaming of mental health as a strategic objective in legislation should be developed in close consultation with people with lived experience and with the commitment to integrate a rights-based approach.

**Box 4. Examples of mainstreaming mental health as a strategic objective in general legislation**

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

### Challenging stigma and discrimination

There is a widespread and long-standing stigma associated with mental health conditions and psychosocial disability within society and mental health services themselves. For example, persons with mental health conditions and psychosocial are commonly believed to be violent and dangerous, a stereotype that is constantly reinforced by the media. As a result, they are often treated with fear and contempt, resulting in human rights abuses. Within mental health services, these prejudices are daily reinforced by the widespread practices of discrimination that occur in such settings, such as coercion and institutionalization, which shape the attitudes of existing and future health professionals. The prevalent stigma that exists in families, communities and even among health professionals may also impact the self-perception of individuals with mental health conditions and psychosocial disabilities who sometimes internalize these negative attitudes, thus furthering their disempowerment and exclusion.

Tackling stigma and discrimination is part and parcel of a rights-based mental health framework. Not only does it ensure equal access to quality mental health services, but it serves to eliminate barriers to participating in the community, promotes acceptance to embrace diversity, and contributes to developing inclusive communities that foster attention to the mental health and well-being of their members *(21)*. Awareness-raising is an essential tool for changing of attitudes that underlie stigma and discrimination. In recognizing its importance to achieve a lasting cultural shift, the CRPD is the first human rights treaty to enshrine a stand-alone provision on awareness-raising (article 8). This entails various measures to foster respect for rights and combat stereotypes through the use of public awareness campaigns, education and training targeting health professionals, the wider public, the media, individuals themselves and their families.

Experiences of discrimination in accessing quality mental health services are manifold, in particular for persons belonging to marginalised groups who are at higher risk of intersectional discrimination. Legislation on mental health must recognize the universal nature of human rights and adopt and integrate the principle of equality and non-discrimination across policies and interventions. Allowing for limitations or lower levels of human rights standards for certain groups is contrary to the very essence of human rights. Moreover, the principle of equality, in addition to prohibiting all forms of discrimination, calls for positive action to achieve equal enjoyment of rights, including provisions on accessibility, reasonable accommodation and individual supports so people can benefit equally from the law. Specific measures such as quotas and other forms of affirmative actions may also be needed to accelerate or achieve de facto equality of persons with mental health conditions and psychosocial disabilities, in the pursuit to ‘leave no one behind’.

### Access to quality, person-centered, rights-based mental health care and support

Many people around the world are denied access to quality mental health services and suffer from inadequate care. A rights-based approach to mental health calls for equal access to quality care and support that is holistic and person-centred. Health facilities, goods and services for mental health must be available in sufficient quantity and be accessible and affordable on the basis of non-discrimination *(95)*. They must also be gender-, age- and culturally appropriate, of good quality and respectful of medical ethics, such as respect for autonomy and individual choice *(95)*.

Respecting human rights in mental health requires a person-centred approach based on people’s unique identities and lived experiences. The CRPD calls for the respect for difference and acceptance of human diversity as well as the right of children to preserve their identities (article 3(d) and (h)). While the biomedical model reduces mental well-being to a medical phenomenon, a rights-based perspective embraces human differences and accepts persons with mental health conditions and psychosocial disabilities for who they are, rather than pitying them or seeing them as a problem that needs to be ‘cured’ or ‘fixed’. Feelings, behaviours and experiences should not addressed in isolation through medicalized interventions, but approached and understood in the wider context of personal and environmental factors underlying distress *(61)*.

Legislation providing for a person-centred and rights-based approach is fundamental not only to challenge biomedical approaches that reduce mental health experiences to illnesses, but also to reassess the role of mental health services in people’s lives. Recovery is a personal process, different for everyone, tied to self-determination, healing relationships, and social inclusion. Mental health services are one of many services that people with mental health conditions and psychosocial disabilities can benefit from to pursue the lives they want to live. Some people may decide not to resort to such services based on different reasons, such as previous traumatic experiences with those services, and those decisions must be respected and supported. The rights of individuals, such as the right to social security, cannot be conditioned to whether they use mental health care and support or not; mental health services should not become gatekeepers to the exercise of rights.

### Transition to community-based mental health care and support

Although the importance of primary care has been reaffirmed since the Alma-Ata Declaration of 1978, mental health systems are yet to bring care and support into the community. A key aspect of a rights-based approach to mental health is ensuring that care and support is accessible and within safe physical reach for all sections of the population, especially marginalized groups *(95)*. This makes it easier to maintain family relationships, friendships and employment while receiving care and support.

Article 19 of the CRPD calls for the transformation of care and support systems, including mental health services, to enable independent living and community inclusion. Practices of institutionalization and segregation of services have resulted in centuries of social exclusion and marginalization of persons with mental health conditions and psychosocial disabilities from their communities *(21)*.To unlock and dismantle these systems,a strategy and plan of action to close psychiatric institutions and transform mental health services is needed to ensure respect for people’s right to live in the community *(120)*.

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

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

Ending coercion has not been a priority for mental health systems; in fact, coercion has been considered a necessary instrument of service provision. As noted above, the CRPD requires States to rethink their mental health systems to end all forms of coercion and to develop non-coercive responses that respect the rights of service users. This implies rethinking the role of legislation - from a focus on restrictions of rights to the provision of support to guarantee them.

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

The legal reforms necessary to recognize the full legal capacity of people with mental health conditions and psychosocial disabilities are beyond the scope of this Guidance. Section 2.2 provides guidance on how the law can ensure respect for legal capacity in mental health systems and facilitate access to support measures for its exercise.

### Community inclusion

Full and effective inclusion and participation in society is a general principle of the CRPD *(121)*. Being included in the community means having access to services and support to enable participation in all areas of life *(122)*. The implementation of a human rights-based approach to mental health requires responding both to people’s immediate and longer-term needs which are shaped by social determinants and intersecting forms of oppression.

A critical role for mental health services is thus to support people to access relevant services and support that can enable them to live and be included in the community. It is not the sole responsibility of the health sector to provide for all the range of support services that the people it supports may need to effectively participate and be included in the community. Mental health services, however, can serve as an interface with other sectors including social protection, housing, employment and education, and vice-versa, to overcome barriers and obstacles in a holistic manner *(21)*.

Additionally, there is a need for governments to transform and empower communities, so they can better respond to distress and provide support to their members.

### Participation

The meaningful participation of all stakeholders, particularly of those concerned, in public decisions and policies on mental health, should be ensured through transparent processes. For too long, service users have been seen only passively as ‘patients’, and not recognized as key contributors and partners in the development of mental health responses, while mental health professionals, service providers and family members have substituted their voices in decision-making processes.

Echoing the motto of the disability movement ‘nothing about us without us’, Article 4(3) of the CRPD obliges States to ensure the participation of persons with mental health conditions and psychosocial disabilities, including children and adolescents, in all public decisions affecting them. Their meaningful participation at all stages of policymaking –from design and implementation to monitoring and evaluation— is key to upholding a rights-based approach to mental health. This ensures that their valuable expertise and experiences inform the development of policy responses that are relevant and effective and prevent harmful practices *(123)*. The Committee on the Rights of Persons with Disabilities has issued authoritative guidance on these obligations in its General Comment No. 7 (2018) *(124)*.

Partnership and collaboration can further improve person-centered and rights-based responses and accountability, contributing to sustainable system transformation. With this objective, countries should support organisations of persons with persons with mental health conditions and psychosocial disabilities to build their capacities to participate in decision-making and to claim their rights *(125)*.

### Accountability

Accountability is an important component of the human rights framework. Without accountability, human rights lack enforcement and are rendered meaningless. Governments and other actors are accountable to rights holders, and mechanisms need to be established to define clear responsibilities, to measure and monitor progress, and to engage with rights-holders to improve policy-making.

Countries should integrate accountability mechanisms in all aspects of mental health policy through to legislation. Such mechanisms play a central role in monitoring and improving mental health services. For example, complaint mechanisms can help to identify gaps and trends in the exercise of rights, and serve to facilitate service improvement *(126)*. Similarly, the work of monitoring and accountability bodies, such as national human rights institutions or courts, contribute to raising the visibility of human rights challenges and foster the respect and protection of human rights. Data collection and public access to information are also necessary to ensure the transparency of mental health services and to enable monitoring, by both civil society and the general public *(127)*.

Access to justice is also key to accountability. It allows persons interacting with mental health services to challenge human rights violations and to enforce rights. Training staff, including the police, judges and lawyers, on the rights of service users and persons with mental health conditions and psychosocial disabilities is fundamental to understand and recognise the rights violations they encounter and to ensure peoples’ access to effective remedies. Providing necessary support to persons with mental health conditions and psychosocial disabilities to facilitate their access to justice is another fundamental component required to achieve equality in this area.

# CHAPTER 2

# Legislative provisions for person-centered, recovery-oriented and rights-based mental health

## Introduction

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

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

A practical format is provided for the content of mental health-related provisions in legislation. Using real examples of different texts and provisions that have been adopted by different countries, some of which have been edited to better reflect current human rights language, the chapter offers detailed guidance for drafting rights-based provisions. These examples are not intended to be prescriptive as each country should consider and adapt them to their particular context and legislative framework, maintaining the adherence to human rights standards. Also, references to specific provisions from national legislation do not mean an endorsement of all aspects of such laws.

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

## Ensuring equality and non-discrimination

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

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

### Prohibition of all forms of discrimination

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

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

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

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

**Box 5. What the law can say**

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

**Box 6. Key legal reforms beyond legislation on mental health**

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

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

### Provision of reasonable accommodation

Some people may require individualized accommodations to access information, make decisions, work, or interact with mental health care and support services. This can be for many reasons, including disability, religion, and age. Mental health systems must, therefore, ensure the provision of reasonable accommodation to enable all service users to exercise their rights on an equal basis with others.

Reasonable accommodation is an intrinsic part of the duty of non-discrimination *(128)*. According to the CRPD, reasonable accommodation means any necessary and appropriate modification and adjustments, not imposing a disproportionate or undue burden, where needed in a particular case, to ensure the equal enjoyment or exercise of rights (art. 2) *(129)*. Not accepting an accompanying person during a consultation or refusing to accommodate religious beliefs in mental health settings are examples of denial of reasonable accommodation.

The term ‘reasonable’ speaks to the relevance, appropriateness and effectiveness of the accommodation; an accommodation must achieve the purpose (or purposes) for which it is being made, and be tailored to meet the requirements of the individual *(128)*. Furthermore, the concept of ‘disproportionate or undue burden’ sets a limit to what a third party must do to provide an accommodation; an accommodation should not pose a possible excessive or unjustifiable burden on the accommodating party *(128)*.

A country’s anti-discrimination and other related legislation can ensure people using mental health services are provided with reasonable accommodation as an intrinsic part of the right to equality and non-discrimination. It is important that legislation recognise and incorporate the denial of reasonable accommodation as a form of discrimination. Given the importance of legal capacity, countries can recognize explicitly a duty to provide reasonable accommodation in the exercise of legal capacity *(130)*.

**Box 7. What the law can say**

* Denial of reasonable accommodation constitutes a form of discrimination. The right to non-discrimination is an immediate obligation not subject to progressive realization.
* A person using mental health services who requires reasonable accommodation to exercise their legal capacity may request this specifically.
* The need for reasonable accommodation for the exercise of legal capacity shall not be used to question a person’s legal capacity.
* A person using mental health services, who so requires it, shall be provided with reasonable accommodation for the exercise of rights.
* Guidance on how to assess whether a reasonable accommodation imposes a disproportionate or undue burden on the duty bearer shall be prepared by the competent authority.
* Earmarked funds for the implementation of reasonable accommodation shall be allocated by relevant public institutions.

### Discrimination in health insurance

In many countries, individuals need health insurance to obtain health care. Legislation in such countries should contain provisions to prevent discrimination against people when obtaining adequate public, private or mixed health insurance for the care and treatment related to physical and mental health *(131)*. In the Marshall Islands, for example, legislation establishes that access to and fees for health care, health services, health insurance, and life insurance must not differ on the basis of disability *(132)*.

Legislation can also ensure that health insurance companies do not discriminate on the basis of pre-existing mental health conditions or predicted probabilities of mental health conditions, for example, on the basis of family history or alleged genetic pre-disposition. In many countries, private insurance will refuse covering such cases or will significantly increase premiums, raising equity concerns *(133, 134)*.

**Box 8. What the law can say**

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

### Challenging stigma around mental health

Legislation plays a fundamental role in framing attitudes and behaviour towards people with mental health conditions and psychosocial disabilities *(135)*. Discriminatory laws reinforce a culture of stigma, shame and secrecy around mental health. This environment discourages people from seeking support and often results in marginalisation and human rights violations. Therefore, directly confronting discriminatory practices resulting from stigma is key to challenging stereotypes and prejudice around mental health.

The law itself can also be a vehicle to reinforce stereotypes and prejudice. For example, legislation may use derogatory language, such as ‘idiot’, ‘lunatic’, ‘unsound mind’ and ‘mentally ill’. These terms carry significant symbolic value and negatively impact public and self-stigma. The criminalization of suicide and the legal authorisation of coercive practices are also drivers of stigma and actual manifestations of discrimination towards people with mental health conditions and psychosocial disabilities (see chapter 2.3).

Conversely, there are many ways that law reform can be used to help address mental health stigma. Legislation can mandate positive action related to mental health awareness-raising, training, and education those providing mental health care and support and for the general public. These measures can help to de-stigmatize mental health, promote acceptance and inclusiveness, enable understanding of the role of social determinants, and debunk myths that link mental health conditions and violence. As part of these efforts, countries should consider mandatory mental health training for healthcare providers and other actors developed in collaboration with persons with mental health conditions and psychosocial disabilities (see chapter 2.1.6).

For example, in the United States of America, some states have mandated mental health education in public schools as a way to improve students’ mental health awareness *(136)*. It is important that awareness and training initiatives on mental health are guided by rights-based approaches and do not reinforce a biomedical paradigm.

Prejudices and discriminatory attitudes within mental health services could also lead to incorrect diagnosis and interventions. Biases in psychiatric diagnosis are well-known; for example, racial and gender biases have shown to lead to both overdiagnosis and underdiagnosis of mental health conditions *(137, 138)*. In addition, existing diagnostic tools and criteria of mental health conditions have been criticised for being too wide and all-encompassing to be clinically helpful, potentially leading to ineffective, stigmatising and harmful interventions *(139)*. As the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras has noted, mental health diagnoses have been misused to pathologize identities and other diversities *(140)*. Although combating the medicalization of everyday life is a task beyond the law, legislation can establish certain frameworks for diagnostic work to prevent its misuse.

**Box 9. What the law can say**

* Inappropriate, stigmatizing and outdated terminology related to mental health and marginalised groups shall be removed and replaced by appropriate language, such as regarding persons with psychosocial disabilities and lesbian, gay, bisexual, transgender, queer an intersex persons.
* The mental health authority shall conduct awareness-raising campaigns to combat stigma and discrimination in mental health services.
* Public campaigns to improve awareness of mental health and respect for the rights of persons with mental health conditions and psychosocial disabilities shall be conducted in a multisectoral manner and with the active participation of persons with lived experience.
* The Ministry of Education shall ensure mental health education throughout the school curriculum to increase awareness about mental health and rights-based approaches to mental health.
* Mental health diagnosis shall not be determined on the basis of political, economic or social status or membership of a cultural, age, racial or religious group, or for any other reason not directly relevant to mental health status of the person.
* Non-conformity with gender roles, or moral, social, cultural, work or political values or religious beliefs prevailing in a person’s community must not be a reason for making a psychiatric diagnosis.
* A mental health diagnosis may not be based only on knowledge from a previous medical intervention.

### Equal recognition of rights within mental health services

No one should be limited in their rights resulting from accessing mental health care and support. Every person using mental health services should be recognized as having the same rights as everyone else within mental health settings. In efforts to ensure this, some countries have established charters or a list of rights of users of mental health services that must be respected. However, in most cases this list is incomplete, sets exceptions, or is misinterpreted to be an exhaustive list of service user rights. A better option may be for legislation to indicate that people using mental health services have the same rights as any person who uses other general health services and should not be subject to limitations based on diagnosis or capacity. Exceptions to the enjoyment of any rights based on mental health conditions or psychosocial disability constitute discrimination and should be abolished.

**Box 10. What the law can say**

* A person using mental health services shall enjoy, on an equal basis with others, and without discrimination, all rights guaranteed by national and international law.
* A person using mental health services shall enjoy the same conditions and standards of treatment as other people in all health settings.
* Health services shall respect, protect and fulfil the rights of persons with mental health conditions and psychosocial disabilities, on an equal basis with others

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

#### Access to information

People using mental health services have the right to access information about their diagnosis, treatment and prognosis as everyone else *(141)*. This includes copies of their medical files, records and any other relevant reports and documents. This information should be given in a way that people understand, without oversimplification and a paternalistic approach, and respecting the dignity of persons. If desired, service users should be allowed to be supported by someone they trust or an independent advocate to understand the information. A service user should have the right and means to complain about lack of access to the medical files, as well as about other potential issues, to an independent authority.

People using mental health services have the right to access their health-related data on an equal basis with others. Protocols on access to information can be developed to ensure respect for the dignity and privacy of those concerned, including for example, the offer of support to review and explain the information in peoples’ file or record.

**Box 11. What the law can say**

* A person using mental health services is entitled to receive full information, in an individualized form, about their diagnosis, treatment and prognosis.
* Prior to any intervention, a person using mental health services is entitled to receive detailed information in a clear and understandable manner concerning:
* their state of health, including their medical assessment,
* the proposed examinations and interventions,
* the expected effects of any examination or intervention offered, including the potential benefits, risks, side effects and harms,
* their right to decide on the proposed examinations and interventions, and

possible alternative procedures.

* A person using mental health services is entitled to ask further questions during and after receiving the information.
* A person using mental health services is entitled to get to know the results of the individual examinations and interventions during their care.
* Medical records shall be completed at the time of service and in a way that respects the dignity and privacy of the individual.
* A person using mental health services is entitled to access and receive copies upon request of the information and documentation contained in their medical and other health records, and the same shall be provided in accessible formats where required.
* The right of access to medical records can also be exercised by duly accredited legal representation.
* A person using mental health services has the right to request that their comments be inserted in the medical records without altering the existing records.
* A person using mental health services has the right to complain or take legal action if the right to information is not respected.

#### Confidentiality

People using mental health services have the right to the highest standard of protection for their health-related information, on an equal basis with others *(141)*. Such information should not be revealed to third parties without the consent of the person concerned. Mental health-related information disclosed to third parties commonly leads to discrimination against persons using mental health services in various areas such as employment, education, health insurance, and migration.

Mental health professionals are bound by professional codes of conduct that generally include rules for confidentiality. The exchange and disclosure of data between health workers must be limited to the information necessary for the coordination or continuity of care *(142)*. It is important that all members of the mental health care team be aware of the rules that bind them to maintaining confidentiality.

Authorities in charge of mental health settings should also make sure that adequate processes are in place to safeguard the confidentiality of people using mental health services. This means having an effective system in place so that only relevant, authorized individuals can access people’s clinical notes or other data-recording mechanisms such as electronic medical records or cloud-storage solutions. Legislation may also protect confidentiality by providing sanctions and penalties for breaches of confidentiality, either by professionals or mental health services.

Disclosure of mental health-related information for purposes other than providing health care, for example, for planning, improving or monitoring health-care services, may happen if authorized by law under necessary and proportionate criteria, and on an equal basis with other health-related information *(143)*. Insurance companies, employers and external contractors cannot be regarded as recipients authorized to have access to this information without the consent of the person concerned *(144)*.

Individuals cannot be compelled to disclose their mental health-related information or disability status. Where certification of disability is needed to access a benefit or service, the certification of having a disability by an authority is sufficient to establish entitlement *(145)*.

**Box 12. What the law can say**

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

#### Privacy

Every person is entitled to the full enjoyment of the right to privacy. The right to privacy limits how far society can intrude into a person’s affairs and covers privacy of personal information, privacy of communications, bodily privacy, and privacy of personal environment. The right to privacy of persons using mental health services is frequently violated, particularly in inpatient settings. They face the risk that staff or other people using the services may violate their privacy.

Legislation can guarantee the right to privacy within mental health services by establishing a clear mandate to respect it. Importantly, interferences with the right to privacy are only permissible if they are neither arbitrary nor unlawful. The use of new tracking and sensing technologies in the context of mental health care, such as ‘smart pills’ and remote monitoring, pose significant ethical challenges which warrant additional safeguards to ensure data privacy and the respect of each person’s informed consent.

**Box 13. What the law can say**

* A person using mental health services has the right to privacy on an equal basis with others, in physical spaces and online.
* Mental health interventions shall be conducted respectful of the right to privacy of the person.
* A person who receives inpatient services shall have the opportunity to communicate and correspond with other persons privately, including counsels and personal representatives.
* A person who receives inpatient services shall have appropriate space and privacy in order to practice their cultural, religious and spiritual beliefs.

#### Communication

Persons using mental health services have the right to communicate with anyone they choose, on an equal basis as everyone else. Communication is an important tool to ensure accountability, which operates as a standing informal monitoring system to prevent violence and abuse. Regretfully, in many inpatient mental health services communication is curtailed and monitored, and correspondence is opened and sometimes censored on the basis of the ‘best interests’ standard. Intimate meetings with family, including one’s spouse and friends, are also often restricted. Even in some outpatient services, communication is occasionally limited. Legislation can explicitly ban such practices moving away from best interests towards the equal recognition of rights.

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

**Box 14. What the law can say**

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

#### Receiving information about rights

Although legislation may enshrine the rights of people using mental health services, they are frequently unaware of their rights and thus unable to exercise them. It is therefore essential that legislation include a provision for informing service users of their rights when interacting with mental health services.

Legislation can ensure that service users are given information about their rights at the time of any contact with mental health services, whether primary care or inpatient services. This information should include an explanation of what these rights mean and how they may be exercised, and be conveyed in such a way that service users are able to understand .

In countries with various official languages, the rights should be communicated in the person’s official language of choice. People should also be informed about their rights in accessible formats.

**Box 15. What the law can say**

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

#### Environmental and social conditions within services

The provision of safe, hygienic and conducive mental health services is critical to a person’s recovery and overall well-being. No individual should be subject to unsafe or unsanitary conditions when receiving mental health care and support, such as lack of water and sanitation, dirty or dilapidated walls and floors, or bad heating. Poor conditions in mental health services, particularly inpatient services, may constitute torture and ill-treatment *(146)*.

Environmental conditions in mental health services should be as good as in any other healthcare facility where an inpatient stay is required to provide treatment, care and support. Legislation and its subsequent regulations can set out minimum conditions to be maintained in mental health services to ensure an adequately safe, hygienic, therapeutic and welcoming living environment, including those needed to facilitate interaction and social activities *(147)*. Adequate monitoring and accountability mechanisms are needed to ensure these obligations (see chapter 2.7).

In some mental health services, under the guise of occupational therapy, service users are forced to work. Such practice constitutes inhuman or degrading treatment and is in breach of Article 7 of the ICCPR. Legislation can ban the use of forced labour and exploitation in mental health services. There are certain grey areas; for example, situations where, as part of a programme, service users must participate in household activities such as making their beds or preparing meals. Legislation should strive to provide as much clarity on these issues as possible and ensure the voluntary nature of occupational activities.

**Box 16. What the law can say**

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

## Respecting personhood and legal capacity in mental health

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

Article 12 of the CRPD reflects a deeper and fuller understanding of personhood and states that all persons with disabilities, including those with psychosocial, intellectual and development disabilities, enjoy legal capacity on an equal basis with others in all aspects of life. It also provides for access to the support they may require in exercising their legal capacity.

The right to legal capacity concerns all areas of life including health. Recognising legal capacity and supported-decision making is a pre-condition to exercise the right to health and related rights. All people using mental health services, including persons with psychosocial, intellectual and development disabilities, must have the right to make decisions about their health and medical treatment for themselves, and to have those decisions recognized as valid under the law.

This section proposes key legislative provisions to respect the legal capacity of people using mental health services and to provide them with appropriate support if required. In addition to these reforms, States must comprehensively examine all areas of law to ensure that legal capacity of persons with psychosocial, intellectual and development disabilities is not restricted in other areas of life; this include reviewing civil codes, guardianship or family laws, and mental capacity acts *(148)*. Although these wider reforms are outside the scope of this Guidance, they are essential to ensure their full participation and inclusion in the community.

### Respecting legal capacity in mental health services

Since the adoption of the CRPD, a number of countries have adopted provisions recognising the legal capacity of persons with disabilities, including those with psychosocial, intellectual and development disabilities *(149)*. In some countries, the recognition of legal capacity has been included in legislation on mental health to reaffirm that persons with mental health conditions and psychosocial disabilities enjoy legal capacity in the context of mental health provision and facilitate access to supported decision-making (see section 2.2.3).

In this regard, legislation can help mental health services respect the legal capacity of all service users, including those with psychosocial, intellectual and development disabilities, by establishing a clear mandate to that effect. The exercise of legal capacity in the context of mental health services is not reduced to respecting free and informed consent (see section 2.3), since legal capacity can be denied in many ways; for example, by limiting the ability to appoint supporters, file complaints or reports, or participate in clinical trials.

Legislation can further recognize the ‘dignity of risk’ of service users, that is, the right of persons to make their own decisions and to take risks. Making mistakes is fundamental to learn and grow.

Respecting legal capacity does not mean ignoring people’s diverse decision-making skills or abilities. In fact, it is in recognition of that diversity of support requirements that supported decision-making regimes should be made available. However, having different decision-making skills or a mental health diagnosis should not lead the restriction of people’s legal capacity to make their own decisions and to have others respect them.

Provisions providing for the respect of legal capacity within mental health services are sometimes contradicted by other provisions within the national legal framework. However, mandating the respect for legal capacity of all persons using mental health services, including those with psychosocial, intellectual and development disabilities, helps to reinforce a paradigm shift and can be a first step to opening the space for further law reforms and court interventions in accordance with new provisions *(150)*.

**Box 17. What the law can say**

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

### Prohibiting substitute decision-making in mental health services

An important aspect of upholding the legal capacity of people using mental health services, particularly those with psychosocial, intellectual and development disabilities, is ending ‘substitute decision-making’. According to the Committee on the Rights of Persons with Disabilities, substituted decision-making occurs when:

* legal capacity is removed or restricted from an individual (even if this is with respect to a single decision);
* substitute decision makers such as guardians, judges or experts are appointed by someone other than the individual concerned against their will; or
* decisions are made by substitute decision makers based on the ‘best interests’ of the individual concerned, as opposed to being based on the will and preferences of such person *(151)*.

Some countries such as Costa Rica, Colombia and Peru have abolished guardianship and other substitute decision-making regimes from their legal systems. Other countries have only removed plenary guardianship – which limits the exercise of all legal rights and powers of the person -- from their legal systems, restricting substitute decision-making to health or financial matters under limited circumstances. However, no country has yet expressly prohibited all forms of substitute decision-making in context of mental health services.

It is important that the law clearly prohibits substitute decision-making in the provision of mental health care and support. This includes repealing the provisions that allow guardians and family members to make decisions for people receiving mental health care or support, as well as eliminating all instances in which the law allows the treating doctor to decide for the person in their ‘best interests’. The law should also expressly prohibit health professionals from making decisions without the person's informed consent (see section 2.3).

The development of supported decision-making options in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the CRPD *(152)*.

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

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

While the scope and formality of supported decision-making may vary from country to country, generally it allows individuals to appoint one or more persons to assist them to: (i) obtain and understand information, (ii) evaluate the possible alternatives and consequences of a decision, (iii) express and communicate a decision, and/or (iv) implement a decision *(153)*. People should be free to choose from regimes and arrangements of varying types, intensities and formalities; for example, circles of support, support networks, support agreements, peer support, independent advocates, personal ombudspersons, personal assistance, advance directives, support from family and friends, and online communities.

The regulation of the provision and access to these different forms of support does not fall under the domain of legislation concerning mental health. It is important, however, that the law concerning mental health provision recognize and reinforce supported decision-making in the exercise of legal capacity for people who use such services, including those with psychosocial, intellectual and development disabilities.

For example, legislation can establish specific forms of supported decision-making taken in the context of health and related social services. These supports can include the right to be accompanied and supported by a trusted person when making healthcare decisions; the adoption of advance directives; and the appointment of nominated persons to be informed and/or consulted during a crisis situation (see section 2.3.2). Legislation can also ensure that independent advocates, truly independent from mental health services, are available to provide support and advocate on behalf of people’s rights at no cost. The lack of financial resources should not be a barrier to accessing support in the exercise of legal capacity *(154)*.

Some countries have legislated co-decision-making regimes where a co-decision maker can be appointed to help an individual to make decisions jointly. This means the co-decision maker and the individual supported will consent to interventions together. These arrangements cannot be considered as a form of supported decision-making unless they are voluntary, and the individual has the right to select the co-decision-maker and to end or change the relationship at any time *(155)*.

Supported decision-making should never be imposed on people. If a person chooses not to have support, then their wishes should be respected.

**Box 18. What the law can say**

* A person using mental health services shall be provided with access, without undue influence or coercion, to the support of their choice that they consider appropriate to exercise their legal capacity. The person concerned determines the form, identity, scope, duration and number of supporters.
* Supported decision-making is a form of assistance to facilitate the exercise of their legal capacity that entails support in: (1) understanding the options, responsibilities, and consequences of a person’s decisions; (2) accessing, collecting, and obtaining information that is relevant to a given decision; (3) understanding such information; and/or (4) implementing the person’s decision, including assistance in communicating the person’s decision vis-à-vis third parties.
* A support person, based on the consent of the person concerned, shall have the authority to: (1) access the person’s medical information and records; (2) assist the person vis-à-vis any proposed treatment or therapy; and/or (3) be present during person’s appointments and consultations with mental health professionals, workers and other service providers during the course of a treatment or intervention.
* Mental health services shall recognise and respect supported decision-making agreements and arrangements.
* The existence of a supported decision-making agreement or arrangement does not preclude a person using mental health services from exercising their legal capacity without the supporter.
* Independent advocates shall be available in mental health services, upon request at any time, to provide support to service users to access information, understand their rights and options, and have their rights, will and preferences respected. They must be independent, have appropriate experience and training, and be guided by human rights principles. Mental health services shall facilitate the exercise of the functions of independent advocates.

### Safeguarding will and preferences

Legal safeguards are needed to ensure the respect for the rights, will and preferences of the individual being supported for the exercise of their legal capacity, as well as to prevent abuse in the provision of supported decision-making. These safeguards are not meant to prevent people from making decisions, nor the possibility of taking risks and making mistakes. Their goal is to ensure that the person’s will and preferences are respected *(156)*. Hence, they must: (i) be based on the person’s rights, will and preferences; (ii) offer protection against conflict of interest, exploitation, abuse and undue influence; (ii) be proportional and tailored to the individual; and (iv) include complaint and redress mechanisms.

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

#### Respecting will and preferences in supported decision-making

Support should never amount to substitute decision-making. Legislation can mandate that supported decision-making in mental health services must respect the will and preferences of the person concerned.

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

**Box 19. What the law can say**

* Support for the exercise of legal capacity shall be provided in accordance with the will and preferences of the person concerned.
* Safeguards shall be established to guarantee respect for the rights, will and preferences of the person concerned; and to prevent conflict of interest, exploitation, abuse and undue influence of the supporter.
* A supporter is prohibited from: (1) exerting undue influence upon the person concerned; and (2) acting outside the scope of authority provided in the supported decision-making agreement or arrangement.

#### Protection against abuse and undue influence

Legislation can help to offer protection against abuse and undue influence in supported decision-making in the mental health context. Undue influence occurs when the support person takes advantage of a position of power over the person being supported, reflected in signs of fear, aggression, threat, deception or manipulation *(157)*.

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

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

**Box 20. What the law can say**

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

#### Best interpretation of will and preferences

In some exceptional cases, it is difficult, if not impossible, to ascertain a person’s will and preference. For example, when a person is unconscious or there is no one with intimate knowledge on how to communicate with a person with significant communication difficulties. For these situations the Committee on the Rights of Persons with Disabilities have introduced the standard of ‘best interpretation of will and preferences’ *(158)*. This standard implies ascertaining what the individual would have wanted instead of deciding on the basis of their ‘best interests’.

While the notion of best interests varies across jurisdictions, best interests determinations often rely on an external evaluation of the person’s care and welfare needs, which may be in conflict with what that person wishes. On the contrary, best interpretation of will and preferences involves the consideration of the person’s life trajectory, such as beliefs, values, attitudes, feelings and everyday actions, including non-verbal cues.

This interpretation process is complex and imperfect --as is life itself. It is also a resource and time-intensive process. Moreover, there is a risk that the person’s will and preference are ‘manufactured’ to meet the wishes of supporters. However, all things considered, it is a better approach than attempting to determine ‘what is good for them’ because it keeps the will and preferences of the person at the centre of all efforts.

There is no consensus on the use of the ‘best interpretation of will and preferences’ standard in the specific context of mental health provision. A main concern, particularly from people with lived experience, is that mental health services, based on widespread existing prejudices and paternalism, may consider most people in a crisis situation to be unable to express their will and want to be ‘treated’. Plus, applying the best interpretation standard requires a substantial, thorough process; during a crisis, there is no time to collect sufficient information to understand the individual will and preference. As a result, the most likely outcome is for someone experiencing a crisis to be forcibly committed and medicated, even if they are actively refusing it. A similar situation can occur with people with intellectual or cognitive disabilities, about whom there is a strong presumption of ‘incapacity’. It could be argued that what is really needed in these cases is not ‘interpreting’ what the person wants, but rather, developing and making available practical support for individuals to deal with the crisis and exercise their legal capacity (see section 2.3.3).

For this reason, states must strictly regulate the use of the best interpretation standard.

Legislation on legal capacity should ensure that it is used only as a last resort, where, after significant efforts have been made, there are no practicable ways to determine the will and preferences of a person. It should also be subject to close judicial review to prevent abuse. The application of the best interpretation standard in the mental health field must be carefully considered and discussed with the active engagement of persons with mental health conditions and psychosocial disabilities.

### Respecting children’s evolving capacities

Children should be involved in healthcare-related decisions in a manner consistent with their evolving capacities *(159)*. According to Article 12 of the Convention on the Rights of the Child, states have the obligation to respect their right to express themselves and to participate in all matters affecting them, in accordance with their age and maturity.

Legislation can ensure the child’s views are actively sought and given due weight in healthcare-related decisions in accordance with their evolving capacities. Children should be provided with adequate and appropriate information in order to understand all the relevant aspects in relation to healthcare decisions, and be allowed, when possible, to give their consent in an informed manner *(160)*.

In the case of adolescents, they should be provided with access to adequate information that is essential for their health and development in order to make appropriate health behaviour choices *(160)*. Moreover, legislation should recognise their right to have access to confidential mental health counselling and advice without the consent of a parent or guardian, if they so wish *(160)*. The Committee on the Rights of the Child has stressed that this obligation is distinct from the right to give medical consent and should not be subject to any age limit *(160)*. While involving parents or guardians in young people’s health care decisions is sensible, many adolescents will not seek support if they are forced to involve their parents.

Legislation can also ensure that the will and preferences of children and adolescents with mental health conditions and psychosocial disabilities concerning mental health interventions are respected on an equal basis with other children *(161)*. In addition, legislation can recognize the right of children and adolescents to be provided with age- and disability appropriate support to express their views and make decisions.

**Box 21. What the law can say**

* Children and adolescents shall be given the opportunity to provide their informed consent to mental health care, in a manner consistent with their age and maturity *(162)*.
* All adolescents have the right to have access to confidential mental health counselling and advice without the consent of a parent or guardian, irrespective of age, if they so wish *(163)*.
* Emancipated adolescents shall be recognised as having the right to provide informed consent for themselves.
* Children and adolescents shall be provided with age- and disability appropriate supported decision-making support if they so wish, in a manner consistent with their evolving capacities.

## Informed consent and eliminating coercive practices in mental health care

Free and informed consent should be the basis of all mental health-related interventions. Being able to make our own decisions about our healthcare and treatment choices is a basic human right.

Ending coercive practices in mental health – such as involuntary commitment, forced medication, seclusion and restraints -- is essential in order to respect the rights of people using mental health services. Coercion is harmful in terms of both physical and mental health. It alienates people away from mental health and support systems. Moreover, many persons with mental health conditions and psychosocial disabilities have experienced trauma in their lives. When violence, coercion and abuses occur in mental health services, not only does the service fail to help people but they compound the original difficulties by retraumatizing people using the service *(164)*. Once considered a ‘necessary evil’, there is a growing evidence base to support the implementation of non- coercive practices *(21, 165)*.

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

### Promoting and protecting the right to free and informed consent

The right to informed consent is a fundamental element of the right to health. It encompasses the right to consent to, refuse or choose an alternative medical treatment *(166)*. In general, all adults have the right to refuse any treatment, even if that treatment would be lifesaving. The CRPD requires that persons with mental health conditions and psychosocial disabilities are able to enjoy this right on equal basis with others *(167)*.

Legislation can ensure the right to consent to treatment is respected, protected and fulfilled within mental health services, including in challenging situations such as when persons are experiencing crisis or severe distress (see section 2.3.3), so that all support and treatment is provided voluntarily. For example, legislation can state that persons with mental health conditions and psychosocial disabilities have right to free and informed consent on an equal basis with others, and no mental health treatment shall be given without the free and informed consent.

In addition, legislation can ensure that persons using mental health services have access to the information and support required to understand and weigh up the treatment options, including potential benefits and side effects, to make a truly informed decision (see sections 2.1.5 and 2.2.3). This includes the chance to nominate a support person to make decisions about their health and medical treatment. Everyone, including persons with mental health conditions and psychosocial disabilities, should be given the opportunity and support to write advance directives to anticipate future support needs and express in advance their preferences (see section 2.3.2).

As a general rule in health care services, no medical treatment or procedure can be performed without the person’s informed consent. Only exceptionally healthcare professionals can provide treatment without consent; for example, when a person needs emergency treatment to safe their life and is unconscious or unable to communicate their will. In such cases, it is assumed no one would want to be denied necessary medical care under those circumstances. It should be noted, however, that most patients in emergency settings, including those with traumatic injury, do not require immediate intervention to prevent death or serious harm and have the capacity to provide consent *(168)*.

This exception is regularly applied in a discriminatory manner when it comes to persons with mental health conditions and psychosocial disabilities; either because they are not recognized as having the capacity to provide their informed consent, or because mental health crises are immediately treated as life-threatening medical emergencies. In this regard, legislation must not discriminate against persons with mental health conditions and psychosocial disabilities by setting a different standard for mental health crises.

Another common exception to informed consent, particularly used in mental health care, is the lack of ‘capacity’ or ‘competency’ to provide consent. As noted, this exception is contrary to the CRPD. When the will and preferences of the person in relation to a health care treatment cannot be ascertained by any means, and there are no advance directives, medical procedures should not be administered unless necessary to save a person’s life or prevent irreparable harm to their physical health.

Children and adolescents also have the right to consent to or to refuse treatment, including admission to a mental health inpatient services, as expressed by themselves and not a third party, in accordance with their age and maturity. Legislation can ensure children and adolescents with disabilities have the right to consent or refuse treatment on an equal basis with other children and have access to appropriate support to realize that right (see section 2.2.5). The consent of adolescents to mental health care and support should be always obtained, whether or not the parent or guardian consents *(164)*.

**Box 22. What the law can say**

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

#### Prescription of psychotropic drugs

Countries can adopt a higher standard for the informed consent to psychotropic drugs given their intrusive nature and potential risks of harm in the short and long term *(169, 170)*. Countries, for example, can require written informed consent after providing detailed information on potential negative and positive effects, and the availability of alternative treatment options.

Legislation can also require medical staff to inform about the right of service users to discontinue treatment and to receive support for that. Support must be provided to help people safely withdraw from drug treatment.

**Box 23. What the law can say**

* The prescription of psychotropic drugs is regulated by the technical and ethical standards that govern medical activity and requires informed consent.
* The prescription of psychotropic drugs shall be carried out within the framework of interdisciplinary approaches.
* Medical professionals have the obligation to inform persons using mental health services of the possible risks, harms and side effects in the short, medium and long term associated with the proposed psychotropic drugs, and of the right to initiate a process of discontinuation and to be supported to do this safely.
* The prescription of psychotropic drugs should only respond to the fundamental needs of the person and will be administered exclusively for therapeutic purposes and never as punishment, for the convenience of third parties, or to meet the need for therapeutic support or special care.
* The indication and renewal of the prescription of psychotropic drugs can only be carried out based on the pertinent professional evaluations and never automatically.
* A medical practitioner shall not administer psychotropic drugs in a dosage that, having regard to professional standards, is excessive or inappropriate.
* A medical practitioner shall ensure the monitoring for negative effects and put in measures to ensure safety including discontinuation of the drugs.
* The health authority shall report annually on the availability of psychotropic drug discontinuation programs.

#### Other specific safeguards

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

Significant controversy surrounds the use of electroconvulsive therapy (ECT) and its associated risks *(171)*. In Slovenia and Luxembourg, ECT is not available *(172)*; and in many countries, there has been a dramatic decline in its use *(173)*. Moreover, there are calls to consider banning ECT altogether *(174, 175)*. If permitted, ECT must only be administered with the informed consent of the person concerned. International human rights standards are very clear that ECT without consent violates the right to physical and mental integrity and may constitute torture and ill-treatment *(77)*. People being offered ECT should also be made aware of all its risks and potential short- and long-term harmful effects, such as memory loss and brain damage *(176, 177)*. Moreover, it should only be administered in modified form, i.e., with the use of anaesthesia and muscle relaxants. ECT is not recommended for children, and hence this should be prohibited through legislation.

Psychosurgery is another contentious procedure in mental health care history. While today ‘lobotomy’ or ‘leucotomy’, a form of psychosurgery, is hardly performed, it was carried out on more than one hundred thousand people with mental health conditions and psychosocial disabilities around the world in the mid-20th century, causing severe irreparable brain damage and, for many, death *(178)*. Nowadays, psychosurgery continues to be practiced in very rare occasions, albeit not without controversy, for the treatment of cases which do not respond to medications or therapy. Many jurisdictions prohibit certain forms of psychosurgery altogether, or their use in certain populations (e.g., children, prisoners) *(179)*.

Performing psychosurgery and other irreversible mental health treatments should be prohibited without free and informed consent. Furthermore, in view of the irreversible nature of certain treatments, legislation may provide an additional level of protection to consenting service users by making it mandatory that an independent review body, or similar safeguard, sanction the treatment. The review body should interview the candidate, ensure that they have given their informed consent after being provided with comprehensive and detailed information on risks, possible complications harmful impacts and side effects; and review their medical history and records.

Some countries may also consider specifically banning certain interventions which are not deemed safe or disproportionately affect persons with mental health conditions and psychosocial disabilities.

**Box 24. What the law can say**

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

#### Medical research and experimentation

Article 7 of the ICCPR prohibits clinical and experimental research without informed consent. This article, which is echoed by article 15 of the CRPD, is a non-derogable provision; the protection can never be limited even under conditions of national emergency. The Committee on Economic, Social and Cultural Rights has also stressed that freedom from non-consensual medical treatment and experimentation is part of the content of the right to health *(180)*.

Although some pre-CRPD, non-legally binding instruments introduced exemptions to the prohibition of conducting research or experimentation without consent, the Human Rights Committee has made it clear that ‘no justification or extenuating circumstances may be invoked to excuse a violation of Article 7 for any reasons’ *(181)*. The CRPD Committee has also contested exceptions to the prohibition of medical experimentation for the purpose of scientific research in several of its concluding observations *(182-186)*.

Legislation therefore should prohibit medical or scientific research without informed consent. This includes research on persons with mental health conditions and psychosocial disabilities.

Informed consent obtained through supported decision-making (see section 2.2.4) shall be subjected to appropriate safeguards to ensure the respect of the person’s rights, will and preferences.

**Box 25. What the law can say**

* No one shall be subjected without their free consent to medical or scientific experimentation.
* Informed consent for medical or scientific experimentation provided through supported decision-making shall be subjected to appropriate safeguards to ensure the respect of the person’s rights, will and preferences.

### Advance planning

Advance planning is a form of supported decision-making which allow individuals to express their will and preferences beforehand, so they can be followed at a time when they may not be in a position to communicate them. Advance plans are sometimes called advance directives or living wills, and they are used in different domains, from healthcare to end-of-life and social care decisions.

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

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

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

Legislation can also make advance planning documents binding. In many countries a healthcare professional is not required to follow an advance decision in certain circumstances, including situations involving involuntary commitment (see section 2.3.3). For example, in Germany, living wills are binding and allow people to refuse or limit specific treatments in advance, including hospitalisation. In case of ambiguity, the will of the person must be established based on their previous statements, believes and personal values *(187)*. Legislation should only allow for advance decisions not to be followed where there are clear signs of undue influence or coercion (e.g., the advance directive was concluded under duress or undue influence), or total lack of practicability of the advance decision (e.g., the proposed treatment or procedure is not feasible).

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

**Box 26. What the law can say**

* Every person of legal age shall have a right to make advance directives with regard to health care interventions specifying any or all of the following, namely: (1) the way the person wishes to be supported and treated; (2) the way the person wishes not to be supported or treated; (3) the individual or individuals, in order of precedence, they want to appoint as their nominated representative or supporter to make or communicate decisions on their behalf. The document shall state the moment or circumstances in which the advance directives enter into force.
* An advance directive may be made by a person irrespective of their past mental health diagnosis or treatment.
* An advance directive can be expressed in written documents or expressed by a recording in video or audio formats.
* A person retains the right to make healthcare decisions directly after the advance directive has been drafted.
* An advance directive may be modified or revoked at any time by the person concerned. Any new decision related to mental health care and treatment shall over-ride any previously written advance directive.
* An advance directive shall be binding on all providers of medical services who apply medical procedures.
* Mental health services have the duty to inform service users of their right to make an advance directive, provide information related to it, and ensure access to support for developing them.
* Mental health practitioners who adhere to advance directives and respect the will and preference of service users will not be held legally responsible for any unsatisfactory outcomes that may occur and will be indemnified from any unforeseen consequences arising from adhering to advance directives.

**Box 27. Self-biding advance directives**

To deal with the question of how to resolve potential contradictions between the will at the time of making an advance directive and the will at the time of crisis, some jurisdictions allow individuals to insert self-binding clauses authorizing mental health services to act over their objections to a pre-determined directive during a crisis. These are often called ‘Ulysses’ clauses or contracts. The individual can revoke the ‘Ulysses’ clauses, but through a special procedure that may be difficult to perform during a mental health crisis.

Some argue that these self-binding directives would allow individuals who have experience of episodic crises to better anticipate some of the potential problems in implementing their advance directives and avoid unwanted consequences of a crisis *(188)*. Others consider that their legalization poses a risk for all service users, since people using mental health services may be pressured to establish this type of clause, leading to a legitimization of coercion.

This remains an area in progress where more research, practice and engagement with people with lived experience are needed to understand all human rights implications.

### Support in mental health crises

Legislation can establish a positive obligation to provide access to support to people experiencing mental health crisis (e.g., hallucinations, restlessness, agitation, self-harm, aggression, threatening harm). Nowadays, most crisis intervention happens in emergency departments or psychiatric hospitals which often serve to exacerbate a crisis rather than resolve it *(189, 190)*. Traditionally, this is dealt with under mental health laws or general health laws, which contain provisions on involuntary hospitalization or psychiatric emergencies. These procedures are either inherently coercive or assume that there are no alternatives to the use of coercion.

Legislation can establish a framework for crisis support to eliminate the use of coercion. The law can provide for the implementation of community-based crisis support services, hotlines and respite services, which can offer support and counselling to people in crisis situations, twenty-four hours a day, seven days a week, helping to de-escalate conflicts and minimize the need for hospitalization. The WHO Guidance on community mental health services: Promoting person-centred and rights-based approaches showcases a selection of mental health crisis services that provide effective care and support for people experiencing acute mental distress, while respecting their legal capacity and other human rights, and without resorting to the use of force or coercion *(21)*.

The law may regulate the composition and functions of crisis support services. These services should also aim to eliminate the need for law enforcement involvement in mental health crisis. Moreover, based on the past and ongoing systematic harms to service users by mental health systems, it is important to ensure non-medical options for crisis support. The literature on crisis intervention indicates that providing individual non-medicalised support carries significant value to service users *(190, 191)*. Therefore, the law can mandate the availability of non-medical crisis support services, for example, by supporting the financing of peer-run crisis services managed and staffed by persons with lived experience (see section 2.5.3).

Legislation can also set up basic principles and guidelines for crisis intervention, applicable for any service provider, such as respect to legal capacity, conflict de-escalation, non-judgemental and open communication, flexibility, continuity of support, peer involvement, harm reduction, temporary respite accommodation, and practical response to basic needs *(192, 193)*. Respecting someone’s legal capacity should not mean giving up or neglecting someone experiencing a crisis. Rather, instead of being coerced into mental health services, as is currently often the scenario, people should be actively reached out to and offered support in crisis situations.

Legislation can establish mandatory training for all first responders, such as firefighters, emergency healthcare workers, community workers or crisis workers, who are among those responsible for going immediately to the scene of an emergency or crisis and being the first point of contact to provide assistance.

**Box 28. What mandatory training can cover:**

* Respect for legal capacity
* Rights-based approaches to crisis intervention
* Zero-coercion strategies
* De-escalation and communication techniques
* Rights of persons with mental health conditions and psychosocial disabilities
* Intersectional and life course approaches

**Box 29. What the law can say**

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

### Prohibition of involuntary hospitalisation and treatment

As explained in chapter 1, a significant number of countries maintains legislation on mental health regulating coercive practices, such as compulsory hospitalisation and forced treatment and medication. In addition, general exemptions to informed consent in health laws are often applied in a discriminatory manner, facilitating coercive practices during mental health crises. The CRPD Committee and other human rights mechanisms have asserted that all coercive practices in mental health services are prohibited under the CRPD.

To ensure a complete paradigm shift of mental healthcare away from coercion, in addition to advance directives and crisis support, legislation should clearly prohibit all involuntary measures and mandate that all services, regardless of whether they are provided on an outpatient or inpatient environment, implement non-coercive interventions. No country has yet eliminated all forms of coercion in mental health systems, but there is evidence that legislative changes can help prevent involuntary commitment *(68, 194, 195)* and support moving in this direction.

On most occasions, the availability of community-based services, advance directives, supported decision-making and appropriate crisis support will help to successfully resolve a crisis. In exceptional cases, however, they may be insufficient to de-escalate situations. While some have suggested that these are the sole cases for which some form of coercion should be authorized *(196)*, experience shows that even when laws seek to regulate the most exceptional cases, the use of coercion is still normalized, and coercion rates do not decrease *(68)*.

Against this background, governments should commit by law to a ‘zero coercion’ policy which embraces a non-coercive approach and addresses difficult circumstances case by case. Such a policy is particularly important because there cannot be a ‘one size fits all’ solution for a complex situation. For example, if the person is suicidal, first responders trained in suicide prevention can provide ongoing support to the person and eliminate access to lethal means. Appropriate support and follow-up can be provided to avoid a life-threatening outcome. Similarly, through de-escalation and conflict resolution, crisis intervention services can help to eliminate the need for law enforcement involvement in those few occasions where a threat of violence may exist. Even if de-escalation fails and a situation of violence arises, crisis intervention teams could provide protection against interpersonal violence and support law enforcement to ensure the person is safely taken into custody where the person could be offered appropriate accommodations and support *(197)*. Any breaches to such no-coercion policy should be dully assessed and used as a learning opportunity to improve service provision.

In many countries, community treatment orders have been introduced as a way to reduce the need for hospitalization. Community treatment orders are legal orders made by courts which mandate service users to continue outpatient mental health medication and treatment *(86)*. However, overwhelming evidence indicates that community treatment orders do not work; there is no evidence of decrease in hospitalization nor benefits for persons using mental health services *(86, 198, 199)*. On the contrary, the use of such forms of coercion raises human rights concerns and can lead to significant abuses as documented by the UN Special Rapporteur on the rights of persons with disabilities *(200)*. Countries should review their legal frameworks to repeal community treatment orders.

While the law can play a critical role in ending coercion in mental health care, system transformation, community attitudes and accountability mechanisms are indispensable to ensure services free of coercion.

**Box 30. What the law can say**

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

**Box 31. Responding to challenging and complex crisis situations**

There is an aphorism in law that says, ‘hard cases make bad law’, which aims to convey the idea that highly unusual or difficult-to-solve cases are ill-suited to be used as the basis of general rules. However, in the field of mental health, it is common to present complex and challenging situations, often referred to them as ‘hard cases’, as evidence that a total paradigm shift from substituted decision-making to supported decision-making is not possible, particularly in the context of mental health provision.

These examples, regularly used in legal and clinical discussions, include cases where an individual is suicidal, the individual is behaving aggressively or violently, or when the individual is experiencing psychosis, or has intense support needs. The traditional medical framing of these cases as ‘hard cases’ fails to acknowledge that these complex and challenging situations are often the result of the failures of existing mental health systems, many of which are unable to adequately respond to trauma, distress and crisis.

***A person who is suicidal***

When a person is threatening immediate harm to themselves (e.g., threatening to cut themselves or jumping out of a building), traditionally, legislation will consider them at risk to themselves and therefore authorize the use of coercion. First responders, often police officers and firefighters, will intervene to contain the situation. This may include the use of physical or chemical restraints. The person will then be taken to an inpatient service where, in many cases, they will be involuntarily admitted and kept for many days, even weeks. On many occasions, due to risk considerations, the person will be placed in a seclusion room at the beginning of their stay. Forced administration of psychotropic medication is also common. The person may even be required to appear before a judge to demonstrate their ability to consent or refuse treatment. All these experiences can have a profound traumatic effect when the person most requires support and understanding.

Under a rights-based approach, first responders will be prohibited to use coercion. Instead, crisis services will be mandated to intervene, helping to de-escalate the situation and offering support. They can provide supportive communication and ensure a personal connection through listening and practical and non-judgemental support. Once the immediate crisis is resolved, depending on their will and preferences, the person could be referred to an inpatient service, to a respite service or go home with appropriate support. Responses will be flexible depending on the needs of the individual, and there will be no need for judicialization. A support plan could be put in place bringing together people and community resources, including people’s close networks, to ensure continuity of care. Since having or lacking ‘mental capacity’ is irrelevant for crisis support services, no one would be left to perish based on such considerations. Moreover, as this approach does not undermine trust in services, the person is less likely to become alienated from the service.

Unsuccessful suicide attempts would be dealt with as any other medical emergency, taking immediate action to preserve life and prevent further harm if the person is not in a position to communicate their will and preferences (e.g., the person is unconscious due to overdose or injury) *(193)*.

***A person is threatening violence or behaving aggressively or violently***

Due to the dominance of the biomedical approach, some behaviours that occur during a mental health crisis are considered a risk to the physical safety of others. For example, when a person is agitated, raising their voice, pacing or slamming doors. On some rare occasions, these behaviours may involve the use of threats and violence against people or property.

To respond to this, legislation on mental health often provides that those with a mental health diagnosis deemed at risk of harm to others can be involuntarily admitted to an inpatient mental health service. Usually, the police will intervene, arrest, and take the person to such facilities. In too many instances, police intervention will further aggravate a crisis situation leading to injuries and fatalities. Once inside the service, the person will be restrained or isolated for several days, even weeks. Again, forced administration of psychotropic medication will be considered, and legal safeguards will be triggered to review the length of the stay. Depending on the jurisdiction, this may lead to a community treatment order. It is also possible that the police may not consider it a ‘mental health’ case and instead channel the person into the criminal justice system.

Under a rights-based approach, crisis services will be the first ones to intervene to de-escalate the situation and prevent further violence instead of the police. Experienced community-based crisis teams will engage with the person aiming at establishing effective dialogue and conflict resolution. These teams will be aware that aggression may be triggered by internal, interpersonal, or external experiences, including anxiety, frustration, neglect, fear, threats, and traumatic experiences. This includes the fear of being involuntarily committed to a psychiatric service. To carefully listen to the person, engage with them in a meaningful dialogue, and understand where they are coming from is thus key. Crisis support services can also help prevent further violence by facilitating the security of people threatened by the situation of violence and cutting off access to lethal means. Once the immediate crisis is resolved, people could be offered various care and support options, and continuity of care will be ensured. If the intervention is successful, the individual will not have to engage with the criminal justice system.

***A person experiencing psychosis or with intense support needs***

When a person is actively experiencing psychosis or has advanced dementia, or intense support needs, in most jurisdictions, these individuals are deemed to lack the capacity to make decisions. Therefore, their legal capacity will be restricted. If medical interventions are needed, a judge, a doctor or a family member, depending on the urgency of the case, will act as substituted decision-makers and decide for them based on their ‘best interests’. If the person disagrees, the use of force can be authorized, including physical and chemical restraints.

Under a rights-based approach, these persons would retain their legal capacity and should be supported to express their will and preferences. For example, if a medical or surgical intervention is needed, the person could receive accessible information concerning all the risks and alternatives and make a decision for themselves through supported decision-making. When supporters cannot ascertain the person’s wishes by any means, the best interpretation of will and preferences standards may be considered (see section 2.2.4).

However, a significant challenge is dealing with situations when the person refuses a necessary medical procedure to end a painful condition (e.g., toothache) or refuses an intervention for a medical emergency that could result in serious health consequences or even death (e.g., appendicitis), even though they express the desire to end the pain or prevent their health from getting worse. A mistake would be to jump to a conclusion based on the best interpretation of their will and preference, and forcibly treat the person. A rights-based route will be to conduct a support needs assessment involving the person and their support network to understand how to support the person better (see section 2.3.6). A lot of work, time and flexibility may be needed, so the person understands the nature and need for the procedure. Also, adjustments may be required to ensure the person is comfortable with some procedures, such as having trusted people present or dosing and spacing the required medical interventions so that they are easier to cope with.

These cases are not straightforward, and solutions will have to be evaluated on a case-by-case basis. Sometimes there will be no optimal solution. However, approaches can be changed to better ensure respect for the rights of persons in crisis. By applying a paradigm shift to these difficult cases we can develop best practices to solve them. The WHO Guidance on community mental health services: Promoting person-centred and rights-based approaches (2021) provides examples of good practice services around the world and recommendations for integrating such services into national health and social care systems and services *(21)*.

### Eliminating seclusion and restraint

There is a growing consensus that all forms of restraint and seclusion in mental health services should be eliminated. Seclusion entails locking or confining a person to a space or room, while restraint involves one of a number of actions with the purpose of controlling a person’s physical movement or behaviour (e.g., mechanical, physical, or chemical restraint) *(201)*. Apart from being contrary to international human rights law, the use of seclusion and different forms of restraint is not therapeutic, is incompatible with a recovery approach and is contrary to the purpose of care *(202)*. Furthermore, they can also lead to physical and psychological harm and even death *(203-205)*.

Legislation can prohibit the use of seclusion and restraint in any health or social care facility. For example, countries as varied as Italy, India, Peru and Mexico have banned the use of seclusion or solitary confinement from their mental health systems. In the case of Mexico, the prohibition expressly includes restraints *(206)*. To reinforce this shift, countries will need to develop and reorganize their mental health services, as it is often a lack of resources, training and awareness that lead to the use of these interventions. Service culture change, comfort rooms, de-escalation strategies and response teams could be implemented. There are always alternatives to seclusion and restraint *(202)*.

Coercion also takes place outside hospitals in community based mental health services, residential facilities, family homes and the community in general. For example, the practice of shackling persons with mental health conditions and psychosocial disabilities has been documented in various countries *(38)*. Coercion within the community, including shackling, should be banned by law. For example, in India, the Mental Healthcare Act 2017 explicitly prohibits people with mental health conditions and psychosocial disabilities from being ‘chained in any manner or form whatsoever’ *(207)*. In Indonesia, Law No. 18 of 2014 on Mental Health considers shackling as a criminal offence *(208)*.

Especially because they are prohibited, any and all episodes of physical restraint and seclusion should be recorded and made available to the independent monitoring body (see section 2.7.2). Debriefing of incidents of restraints and seclusions, in collaboration with persons with lived experience, should be promoted. Legal provisions can support the investigation of such incidents, including all those concerned so authorities can take corrective action, including the provision of redress.

**Box 32. What the law can say**

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

### Care process redesign

Ending all forms of coercion in mental health services requires rethinking admission and treatment processes. Traditionally, mental health care processes have been designed taking hospital admission as a starting point and two possible routes: voluntary and involuntary admission. Hence, the emphasis has been on whether the conditions for voluntary or involuntary internment are met, such as diagnosis, determination of mental capacity or risk to self or to others, and availability of less restrictive alternatives. However, if services embrace a community-based approach that respects legal capacity and facilitates supportive, non-coercive interventions, a different pathway needs to be envisaged.

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

In addition, mental capacity and risks assessments should be replaced by an assessment of support needs. The purpose of such assessment should be to find out what the person wants, what support the person already has in place (e.g., if there is an advance directive or an appointed supporter for such cases) and the psychosocial and practical support the person may require in the concrete situation. This assessment could be carried out by the mental health team or the crisis support team. For example, during a crisis, assessing the person’s support needs can help to determine if the person wants to go to an inpatient mental health service, a community crisis house, or simply be supported to stay at home.

Based on the support needs assessment, mental health services should provide service users with a range of support and treatment options, such as crisis services, community centres, peer support, hospital-based services, or combination of them.

### Decriminalization of suicide

Suicide prevention is an international priority. More than 700 000 people lose their life to suicide every year *(209)*. Reducing the global suicide mortality rate by one third by 2030 is both an indicator and a target of the Sustainable Development Goals. As part of these efforts, the WHO has developed the LIVE LIFE approach to suicide prevention, which prioritizes four interventions: limiting access to the means of suicide; interacting with the media for responsible reporting on suicide; fostering social and emotional life skills in adolescents; and early intervention for anyone affected by suicidal behaviors *(209)*. It is important that all suicide prevention measures embrace a rights-based approach *(210)*.

Legislation that criminalizes suicide or suicide attempts is not only contrary to human rights, but also hampers the implementation of suicide prevention strategies and interventions. Although most countries have decriminalized suicide, suicide remains illegal in number of countries, in addition to those where suicide is punishable under Sharia law *(211, 212)*. Penalties stipulated in the laws range from fines to imprisonment. As a result, people who have attempted suicide can be arrested, which deters people from seeking support. Decriminalization of suicide attempts can help to reduce stigma, ensure appropriate support and facilitate a more accurate collection of suicide-related statistics for better informed policy responses.

Several countries have de-criminalised attempted suicide in recent years. In India, the Mental Healthcare Act 2017 prevails over section 309 of the Indian Penal Code which criminalises attempted suicides. In 2019, attempted suicide was also decriminalised in Singapore, when section 309 of Singapore’s Penal Code was finally abolished. More recently, the Cayman Islands decriminalised suicide in December 2020.

There is no evidence that decriminalization increases suicides; on the contrary, suicide rates tend to decline in countries after decriminalization *(211)*. Furthermore, criminalisation is associated with higher suicide rates in women *(213)*.

**Box 33. What the law can say**

* Suicide attempts shall not be subjected to criminal prosecution.
* Mental health systems shall plan, design, and implement rights-based suicide prevention programmes.

## Access to quality mental health services

As mental health is an integral part of health, the right to mental health is equally an integral part of the right to health, as recognized by the International Covenant on Economic, Social and Cultural Rights (art.12) *(92)*. Legislation can play an important role in improving the enjoyment of the right to mental health by increasing availability of services; improving geographical, physical, financial, and information accessibility; providing services that are acceptable, respect medical ethics and are gender-responsive and culturally appropriate; and ensuring services are of adequate quality.

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

### Parity between physical and mental health

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

Legislation can reinforce the recognition of an enforceable right to mental health at national level. This could be attained by recognising mental health as a component of the right to health or by explicitly recognising a right to mental health. This would provide people with the opportunity of invoking this right in national courts, which is particularly relevant in legal systems where international law is not automatically applicable. In addition, as the right to health is an inclusive right, the recognition of a right to mental health can facilitate better protection of its essential elements (e.g., availability, accessibility, acceptability and quality). Furthermore, it can facilitate the development and implementation of policies and regulations aimed at guaranteeing access to person-centered and rights-based mental health services and approaches.

Legislation can also put mental health on par with physical health as a way to ensure equal access to mental health services and equal efforts to improve the quality of care. Legislation may state that people using mental health services should receive care and support of, at least, equivalent quality and standards as individuals receiving other types of medical treatments. For example, the United Kingdom Health and Social Care Act 2012 created an obligation to deliver ‘parity of esteem’ between physical and mental health, which helped to ensure further commitments and action to ensure that mental health is valued equally and on the same terms as physical health *(214)*.

Health insurances may also be required to apply equitable funding principles for mental health and physical health. For example, in the United States of America, state and federal laws have attempted to address discriminatory practices in health insurance by creating requirements around parity. In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) requiring comprehensive standards for equitable coverage of mental health care and coverage of medical/surgical treatment. The Patient Protection and Affordable Care Act of 2010 (PPACA, Public Law 111–148) further expanded the reach of the parity laws by requiring most health plans to cover mental health care and expanding the scope of MHPAEA *(215)*.

Recognizing an unambiguous right to mental health and valuing mental health equally with physical health can be a step forwards in building consensus about the priority of mental health and ensuring that human rights obligations related to the right to mental health are taken seriously.

**Box 34. What the law can say**

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

### Financing of mental health

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

Depending on the health financing scheme of the country, legislation may establish earmarked funds for mental health care, or progressive budget targets in their health budget aimed at increasing mental health investment. For example, in Argentina legislation establishes a minimum budget target for mental health care in the health budget *(216, 217)*. While less common, legislation can also order prioritization of investment on mental health services, parity with investments in other areas of health, or levy or taxation for mental health care funding *(218)*.

Where this is possible, it is advisable to indicate where resources should be spent, thereby ensuring investments are made in services and supports that align with human rights requirements and enabling adequate provision in areas such as community mental health care and services and supports that address the full range of social determinants impacting on people’s mental health *(21)*. In this way, legislation may help to re-direct funding from psychiatric institutions to community-based services and to ensure the availability of funding to be provided to concrete strategies and plans of action for deinstitutionalization (see section 2.5.4).

Adopting legislation related to increasing the resources committed to mental health might make legislators cautious about its financial implications; however, there is a strong economic argument for mental health investment. Without explicit financing mechanisms, mental health will lag behind other health priority areas of States.

**Box 35. What the law can say**

* Budget allocation for mental health care shall progressively increase to the maximum of its available resources, within a clear time frame.
* Funding for mental health care shall be included in the budget lines of each level of government (e.g., local and regional authorities).
* Budget increases in mental health funding shall be geared towards community-based services and support.
* Budget allocation for services and interventions contrary to international human rights standards is prohibited.
* Sufficient funding shall be allocated to sustain programs that address social determinants of health.
* Budget allocation shall be governed by transparency, accountability and participation mechanisms.

### Affordable and equitable access to mental health care

Legislation can play an important role in ensuring affordable and equitable access to mental health care. Disparities in service provision and access to mental health care are very common within and among countries. Identity and demographic factors, such as race, ethnicity, sex, gender, age, disability, sexual orientation, socioeconomic status, nationality, migrant status, and geographic location, can all affect a person’s ability to access mental health care.

Legislation can function as an enabler for Universal Health Coverage (UHC) for mental health. For example, laws can create a legal mandate to include or expand rights-based mental health coverage as part of national efforts towards UHC (e.g., inclusion in national health insurance schemes or entitlement packages). Laws can also set and enforce fair rules and incentives to ensure that the health system and its actors act consistently with the goals of Universal Health Coverage (UHC) for mental health, and it can provide a means for implementing and monitoring such policies and programmes *(219)*.

Legislation can further help to reduce disparities in access to mental health care by laying down criteria for needs-based allocation of services. For example, by mandating that mental health services and supports be available, accessible and acceptable and of good quality for specific groups such as children, adolescents, women, older persons, as well as indigenous peoples, refugees, asylum seekers, and persons deprived of their liberty.

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

**Box 36. What the law can say**

* Mental health shall be integrated into all UHC strategies and policies and shall be free or affordable to all.
* National insurance schemes shall guarantee access to person-centred and rights- based mental health services and supports.
* All health insurance plans, regardless of insurance company, shall cover mental health services, including person-centred and rights-based community-based support, outpatient and inpatient services, and access to psychosocial interventions, psychological therapies, and psychotropic drugs.
* Persons living in poverty, destitution or homelessness are entitled to mental health services and support free of charge and at no financial cost.
* Refugees and asylum seekers are entitled to access to mental health services and support on an equal basis with others.

### Gender-responsive mental health care

Gender differences have an impact on the experience of mental health conditions and care in mental health services *(220)*. Legislation can help to promote gender-responsive mental health services by requiring mental health care to be informed by knowledge and understanding of the differences between women, men, transgender and intersex individuals, including life experiences (e.g., violence and abuse); day-to-day social, cultural, and family realities; expression and experience of mental health conditions; and care and support requirements and responses.

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

Legislation can also ban harmful and discriminatory practices against girls, women and lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) people in the context of mental health service provision, including forced sterilization, forced abortion, forced contraception, and menstrual suppression. Conversion therapy to change a person’s sexual orientation, gender identity, or gender expression should be also banned. Mental health services should not serve as a gatekeeper for the restriction of sexual and reproductive health and rights. Laws should protect the rights of intersex children and ban unnecessary and irreversible medical or surgical treatment without their informed consent.

**Box 37. What the law can say**

* No one shall be discriminated against with respect to community-based support, outpatient and inpatient mental health services, or mental health treatment, based on their sex, gender, age, actual or perceived diagnosis, membership to a minority or any other ground.
* Mental health services uphold the right of users, wherever possible, to request a staff member of their preferred gender if desired.
* Women in an inpatient mental health service shall have separate sleeping accommodation from men.
* The sexual and reproductive health and rights of girls, women, and sexual and LGBTQI+ persons shall be respected and protected in all circumstances.
* Sterilization without the free and informed consent of the person is prohibited.
* Conversion therapies to change a person's sexual orientation, gender identity, or gender expression are prohibited.

### Age-appropriate mental health care

Legislation can contribute to ensure age-appropriate mental health care and support, which are necessary to safeguard the rights of children, adolescents and older persons.

Legislation can provide for age-appropriate mental health services, for example, the separation between adults and children, access to suitable recreational areas for children and adolescents, physical accessibility for older persons, among others. It can also ensure access to services and programmes geared towards protecting children who are being subjected to, or are at risk of, adverse childhood experiences.

Admission to a mental health service is a stressful experience for children and their families and should be avoided. Instead, community support should be available for children and adolescents to be supported at home and within their communities.

**Box 38. What the law can say**

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

### Culturally-appropriate mental health care

Understandings and experiences of mental health are also culturally bound *(221)*. However, services offered to racial and ethnic minorities and indigenous people, particularly refugees, asylum seekers and migrants, are often culturally inappropriate and do not take into account their healthcare experiences and requirements. For example, racial and ethnic minorities often experience coercive practices at higher rates, which is linked to the legacy of colonial mental health laws, responsible for the creation of harmful stereotypes in mental health care settings *(222)*.

In this regard, legislation can help to shape culturally safe and appropriate responses by providing for the provision of culturally appropriate information, support and interpreter services, as well as more diverse recruitment practices and training for staff on culturally appropriate services and supports.

**Box 39. What the law can say**

* Mental health services shall provide care and support that is appropriate to, and consistent with, people’s cultural and spiritual beliefs and practices.
* Mental health services shall provide care and support which respect people’s freedom of opinion as well as their religious and philosophical convictions, and under conditions which respect their cultural development.
* Indigenous peoples and other relevant communities, as appropriate, shall be engaged and consulted in the design and implementation of mental health services.
* Culturally-appropriate advocacy support shall be provided for service users of all ethnic backgrounds and communities.
* A person shall access mental health care in a language that they understand and be provided with interpretation services, including sign language interpretation, if necessary. This obligation includes psychosocial interventions.
* A person admitted to inpatient services shall be able to continue religious or spiritual practices.
* Training of health staff to combat implicit racial and ethnic bias shall be implemented.
* Increased affirmative recruitment and training of mental health and social care staff who represent racial and ethnic groups that have historically been marginalized shall be implemented.
* Mental health systems shall collect information related to the use of mental health services related to racial and ethnic groups that have historically been marginalized.

### Training for healthcare and social care providers

Training is an important investment for developing person-centred and rights-based mental health services and support. Human rights education and training can help healthcare and social care providers to align with a rights-based approach. It could cover different essential topics, such as the right to health framework, international human rights standards, the recovery approach, the respect for legal capacity, the elimination of coercion, amongst others. The WHO QualityRights initiative has produced evidence-based materials for training, guidance and transformation of mental health services from a rights-based perspective *(20)*. It has also developed an e-training program on mental health, recovery and inclusion, which should be completed for all health and social care providers *(16)*.

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

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

**Box 40. What the law can say**

* Mental health professionals, workers, and other service providers shall undergo capacity building, reorientation, or training to develop their ability to deliver evidence-based, gender-responsive, culturally appropriate and human rights-based mental health services, with emphasis on human rights, person centred, recovery models and the community and public health aspects of mental health.
* The curriculum of medicine and other healthcare and graduate programmes shall include mandatory training on human rights and rights-based approaches to mental health care and support.
* Persons with mental health conditions and psychosocial disabilities shall be directly involved in the co-development and delivery of training.

## Implementing mental health services in the community

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

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

### Integration of mental health in general health care settings

Legislation can reinforce the introduction of mental health interventions, services and supports in the first levels of healthcare, particularly primary healthcare, consistent with the principle that mental health should be put on an equal footing with physical health.

Primary healthcare is most often the first level of contact of individuals, the family and community with the national health system. Integrating mental health into primary healthcare is the most viable strategy for improving access for underserved populations, ensuring that anyone can access mental health services early and near their homes and communities *(223)*. This increases the likelihood of recovery and promotes community inclusion. It can also help in reducing the stigma associated with seeking help from centralized and institutional mental health services *(224, 225)*. The law can help ensure access to mental health services in the community by mandating the provision of person-centered and rights based mental health approaches in primary healthcare.

Legislation can also help to improve the availability of specific mental health goods and services at the primary care level. For example, legislation can ensure that psychotropic drugs are as available and accessible as medication for other medical conditions while ensuring a higher standard for informed consent and safe prescribing, and support for discontinuing psychotropic drugs (see section 2.3.1). Similarly, legislation can help to improve access to psychosocial interventions such as counselling, specific psychotherapies, peer support, and social services delivered at primary care level.

Furthermore, legislation can promote the creation of mental health services in general hospitals. In many countries, hospital-based services for mental health care have historically been provided in large, inpatient facilities such as psychiatric hospitals or social care institutions. People in such facilities often stay for extended periods of time, sometimes for many years. Moreover, these settings are often isolated from other general health services and from the rest of the community and associated with extensive coercive practices and human rights violations. Mental health services in general health hospitals, when provided as part of a range of services and supports in the community, can ensure that people receive care and support that is responsive to their requirements and respects their human rights.

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

**Box 41. What the law can say**

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

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

While integration of mental health in general health systems is important, the paradigm shift from a biomedical model towards a human rights model requires the transformation of service provision to develop a range of holistic community-based, person-centred, recovery-oriented options, in line with Articles 19 and 25 of the CRPD. Community-based care services are better than hospital-centred models because they are more accessible, efficient and effective *(226, 227)*. Governments can promote or reinforce these processes by embedding them into legislation.

Indeed, in many countries, legislation has been the starting point for service transformation. Some laws have mandated the reform of mental health systems towards a community-based model. In Brazil, for example, Act No. 10.216 of 6 April 2001 (“Provides for the protection and rights of people with mental disorders and redirects the mental health care model”) was key to redirect resources from psychiatric institutions to the community.

Legislation can also promote the development of person-centred and rights-based community services by stipulating that a range of mental health and support services must be made available in the community. For example, the law can provide for the implementation of community mental health centres, which provide support outside of an institutional setting and in proximity to people’s homes; crisis response services, which help to support people experiencing acute mental distress (see section 2.3.2); community outreach services; or peer support services (see section 2.5.3). All these need to be provided within a rights-based approach

In some countries, legislation may establish that the provision of mental health care should be undertaken primarily at community level or that inpatient services should be provided, on a voluntary basis, only if it can be shown that community-based treatment options are not feasible or have failed. In Vermont, in the United States of America, the Department of Mental Health is obliged under state law (18 V.S.A. § 7256) to report annually regarding the extent to which persons using mental health services receive care in the community.

Legislation can also help to uphold person-centred and recovery approaches by recognizing them as key principles for mental health care. A person-centred approach places people at the centre of the service and acknowledges individuals as persons rather than ‘patients’ *(228)*. As opposed to biomedical approaches, the attention is on the ‘whole person’, not their mental health diagnosis. Therefore, support should be tailored to their needs and unique circumstances, guided by what the person wants out of life.

Similarly, services adopting a recovery approach are not primarily focused on ‘curing’ people or making them ‘healthy’ or ‘normal again’, but on supporting people to identify what recovery means to them. In this way, they support people to gain or regain control of their identity and life, have hope for the future, and live a life that has meaning for them whether that be through work, relationships, community engagement or some or all of these. Moreover, they acknowledge that mental health and wellbeing does not depend on being ‘symptom free’, and that people can experience mental health issues and still enjoy a rich and full life *(21)*. With these approaches in place, it becomes possible to ensure that human rights are upheld.

**Box 42. What the law can say**

* The health authority shall initiate a process of reform of the mental healthcare system in order to implement a community-based model of care. Resources from psychiatric institutions and hospitals shall be progressively reoriented to community mental health services.
* Mental health care shall be carried out primarily at the community level, outside inpatient settings, in order to avoid the removal of people from their communities and to facilitate their recovery and social inclusion.
* The creation and development of person-centred and rights-based community mental health centres, crisis response services, community outreach services, day hospital services, peer support services, among others community-based services and support shall be prioritised.
* Provision of inpatient care in general hospitals shall only be carried out when it provides greater therapeutic benefits than the rest of the interventions that can be carried out in the family, community or social environment, and based on the free and informed consent of the person concerned.
* Mental health services shall be guided by the principles of person-centredness and recovery, participation, community inclusion, non coercive approaches and respect for legal capacity. Mental health services shall collaborate with other sectors to provide a holistic approach and facilitate access to social services and support.

### Integration of peer-led and peer-run services

Peer-involvement in the provision of support are a touchstone of transforming mental health systems as people with lived experience bring understanding, trust and hope to services. Peer support services can help individuals to achieve and maintain wellness and social inclusion, and to navigate the mental health and social system more efficiently *(229)*. Depending on the country context, peer-involvement could take many forms, from peer-support specialists to independent peer-run services.

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

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

**Box 43. What the law can say**

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

### Deinstitutionalization

Deinstitutionalization is an important aspect of the transformation of mental health systems. It involves the closing of long-term psychiatric and related social institutions, as well as the development of person-centred and rights-based mental health services and supports and other levels of community support, such as housing assistance, home support, peer support and respite services. Under article 19 (b) of the CRPD, countries have a positive obligation to prevent isolation or segregation from the community and, therefore, close all institutions for persons with health conditions and psychosocial disabilities.

In some countries, these processes have been initiated or reinforced through legislation. In Italy, the aforementioned law known as Basaglia Law, strengthened the deinstitutionalization process initiated during the 1960s by establishing a ban on building new psychiatric hospitals and on admitting new patients to existing ones. More recently, legislation in Argentina, Uruguay and Mexico prohibited the creation of new psychiatric hospitals in an effort to shift towards community mental health *(206, 230, 231)*.

Legislation can promote the adoption of deinstitutionalization action plans with clear timelines and responsibilities as well as concrete benchmarks and budget lines. An explicit prohibition of institutionalization can serve as an important deterrent against trans-institutionalisation, or moving persons from one institution to another under the guise of deinstitutionalisation. Provisions that facilitate or enable institutionalization should be also abolished.

Legislative measures needed for deinstitutionalization must be accompanied by the obligation to ensure access to the necessary community-based services and networks to realize the right of people with mental health conditions and psychosocial disabilities to live independently and be included in the community (see section 2.8.2).

Governments should consider a person-centered approach, so community services and individualised supports are in place to take on people leaving institutions. It is important to establish substantive and procedural safeguards to ensure the safety and health of beneficiaries as well as timely access to avoid a situation where people are left without support. Experience shows that ill-conceived and under-resourced deinstitutionalization processes could be counterproductive and detrimental to human rights *(232)*.

**Box 44. What the law can say**

* The creation of new asylums, psychiatric hospitals, neuropsychiatric hospitals or monovalent institutions, social care institutions, public or private, is prohibited.
* The health authority, in coordination with other relevant sectors and service users, shall implement a policy for the deinstitutionalization of persons placed in all kinds of institutions, including the adoption of a plan of action with clear timelines and responsibilities, concrete benchmarks and adequate budget, a moratorium on new admissions, and the development of adequate community support.
* Existing institutions must shift their operations to restore the autonomy and choice of residents and ensure the objectives and principles of person-centred and rights-based community-based mental health, until their definitive replacement.
* Every health or related social facility with long-term inpatient residents shall create a deinstitutionalization committee, with representation of service users.
* Mental health systems shall collect information from mental health and related social care services that have either an inpatient psychiatric unit or emergency department receiving service users with mental health conditions and psychosocial disabilities.

### Redistributing financial and human resources

Deinstitutionalization and the development of a robust set of community based mental health services involves more than simply relocating individuals into the community. It demands adequate person-centred and rights-based community support and services for which the redistribution of public funds from institutions to community services is required. The WHO Mental Health Atlas 2020 reports that over 70% of mental health budgets in low and middle-income countries, and 35% in high income countries, go to mental hospitals *(29)*. Costing analysis have also shown that hospitalization costs often exceed the costs of ‘equivalent’ treatment, care and support in the community *(21)*. In this context, legislation can help to underpin the redistribution of financial and human resources from institutions to community services.

Legislation can introduce financial incentives for the development of person-centred and rights-based community mental health services, as well as reduce or eliminate incentives and financial payments for long-term inpatient care and services delivered by psychiatric hospitals or social care institutions. Financial incentives can also help to eliminate coercive practices such as seclusion and restraints *(21)*. In the United States of America, for example, the Community Mental Health Act of 1963 (Law 88-164) contributed to the transformation of the mental health system by shifting resources away from large institutions towards community-based mental health programs. The Community Mental Health Act provided grants to states for the establishment of community mental health centres under the purview of the National Institute of Mental Health.

Legislation can also help correct distortions created by health insurances. In some countries, for example, health insurances may not include coverage for psychosocial interventions, community-based services, or inpatient services. If an insurance only covers medication but not therapies, because the former is cheaper than the latter, it creates a perverse incentive to choose pharmacological treatment over therapy. Similarly, if health insurance only finances inpatient services, there is a little chances community-based services will be developed. Other perverse incentives are created by having case-based payments or reimbursements for inpatient stays but per capita funding for community mental health services.

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

**Box 45. What the law can say**

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

### Implementation within humanitarian contexts and emergencies

Many people affected by conflict situations and humanitarian emergencies experience trauma and psychological distress as a result of related stressful events such as violence and loss, as well as poverty, discrimination, overcrowding, and food and resource insecurity *(233)*. Persons with mental health conditions and psychosocial disabilities are particularly vulnerable to these negative psychosocial effects due to the cumulative impact of the structural discrimination and social exclusion they face, which can curtail their access to basic needs and support they need. This is particularly the case of those placed in institutions, who are often unable to leave the institutions during humanitarian crises, and whose situation tends to become more restrictive and precarious in such times. For example, the COVID-19 pandemic has shown that, apart from the increased risk of infection, people in psychiatric and social care institutions have experienced a higher risk of confinement, overmedication, minimized human contact, no social visits, and no monitoring *(234)*.

Governments can improve the mental health and psychosocial well-being of all affected people, including those with mental health conditions and psychosocial disabilities, by integrating rights-based mental health and psychosocial support into humanitarian and emergency responses. Legislation can help to ensure mental health and psychosocial support is available in emergencies; for example, during disaster situations, pandemic outbreaks, and other complex situations.

In some countries, refugees and asylum seekers may also receive inappropriate mental health care and support. For instance, they may not be granted the same coverage or quality of services as citizens of that country. This amounts to discrimination and violates article 12 of the ICESCR, which ‘recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’. Legislation can stipulate that refugees are entitled to the same mental health care as citizens of the host country.

**Box 46. What the law can say**

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

## Ensuring full and effective participation in public decisions

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

The transformation of mental health systems requires recognising all members of society as rights-holders and ensuring all persons with mental health conditions and psychosocial disabilities have the opportunity to contribute to making mental health care and support more responsive to their needs and hold authorities accountable for their duties in regard to their rights.

This section proposes key legislative provisions to recognize and support the right of people with mental health conditions and psychosocial disabilities, including people using or have previously used services, to participate in all public decision-making process concerning mental health. These provisions can be included in disability laws, laws on civil participation, as well as general health acts and existing mental health laws.

### Recognizing the right to be actively involved and consulted in decision making

According to article 4 (3) of the CRPD, governments have an obligation to closely consult with and actively involve persons with mental health conditions and psychosocial disabilities through their representative organisations in decision-making processes concerning issues relating to them. To fulfil this obligation in the context of mental health care, countries can adopt legal and regulatory frameworks to ensure the full and equal involvement of people using services, as well as their representative organisations, in public decisions concerning issues related to mental health provision, including legislation, policies, strategies and action plans.

Legislation can explicitly require that government authorities consult closely with and actively involve persons with mental health conditions and psychosocial disabilities in the development, implementation and monitoring of legislation and policies concerning mental health care and support. This can include open consultations as well as direct engagement with representative organisations of service users. Countries should not require an organization of people with lived experience to be registered as a prerequisite for taking part in consultation processes *(235)*.

Countries can adopt legislative provisions granting organisations of persons with mental health conditions and psychosocial disabilities seats on, for example, mental health standing committees, temporary task forces, or monitoring bodies (see section 2.7.1).

To facilitate participation and meaningful engagement, legislation can give priority to the views of organisations of persons with lived experience themselves when addressing issues related to mental health *(236)*.

**Box 47. What the law can say**

* Authorities shall closely consult persons with mental health conditions and psychosocial disabilities, and their representative organisations, in the development, implementation and monitoring of legislation and policies concerning mental health care and support.
* Authorities are mandated to involve and consult people using services in planning, service delivery, and evaluation of mental health and support programmes and services.
* Consultation processes shall be developed under the principles of accessibility, good faith, opportunity and transparency.
* Authorities shall facilitate awareness, training and support to maximise the involvement and participation of service users, people with mental health conditions or psychosocial disabilities
* Policies and procedures to ensure the participation of persons with mental health conditions and psychosocial disabilities in the relevant committees, including adequate funding and compensation, shall be adopted.
* Registration should not be a precondition for organisations of persons with mental health conditions and psychosocial disabilities to take part in consultation processes.

### Implementing accessible and fair consultations

To guarantee that the voices of persons with mental health conditions and psychosocial disabilities are taken into account, it is not enough to recognize the right to participation in decision-making, it is necessary to ensure that consultation processes are accessible and fair.

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

Countries can adopt legislation to ensure that the views of persons with mental health conditions and psychosocial disabilities are given due weight and are not only heard as a tokenistic approach to consultation *(237)*. For that purpose, legislation can mandate to take into account the results of consultations and reflect them in the decisions adopted, as well as to inform of the outcome of consultations and duly motivate public decisions. Consultations should aim to ensure representation of the diversity among persons with mental health conditions and psychosocial disabilities and consider intersectionality.

**Box 48. What the law can say**

* Consultations shall be based on principles of transparency, mutual respect, meaningful dialogue and a genuine desire to reach consensus.
* No one shall be discriminated from a consultation on the basis of disability, race, sex, gender, origin, opinion or other status.
* Authorities shall guarantee the accessibility of all facilities and procedures related to public decision-making and consultations.
* Invitations and documents for consultation shall be sent as far in advance as possible so participants can make arrangements to attend and prepare appropriately.
* Reasonable accommodation shall be provided in all dialogue and consultation processes.
* Children with mental health conditions and psychosocial disabilities shall be provided with disability and age-appropriate assistance to allow them to participate in decision-making processes.

## Ensuring accountability

Accountability is critical for ensuring both efficiency and a human rights-based approach in mental health care. It obliges duty bearers to take responsibility for their actions, to be transparent and answer to those concerned, and to ensure that appropriate corrective and remedial action is taken *(238)*. When mental health services are held accountable to the people using the services, it helps ensure better performance and consistency with a rights-based approach.

This section proposes key legislative provisions to ensure and enforce accountability within mental health services. Most of these provisions could be introduced in general health laws, disability legislation or existing mental health acts.

### Information systems

Information systems must guarantee access to information and privacy. Access to information is a key component of accountability; transparency of decisions and decision-making on adopted policies, programmes and protocols, as well as data and information measuring their outcomes, are key to holding duty bearers to account. Transparency in mental health services enables monitoring and empowers service users in their roles- both as sources of information on services, and as active participants in scrutinizing, denouncing, and advocating for redress through legal and policy reform and the enforcement of sanctions.

On the one hand, mental health services have an obligation to collect, compile and disaggregate data and proactively publish and disseminate information publicly, including in accessible formats. This allows for the assessment of policy implementation by examining practice such as admission rates, duration of stays, diversity and use of services, incidents of death, training of staff and user satisfaction and contributes to tracking progress, identifying implementation gaps and, in effect, to adapt policy and practice to enhance service delivery.

On the other hand, access to information is a right that can be exercised individually to obtain information relating to one’s own records (see section 2.1.4), and both individually and collectively to obtain information on decision-making and practices by public authorities that have not been publicly disclosed. In many countries, such requests can be submitted through freedom of information requests.

**Box 49. What the law can say**

* Data should be collected, disaggregated, compiled and disseminated, including in accessible formats, on the use and range of mental health services.
* Any person has the right to request information or to consult or obtain a copy of documents concerning public mental health authorities, bodies or services.
* Information on decision-making by public authorities concerning mental health and related services should be made available including transparency of reasons behind decisions, submissions and inputs considered and participation in decision-making.

### Independent monitoring bodies

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

Legislation can determine the mandate and composition of these mechanisms to ensure institutional, financial and political independence. It is also necessary to decide whether to have a framework with national jurisdiction or to have a number of bodies functioning at local, district or regional levels based on existing administrative boundaries. In order to advance the objective of eliminating involuntary admission and treatment in mental health services, countries may require a revision of the functions of existing review bodies and courts which oversee such processes.

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

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

Countries will determine the composition and number of representatives of these mechanisms based on the functions assigned to them and the availability of human and financial resources. Nonetheless, given the nature of the work, they should include service users, professionals (e.g., in mental health, human rights, legal and social work), advocates, lay persons, among others. Women and representatives from minority groups should be adequately represented.

### Implementing effective remedies and redress

Service users should have the right to report complaints and initiate legal proceedings concerning any aspect of mental health provision. This includes any human rights violation committed in the context of such services.

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

Complaint mechanisms and investigations should also be responsive to each individual, taking into account their gender, age, disability and membership to marginalized groups to guarantee that survivors of gender-based violence are able and willing to come forward safely *(239)*. In particular, specific measures, training and guidance should be in place to enable reporting and filing of complaints and to prevent their dismissal by law enforcement authorities based on gender, disability or other stereotypes. Investigations and ensuing proceedings must be conducted in an environment that provides supports and accommodations to ensure the complainant’s participation throughout processes and averts any risk of re-victimisation and re-traumatisation.

Service users should have the right to choose and appoint a personal representative or a legal counsel to represent them in any appeals or complaints procedure. They should also have access to support and procedural accommodations throughout all stages of the procedure, if necessary. When appropriate, complaint procedures should provide for anonymity and confidentiality.

Legislation can also ensure that complaint adjudicators, such as national human rights institutions or courts, provide remedies that are individually tailored and include redress and reparation for the harm suffered. Victims should be entitled, whenever possible, to restitution, compensation, rehabilitation and guarantees of non-repetition *(240)*. The decisions arising out of these mechanisms should also be expressed in accessible language and copies given to service users and their counsel. When publicizing the decisions of the complaints, due consideration should be given to respecting the right to privacy of complainants and third parties. Persons with mental health conditions and psychosocial disabilities should have the right to judicial review of such decisions.

**Box 50. What the law can say**

* Any service user or the nominated representative they themselves have appointed, shall have the right to complain regarding failures in provision of care, treatment and services in a mental health service to,— (a) the medical officer or mental health professional in charge of the service and if not satisfied with the response; (b) the monitoring body; and, if not satisfied with the response; (c) the health authority; without prejudice to the right of the person to seek any judicial remedy.
* Complaint mechanisms apply for violation of individuals’ rights in a mental health service or by any mental health staff.
* Service users shall be provided with reasonable and procedural accommodations and support to access complaint mechanisms.
* If a person receiving treatment at a mental health service dies or is the subject of an injury or a notifiable incident, an independent inquiry into the circumstances of the death, injury or incident shall be conducted immediately.
* Complaint adjudicators shall provide adequate remedies and redress to victims.

### Professional responsibility and liability

Service providers play an important role in transforming mental health for all and ensuring a rights-based approach is embraced across the system. As part of this role, they have an obligation to respect the rights of persons using mental health services well as the existing legal framework. When a law is transgressed, legislation should provide for effective civil, administrative or criminal sanctions and reparations. Such sanctions should be proportional to the gravity of the offences, the severity of the harm and the circumstances of each case. It is up to each country to determine the system for health and non-health related offences and penalties to be adopted for their national legislation. The determination of such sanction systems must be accompanied by education on the responsibilities and obligations of service providers, including health professionals, taking into account the need for training in human rights (see section 2.4.7).

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

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

**Box 51. What the law can say**

* A health practitioner or a mental health professional shall not be held liable for any unforeseen consequences as a result of following national procedures to implement non-coercive evidence-based interventions.
* A health practitioner or a mental health professional shall not be held liable for any unforeseen consequences upon following a valid advance directive.
* A health practitioner or mental health professional shall not be held liable for not following a valid advance directive, if they have not been given a copy of the valid advance directive or it is materially impossible to implement.
* A health practitioner shall be held liable for failing to offer available non-coercive mental health care options, thereby falling short in upholding their duty of care.

### Developing indicators

Indicators are increasingly used by public authorities as a tool to measure and track the implementation of adopted laws, strategies or policies, thereby strengthening transparency and accountability. They can be used to assess the availability, access, acceptability and quality of mental health services, as well as their human rights compliance. Indicators can also help determine if policy measures are having a positive or negative effect and, thereby, if policy change is needed.

By calling for disaggregation of data, indicators can help to identify gaps in access to services experienced by different groups, thus exposing patterns of exclusion and discrimination. This enables evaluation and monitoring of the impact of measures and generates evidence for informed policy reform.

Although legislation is not the best way to define evaluation indicators, it can establish the obligation to develop indicators to measure, evaluate and review the performance and impact of mental health systems, as well as progress towards implementing human rights in the context of mental health. For example, reporting on indicators can be required as part of periodic review processes, including reporting to international and regional human rights monitoring bodies and donors. Indicators can also be used to monitor resource allocation as well as consultation and participation in public decision-making by persons with mental health conditions and psychosocial disabilities.

The WHO Guidance on community mental health services: Promoting person-centred and rights-based approaches (2021) provides a series of indicators at population, service and individual levels, both within and outside the health sector *(21)*. The OHCHR has also developed human rights indicators on the CRPD as a tool to facilitate understanding and implementation of its provisions, which can serve as a reference to guide actions and measures to be taken in implementing a rights-based mental health system *(241)*.

**Box 52. What the law can say**

* The mental health authority shall develop indicators designed to measure and assess the performance and impact of mental health systems at the national and sub-national levels, as well as progress towards implementing person-centre and rights-based approaches.

## Key cross-sectoral reform for holistic service provision

As highlighted above, mental health and wellbeing are influenced by multiple social, political, economic and environmental factors, and have far reaching consequences in all aspects of our lives. As such, mental health services alone are not sufficient to bring about a real transformation in the lives of people with mental health conditions and psychosocial disabilities *(21)*.

Many people with mental health conditions and psychosocial disabilities have fewer opportunities in education and employment, and face discrimination when it comes to housing, social benefits, and access to justice. Having access to the full enjoyment of these services on an equal basis with others, is a fundamental human right, as well as being an essential component of living a meaningful life and participating fully in one’s community. As such, it is important to develop services that engage with these important life issues in a substantial way and ensure that all services and supports available to the general population are also available, accessible and of good quality for those with mental health conditions and psychosocial disabilities *(21)*.

Making this a reality is not the primary responsibility of the health sector but of other sectors, such as the labour, social protection, and justice sectors. Legislation on mental health can help ensure cross-sectoral coordination so that people using mental health services can receive the support they need from other sectors, thereby addressing the social determinants of mental health. In this regard, this section proposes key legislative provisions which deal with the interface between mental health and the social and justice sectors. However, as has been pointed out throughout the Guidance, other legislative reforms are necessary to achieve the inclusion and full participation of people with disabilities. It is not the role or the intention of this Guidance to address them.

### Promoting community inclusion

Living independently in the community is a human right which most people take for granted. However, many persons with mental health conditions and psychosocial disabilities have this right systematically denied, either because they live in an institution or because they do not have appropriate support to participate in social and public life.

Article 19 of the CRPD recognizes the equal right of all persons with mental health conditions and psychosocial disabilities to live in the community, with choices equal to others, and calls on governments to take effective and appropriate measures to implement this right. Most of these measures fall outside the scope of intervention of mental health services and relate to other sectors and programmes. However, it must be acknowledged that the impact of mental health laws, policies and programmes, has commonly impeded the enjoyment of this right by denying choice of, and the availability of services in the community. This has given rise to the legacy of institutional-based care, isolation, segregation and the perpetuation of stigma and discrimination against this population. Therefore, promoting the social inclusion of persons with mental health conditions and psychosocial disabilities should be a key goal of mental health systems and should contribute to the enjoyment and exercise of the right to live independently and be included in the community, on an equal basis with others.

The following sub-sections propose legislative provisions which aim to promote inclusion and active participation of persons with mental health conditions and psychosocial disabilities in their communities. Many of these provisions can be located in legislation on disability, social care or social protection, and should be complemented by wider legislative efforts to implement article 19 of the CRPD.

### *Recognition of the right to live independently in the community*

Countries should adopt legislative measures to recognize the right of persons with mental health conditions and psychosocial disabilities to live independently in the community, including the opportunity to choose where and with whom they live and not to be forced to live in a particular living arrangement such as a residential institution or a psychiatric hospital.

Although fulfilling the right to live independently and to be included in the community of people with mental health conditions and psychosocial disabilities should not be the sole responsibility of the health sector, mental health systems have an obligation to respect and protect this right, in addition to take positive action to facilitate the enjoyment of basic human rights. The explicit recognition of this right is not only a key condition for its justiciability, but a gateway for communities to seek and develop alternative services and supports for their members, based in the community.

Additional legal reform may be needed to facilitate the access of persons with mental health conditions and psychosocial disabilities to community-based services and support outside the health system. For example, in Israel, the Rehabilitation in the Community of Persons with Mental Disabilities Law of 2000 provides a package of services and programs which includes housing, employment, adult education, social and leisure time activity, assistance to families, dental care and case management. Legislation can further ensure persons with mental health conditions and psychosocial disabilities are not discriminated against by services, programmes and facilities in the community destined for the general population or specifically for persons with disabilities.

**Box 53. What the law can say**

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

### *Multisectoral coordination and action for mental health*

The lack of support and social services in the community is one of the main reasons for institutionalization as well as critical gap for addressing social determinants of mental health. The fragmentation of support and social services and, in particular, the strict separation between health and social care, often leads for some people to fall through the cracks. This especially affects those belonging to disadvantaged or marginalised groups.

Due to the existing correlation between mental health conditions and disadvantage, including poverty, unemployment, and homelessness *(242)*, the mental health systems of many countries have developed programs that seek to address these needs. Many of these programs are successful, but there is always the risk that interventions, being anchored in the health system, are permeated by a medicalised approach. In addition, in many cases, such services are segregated and, although they solve people’s urgent support needs, do not promote their active participation in all areas of community life.

A cornerstone of a mental health system based on choice and human rights is the existence of a diverse range of community support and social services, such as of housing, employment programmes, personal assistance, disability benefits and other social protection programmes, which should be provided by the respective sectors but with a mental health perspective. In this way, the response to mental health issues is integrated into the work of the State as a whole, with greater opportunities to create a society that values, promotes, and supports mental health and well-being.

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

From a health sector perspective, legislation can help to clarify the role of the health sector in relation to the unmet needs of persons with mental health conditions and psychosocial disabilities. The law can help to ensure people using mental health services are referred to other support and social services with proper follow-up and monitoring. Multisectoral coordination for the provision of holistic care and support can help to better respond to people’s changing needs and goals, improve transitions of care, and maximise available resources. The involvement of implementation and monitoring bodies created under article 33 of the CRPD can help ensuring a paradigm shift in care and support.

**Box 54. What the law can say**

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

### *Supporting organisations of persons with mental health conditions and psychosocial disabilities*

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

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

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

**Box 55. What the law can say**

* A mechanism to support the creation and functioning of organisations of persons with mental health conditions and psychosocial disabilities to represent them at national, regional and local levels shall be created.
* Organisations of persons with mental health conditions and psychosocial disabilities shall be provided access to appropriate and sufficient funding to support their activities.
* Organisations of persons with mental health conditions and psychosocial disabilities shall be able to register as legal entities on an equal basis with others.
* Authorities shall promote the participation of persons with mental health conditions and psychosocial disabilities in disability organisations and associations with strict respect of their independence.

### *Supporting families*

Families have an important impact on the lives of persons with lived experience. In many contexts they are the main source of support and in some cases, they are their only advocates. But family support often comes at a high cost. Unpaid family support can affect social relationships, income levels and the general well-being of the household *(243)*. This disproportionately affects women and girls who are, in practice, the main providers of support. In addition, when families are the sole source of support due to the lack of alternatives, persons with mental health conditions and psychosocial disabilities may have no choice or control over the support they receive.

Legislation can create an obligation to offer information and services to families providing informal support. Families may need support to understand mental health experiences in a positive way and to know how to support their family members with mental health conditions and psychosocial disabilities while respecting their will and preferences.

Legislation can also mandate governments to establish specific support services for families, such as financial assistance, respite services, support groups, counselling or training. It is important, however, that support to families does not replace support directed to individuals, and that individuals have access to support that serve their own interests and requirements in accordance with their will and preferences and independent from those of their family.

**Box 56. What the law can say**

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

## Access to justice

Far too many persons with mental health conditions and psychosocial disabilities are denied equal access to justice. Many are prosecuted and imprisoned, often for relatively minor offences. Others are denied the opportunity to go to court to seek justice for the systematic violations of their human rights. In general, they are regularly conferred afforded less substantive and procedural due process protection, which often results in denial of justice, incarceration, and forced treatment *(244)*.

Transforming the justice system to ensure that people with mental health conditions and psychosocial disabilities can exercise their rights on equal basis with others, albeit key to the goals of equity, social justice and inclusion that mental health systems must pursue, is an objective that goes beyond this Guidance. However, there is no doubt that mental health and justice systems interwine, in particular in the context of criminal law. In most countries, persons with mental health conditions and psychosocial disabilities are overrepresented in the criminal justice system. Prisoners with mental health conditions and psychosocial disabilities are often victimized. Moreover, those deemed unfit to stand trial or of comprehending their criminal actions are usually placed in mental health facilities, under strict rules and closed environments, sometimes indefinitely. Legislation on mental health often lays down procedures for dealing with these situations, including within forensic mental health systems.

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

### *Recognizing and supporting legal capacity to access justice*

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

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

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

In this regard, justice and criminal law should recognize and assume the full legal capacity and right of persons with mental health conditions and psychosocial disabilities to participate in the proceedings of all courts and tribunals. This involves also repealing provisions that establish and apply doctrines of ‘unfitness to stand trial’ and ‘incapacity to plead’, which prevent persons with mental health conditions and psychosocial disabilities from participating in legal processes.

To ensure their effective participation in all legal proceedings, legislation can establish an enforceable right to receive individually determined procedural accommodations. These are all the necessary and appropriate modifications and adjustments in the context of access to justice, where needed in a particular case, to ensure the participation of persons with disabilities on an equal basis with others *(245)*. Unlike reasonable accommodations, procedural accommodations are not limited by the concept of “disproportionate or undue burden” *(245)*.

In this way, people can rely on the necessary adjustments and supports to: (i) understand the nature and object of the legal proceedings; (ii) understand the possible consequences of the proceedings; and (iii) communicate effectively with legal counsel. For example, intermediaries or facilitators can facilitate clear communication among and between persons with mental health conditions and psychosocial disabilities and courts, tribunals and law enforcement agencies to ensure safe, fair and effective engagement and the opportunity to fully participate in legal processes *(246)*.

The International Principles and Guidelines on Access to Justice for Persons with Disabilities, adopted by the Special Rapporteur on the rights of persons with disabilities, the Committee on the Rights of Persons with Disabilities and the Special Envoy of the Secretary-General on Disability and Accessibility in August 2020, provides examples on how to provide procedural accommodations in the criminal justice system *(4)*.

To guarantee the right to a fair trial, legislation can also ensure free or affordable legal assistance to persons with mental health conditions or psychosocial disabilities in all legal procedures related to their fundamental rights *(247)*. Legal assistance must be competent and available in a timely manner.

**Box 57. What the law can say**

* All persons with mental health conditions and psychosocial disabilities shall have access to justice on an equal basis with others. No one shall be denied access to justice on the basis of mental health or psychosocial disability.
* Persons with mental health conditions and psychosocial disabilities enjoy legal capacity on an equal basis with others with equal standing in courts and tribunals.
* All people subject to criminal proceedings shall receive the same treatment and have the same opportunities to respond to an accusation or present a defence.
* Where necessary, persons with mental health conditions and psychosocial disabilities shall be provided with appropriate individualized procedural accommodations to exercise their legal capacity and guarantee their access to justice.
* Procedural accommodations shall include the provision of intermediaries or facilitators, procedural adjustments and modifications, adjustments to the environment and communication support to ensure access to justice
* All participants to legal proceedings shall be informed of the availability of procedural accommodations.
* No one shall be deprived of mental health care and support during criminal procedures or investigations against them.
* Persons with mental health conditions and psychosocial disabilities shall be entitled to receive free legal assistance in all legal procedures and proceedings concerning criminal matters and civil matters involving the rights to life, legal capacity, liberty, personal integrity, adequate housing, and family integrity.
* Persons with mental health conditions and psychosocial disabilities have the right to participate in the administration of justice on an equal basis with others, including as judges, lawyers, prosecutors, witnesses, jurors, experts and court officials.
* In cases involving children and adolescents with mental health conditions and psychosocial disabilities, courts shall initiate a process for determining the need for procedural accommodations and its provision. Safeguards shall be established, when necessary, according to their evolving capacities and their right to have their views heard.

### *Police involvement*

Legislation can assist in ensuring a constructive and helpful role for the police with respect to people with mental health conditions and psychosocial disabilities. The police have a primary responsibility for maintaining public order while upholding the human rights of all. In the fulfilment of its functions, police officers are often among those responsible for going immediately to the scene of an emergency or crisis to provide assistance. These interventions occasionally end in violent incidents, with persons with mental health conditions and psychosocial disabilities being seriously or fatally injured.

Legislation can help to limit police intervention in mental health crises and, when unavoidable, ensure it is free from discrimination and any use of force or coercion. For example, legislation can mandate the creation of crisis response services to provide adequate support that is unrelated to and independent of police or law enforcement involvement (see section 2.3.3).

Legislation can also increase safety in encounters with law enforcement by mandating the provision of procedural accommodations to persons with mental health conditions and psychosocial disabilities at the time of police intervention in the criminal justice process, including during an arrest if needed. Accommodations should include procedural adjustments and communication support. Police intervention must also be guided by de-escalation principles and have easy access to a crisis support service for advice.

In many jurisdictions, legislation mandates the police to take a person to an inpatient mental health service during a crisis. This aims to avoid persons with mental health conditions and psychosocial disabilities from entering police custody and the criminal justice system. However, as will be discussed in the following section, mental health diversion practices need to be implemented in line with CRPD standards.

**Box 58. What the law can say**

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

### *Diversion from the criminal justice system*

There is increasing worldwide concern about persons with mental health conditions and psychosocial disabilities being overrepresented in places of deprivation of liberty. Far too many are prosecuted and imprisoned, often for relatively minor offences. This is a by-product of many factors, among others, the existence of discriminatory legislation establishing less substantive and procedural guarantees, the implementation of laws criminalizing nuisance behavior, the widespread misconceptions about mental health and violence, intolerance in society for different, difficult or disturbing behaviour, and the unavailability or reduced availability of support services.

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

While there is a wide range of mental health diversion models across jurisdictions, they can be broadly organised under two categories: pre-booking diversion programs and post-booking diversion programs *(248)*. The former involve diversion before the laying of a criminal charge, so the individual is not charged with an offense but rather is diverted to mental health services without further criminal justice involvement. The latter involves diversion after an individual has been arrested and booked into jail or charged with a criminal offense. Mental health services play an instrumental role in the operation of both types of programs *(248)*.

The development of diversion programs is still relatively new and there is little and contradictory evidence on their effects on reducing recidivism and incarceration among people with mental health conditions and psychosocial disabilities *(248-250)*. However, there is an increasing concern among human rights and disability advocates that such diversion programs fail to address the underlying structural inequalities leading to criminalization (i.e., stigma, ableism, racism, poverty, lack of community support, etc.) and often resort to medicalised approaches and coercive practices which are contrary to their human rights *(251)*. People may stay out of prison but still be subjected to control and coercion, such as community treatment orders. Indeed, in many diversion schemes, if individuals do not comply with the treatment orders imposed, they may return to the criminal justice system. There is thus a risk to increase -- rather than decrease -- the number of persons with mental health conditions and psychosocial disabilities under state control.

There is an urgent need to rethink how to ensure people with mental health conditions and psychosocial disabilities are not inappropriately held in police custody or in prison, while at the same time not falling back to stigmatization and practices contrary to the CRPD. Countries should cautiously consider the potential benefits and harms of implementing diversion programs within their jurisdictions, and in consultation with persons with mental health conditions and psychosocial disabilities (see section 2.6). However, where considered as an integral part of broader efforts to adopt anti-carceral strategies, legislation should ensure diversion programmes:

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

Preventing at-risk people with mental health conditions and psychosocial disabilities from entering the criminal justice system requires long-term systemic change to redress the accumulated disadvantages and inequitable outcomes affecting this group. It is also important that countries review their criminal legislation to ensure that atypical behaviours (e.g., running rampant, temper tantrums, yelling or self-injury) as well as behaviours arising from and perpetuating poverty or homelessness (e.g., begging, sleeping in public spaces, loitering) are not treated as criminal activity *(252)*. As many studies have noted, there is a well-recognized relationship between poverty, homelessness and mental health conditions.

### *Criminal responsibility*

To date, the subject of the CRPD’s impact on criminal responsibility remains significantly under-examined within both disability and legal discourses. There is clear a need for reform of the criminal justice system to eliminate stigma and discrimination, provide support and accommodations and uphold the participation and rights of persons with mental health conditions and psychosocial disabilities on an equal basis with others. However, more debate, research and identification of good practices is needed to advance the reform of existing legal frameworks.

In most countries, legislation states that the mental health condition of the accused at the time of the offence has a significant bearing on whether the accused will be subject to criminal responsibility. Generally, when a court finds that the accused did not appreciate the nature, quality and consequences of their actions at the time of committing the offence due to a mental health condition or impairment, it will conclude the absence of criminal intent (*mens rea*). While this declaration may result in their acquittal, legislation may nevertheless order a ‘security measure’ – an alternative measure to criminal penalties with general preventive purposes – involving admission to a forensic facility or mandatory community treatment. The criterion of ‘dangerousness’ is usually used to assess the need for imposition of these measures *(244)*. As many have noted, the imposition of such a custodial sentence, even in a mental health facility, contradicts the principle of no punishment without guilt. In fact, in practice, people subject to security measures can spend longer periods of deprivation of liberty than those who were found guilty of the same alleged crimes; sometimes for indefinite periods.

For these reasons, many stakeholders have called for a review of criminal justice systems to ensure that persons with mental health conditions and psychosocial disabilities enjoy the same substantive and procedural guarantees as everybody else *(253, 254)*. The Committee on the Rights of Persons with Disabilities, in particular, has raised concerns over legislation related to ‘insanity’ or lack of criminal responsibility as well as security measures *(255)*. Some have proposed to replace them with the use of general criminal defences and prerequisites of criminal responsibility, such as mistake of fact, wrongful intention, self-defence, duress, or provocation, which should be available to persons with disabilities on an equal basis with others *(253)*. In addition, the Office of the UN High Commissioner for Human Rights has recommended to research alternative methods to address criminal offences by persons with disabilities, such as restorative justice schemes and non-custodial measures, in order to better comply with the purposes of redressing victims and society as a whole, and of deterring future crime.

Although more and more voices speak out in this sense, there is no consensus on how to adequately legislate systems of attribution of criminal responsibility to be responsive to the rights of persons with mental health conditions and psychosocial disabilities . This is an area that requires cautious attention and discussion, and significant input from people with lived experience. Meanwhile, it is crucial ensuring that persons with mental health conditions and psychosocial disabilities enjoy all substantive and procedural safeguards recognized in international law on an equal basis with others.

### *Prisoners with mental health conditions and psychosocial disabilities*

Legislation must recognise the obligation to provide prisoners with mental health conditions and psychosocial disabilities appropriate accommodations and support, including access to health services, including mental health services, on an equal basis with others. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to services free of charge and without discrimination *(256)*.

Legislation should also contain provisions providing prompt access to medical attention in urgent cases *(257)*. Prisoners with mental health conditions and psychosocial disabilities who require specialized treatment or surgery shall be transferred to other health facilities if they cannot be adequately treated within the prison, on equal basis with others. Such measures should be based on their free and informed consent.

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

### *Training for the administration of justice*

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

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

**Box 59. What the law can say**

* All justice officials and staff working in the justice system shall be provided with awareness-raising and training programmes addressing rights-based approaches to mental health.
* All police officers shall receive specific training in: (i) combating implicit bias, stereotyping and profiling on the basis of gender, race and disability; (ii) de-escalation principles and techniques; and (iii) procedural and age-appropriate accommodations.
* Persons with mental health conditions and psychosocial disabilities and their representative organisations shall participate in the development and delivery of all training.

# CHAPTER 3

# A rights-based process: developing, implementing and evaluating legislation on mental health

## Introduction

The way in which legislation is adopted is as important for human rights as the content of the law itself. This chapter explains how to ensure that the process of reviewing or adopting legislation related to mental health also reflects a human rights-based approach. It outlines the basic steps to be taken by countries before embarking on the drafting process, as well as the steps for drafting, adopting, implementing and evaluating legislation on mental health. Significant focus is given to the obligation of States to actively involve and consult persons with lived experience and their representative organisations.

The chapter stresses the importance of understanding the international human rights law framework prior to initiating a process of reform. It also guides readers on how to carry out a comprehensive review of legislation on mental health as well as an assessment of the main barriers to rights-based mental health care. The chapter further provides guidance on the process of drafting and debating a mental health-related legislative proposal. Entry points for advocacy and mobilization are identified, including how to ensure collaboration and engagement among different stakeholders. Finally, the chapter deliberates on the process of implementation and evaluation of the law, highlighting key issues to take into account in these processes.

As with legislative content, the legislative process will depend on national norms, customs and contexts. Important practices are outlined and discussed here, but it should be pointed out that these are only guiding principles; each country will follow its own established legal processes and procedures.

## Actively involving persons with mental health conditions and psychosocial disabilities

The process for adopting or reviewing legislation related to mental health may be initiated by government officials, a law commission or similar body, professional groups, civil society, family groups, or directly by persons with lived experience. Whichever the case, it is important to ensure active involvement of persons with mental health conditions and psychosocial disabilities and their representative organisations at each stage of the process. Their direct involvement helps to ensure that any legislative reform is built from the first-person experience and benefit from their collective experiences and knowledge.

When seeking to involve persons with mental health conditions and psychosocial disabilities in the reform process, it is important to engage directly with their representative organisations as they serve as intermediary bodies and play a key role in advocacy for their rights *(258)*. Umbrella organisations of persons with disabilities or national human rights institutions can help to identify organisations of persons with mental health conditions and psychosocial disabilities who could be engaged, always keeping in mind that civil society organizations which provide services or advocate on their behalf do not qualify as such *(124)*.

In some countries, there may be a gap in the representation of persons with mental health conditions and psychosocial disabilities. In such cases, stakeholders should reach out directly to individuals and groups of persons with mental health conditions and psychosocial disabilities, whichever way they identify, working closely with national, regional and international organisations of persons with disabilities, which may have individual members or contacts at the local level *(259)*. It is essential to make space for a diversity of voices of persons and groups with lived experience.

Some persons with mental health conditions and psychosocial disabilities may need support to actively engage in the reform process. Many people may be unfamiliar with legislative procedures or legal terminology. Also, some may not feel comfortable expressing their opinions publicly due to the dominant position of doctors and other health professionals in debates, or traumatic experiences with mental health and related services. People may also come from disadvantaged communities where their opinions are generally not sought. In this sense, it is important to ensure safe and supportive spaces that facilitate participation. In addition, capacity building and financial support may also be needed to ensure meaningful participation.

## A rights-based analysis of existing law and policy

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

In all these steps, it is important to actively involve persons with mental health conditions and psychosocial disabilities and their representative organisations.

### Studying obligations under international conventions and standards

One of the first steps is to understand States’ obligations under international human rights law. Countries that have ratified international human rights treaties have voluntarily committed to protect, respect and fulfil the rights that are enshrined in those instruments through legislation, policy and other measures. For this, it is important that training on rights-based approaches to mental health is carried out for all the actors involved in this process.

As discussed in Chapter 1, there are nine core international human rights treaties, which include the two covenants - the International Covenant for Civil and Political Rights, and the International Covenant for Economic, Social and Cultural Rights – and seven thematic treaties. The CRPD, which enshrines the human rights model of disability and is key to rethink mental health provision, has been ratified by 185 States Parties. It is therefore important that these instruments be taken into account thoroughly when legislation on mental health is being planned.

**Box 60. Understanding the human rights obligations concerning mental health**

**Core human rights instruments**

International Convention on the Elimination of All Forms of Racial Discrimination

International Covenant on Civil and Political Rights

International Covenant on Economic, Social and Cultural Rights

Convention on the Elimination of All Forms of Discrimination against Women

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Convention on the Rights of the Child

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families

International Convention for the Protection of All Persons from Enforced Disappearance

Convention on the Rights of Persons with Disabilities

**Human Rights Council resolutions**

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

**Key UN special procedures mandate holders**

UN Special Rapporteur on the rights of persons with disabilities

UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

**Other UN entities**

Office of the High Commissioner for Human Rights (OHCHR)

World Health Organization (WHO)

UNICEF

UN Special Envoy of the Secretary General on Disability and Accessibility

### Identifying barriers to rights-based mental health care

The second step is to obtain reliable information about the country’s principal mental health-related concerns and existing and likely barriers to the implementation of rights-based mental health policies, plans and programmes. There are many sources of information and evidence to understand the situation on a given country, including:

Data by country from national health information systems;

National quantitative or qualitative studies, e.g., community-based epidemiological studies;

Reports from national human rights institutions, other monitoring bodies, and domestic court decisions related to mental health;

Reports from civil society organisations, including organisations of persons with mental health conditions and psychosocial disabilities;

Other relevant reports, e.g., national reporting to treaty bodies as well as reports from the treaty body system or the Human Rights Council’s Special Procedures mandate holders; and

UN country reports, e.g., from international partners within the UN system.

It is also essential to obtain an understanding of the barriers and obstacles faced by persons with mental health conditions and psychosocial disabilities. Although legislation related to mental health is not the place to ensure CRPD implementation, it is important to identify the barriers and restrictions built into other pieces of legislation when considering legal solutions to challenges related to mental health. The examples shared in box 6, illustrate some of the key challenges that can be tackled by legislative efforts, and identifies priority areas for broader legal reform.

It would be important to hold focus group discussions involving people with lived experience and other key stakeholders to identify and understand what are the critical challenges and gaps, in particular where data is sparse or there are significant gaps in information.

### Comprehensive review of national legislation

The third step is conducting a comprehensive review of national legislation to understand whether new legislation is needed and, more importantly, to know which laws need to be reviewed or repealed due to inconsistencies with human rights obligations. Such a review should be rigorous and comprehensive, recognizing the interdependence and indivisibility of human rights.

A comprehensive review of this kind is required under States’ obligations to implement human rights treaties, including the CRPD. The review might be led by different bodies, depending on the country’s political system. For example, a special independent commission might be established to conduct the review and report to the government, or an existing body, such as a national human rights institution might be assigned the task. In some countries, the parliament might establish a committee to oversee the process or assign that task to one of its existing bodies *(260)*.

The mapping of existing mental health-related legislation will be very different in each country. Some countries have a long history of mental health legislation and mental-health-related legislation, while other countries may be developing such legislation for the first time. For countries with specific mental health laws, these laws will need to be carefully examined against the latest development on human rights standards, in particular the CRPD. In addition, components of other laws, as they relate to mental health, need to be identified and assessed. For countries with no specific mental health legislation, there are still likely to be laws that affect mental health which need to be identified and analysed. A comprehensive review of national legislation will provide an overview of the different sectors that play a role in contributing to achieve the objectives of rights-based mental health policies and programmes, and for assessing which laws may need to be changed.

Occasionally, it will be found that countries have adequate provisions in existing legislation, but that the problem really lies in their implementation. In this case there may be a need to analyse why the law is not being implemented and if there is a need to strengthen or create accountability, monitoring and complaints systems within the law. Sometimes laws are not implemented due to lack of resources allocated for its implementation. This part may also require some legislative changes.

The WHO checklist on rights-based legislation on mental health , which is a companion to this guidance, is a useful tool to help determine the strengths and weaknesses of existing legislation and identify which provisions need to be considered for inclusion in new legislation (see Annex).

### Reviewing legislation in other countries

Reviewing other countries’ legislation related to mental health and persons with disabilities can help to identity components generally covered by legislation in different countries. When examining another country’s legislation, there may be social, economic and cultural variables or factors specific to that country. Certain provisions may therefore not be applicable in one’s own country. Thus, there may be a need to modify and adapt the provisions to suit the social, economic and cultural situation of that particular country, maintaining a focus on human rights compliance.

While conducting such a review, it is important to remember that many countries still have outdated legislation, i.e., legislation which does not reflect the latest human rights standards. The review should therefore focus on countries that have enacted progressive legislation that have incorporated international human rights standards and current knowledge in the area of mental health care and support as outlined throughout this Guidance. It should also critically examine the effect of legislation in improving the situation for persons with mental health conditions and psychosocial disabilities in those countries. Reasons for failure may include poorly drafted legislation and implementation difficulties resulting from legislative provisions that do not take into account the practical realities nor the lived experiences of rights holders in the country.

A useful resource for accessing mental health-related legislation from different countries is WHO MiNDBank (https://www.mindbank.info/), an online platform bringing together country and international resources, legislation and policies covering mental health, substance abuse, disability, general health, human rights and development. The UN Department of Economic and Social Affairs has also systematized disability laws and acts by country *(261)*. It should be taken into account that available legislation in databases may not reflect the latest human rights standards.

## Drafting legislation

Once having established a good understanding of the international and national legal framework, as well as the country’s challenges in relation to mental health, a decision must be made whether to start drafting legislation or not. If the answer is yes, then there are a number of activities that stakeholders should consider, including: i) building a consensus for change, including by reaching out to potential allies and opponents; ii) the drafting process itself, differs across countries depending on their particular legislative, administrative and political structures; and iii) broadly consulting on the draft proposal with different stakeholders.

Again, in all these steps, it is crucial to actively involve persons with mental health conditions and psychosocial disabilities and their representative organisations.

### Building consensus and political will

The process of building consensus for mental health legislation should begin as early as possible so that different views can be incorporated, and subsequent implementation facilitated.

The previous chapter provided guidance on the issues that could be included in legislation or that should direct necessary amendments to existing legislation. For any legal reform to be a success, consensus needs to be built around the issues at stake. Stakeholders include politicians and parliamentarians, policymakers, government ministries (health, social welfare, law and finance), professionals (psychiatrists, psychologists, psychiatric nurses and social workers), family members, service user groups, advocacy organisations, service providers, non-governmental organisations, civil rights groups, faith-based organisations, congregations of particular communities and academic and research institutions. In some countries it may also be necessary to include community leaders and traditional healers in the process.

Consensus building and negotiation have an important role to play, not only in drafting the legislation but also in ensuring that legislation is implemented once it is adopted. A broad consensus is also necessary because a human-rights based approach to legislation related to mental health is bound to fail unless societal misconceptions, fears and ableist views relating to mental health conditions and psychosocial disability are addressed. Unfortunately, there is still considerable stigma and discrimination surrounding mental health, which, if left unaddressed will hamper implementation. As part of the process of building consensus and trust across stakeholders, it is also important to publicly acknowledge the harm caused to persons with mental health conditions and psychosocial disabilities by mental health systems. Recognising the negative legacy of the multiple human rights violations that have occurred in these spaces will help to advance in the eradication of the underlaying values and practices.

Due to a lack of understanding of the CRPD and rights-based approaches among key stakeholders, in many countries there could be resistance to advance reforms. This may lead to opposition to the legislation while it is being processed through the legislature, or even to an undermining of the legislation once it is passed. It is therefore essential that all key stakeholders -- mental health professionals, health workers, public and private service providers, the police and judicial actors, communities and families-- are appropriately informed and educated about rights-based approaches to mental health. Dedicating time and resources to advancing understanding of the human rights-based approach, well in advance of efforts to reform law, facilitates the process of drafting, adopting and implementing legislation.

### The drafting process

The process of drafting new legislation varies across countries depending on the particular legislative, administrative and political structures. Most countries will have well-established structures and processes that should be followed for developing legislation.

In some countries, a specially constituted drafting committee is appointed by the legislature, or the relevant ministry with the task of drafting the law; other countries have a law commission or a similar body that conducts this function. In countries that lack well defined structures for drafting new legislation, the ministries of health or justice can play an important facilitative role. Additionally, in some jurisdictions, provisions are in place for civil society to present a citizens’ initiative through a petition signed by a designated number of registered voters.

The crucial point is not which body drafts the legislation, but rather, that there is significant and sufficient expertise contributing to the process to ensure that the bill produced is thorough, comprehensive, reflects a human rights-based approach, adequately considers all the available relevant information and perspectives, and offers a substantive draft appropriate to the local circumstances. In this regard, if the parliament or government choose to appoint a committee or group of experts to draft the legislation, they should ensure the participation of a diverse range of actors, including organisations of persons with mental health conditions and psychosocial disabilities, and a mandate to draw on the skills of others with the relevant expertise and representing different interests.

### Consultation process

Despite the inclusiveness proposed for the development of the legislation, once legislation is drafted, it should be put forward for consultation so additional (or the same) stakeholders can provide input and influence the final legislation. The consultation process provides the opportunity for potential weaknesses of the proposed bill to be ironed out, conflicts with existing legislation and local customary practices to be rectified, issues that have been inadvertently left out to be added and solutions to practical difficulties in implementation to be identified.

Consultations can take various forms. There is a diverse range of means that can be employed for achieving maximum input and discussion. In some countries there will be a statutory process, while in others consultation is carried out on an informal basis. Nonetheless, a time-bound process that includes the following three stages should be envisaged:

1. Publication of the draft document in the government gazette or the official website of the parliament, including a call for comments and contributions from the general public. This step should be complemented with direct invitations to all key stakeholders to submit written inputs.
2. National and regional public consultation meetings and workshops to analyze, discuss and negotiate the most frequent and important objections or suggestions regarding the draft legislation. Adequate human and financial resources will be required to ensure the consultation process is inclusive, accessible and open. All comments received must be carefully considered and appropriate changes made.
3. At the end of the consultation process, the drafting body could publish a report on suggestions, objections and queries received during that process, and the drafting body's response to them. The documentation of these inputs and exchanges will serve as important records to understand the background and rationale of the final provisions of the legislation.

**Box 61. Examples of key stakeholders to invite for consultation on proposed mental health legislation**

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

If well planned and executed systematically, the consultation process has the potential to influence positively the adoption of the proposed legislation and its implementation, once enacted. Consultation provides an opportunity to raise public awareness about the experiences of persons with mental health conditions and psychosocial disabilities and their rights. It also involves the community and enhances understanding of community- and rights-based approaches to mental health. Wide consultation processes can also facilitate the creation of partnerships. All these factors increase the likelihood of effective implementation of the legislation once it is enacted.

Legislation should be written, as far as possible, in a manner that is easily accessible to the many people who may need to read it. Countries will generally have policies concerning language and accessibility requirements in which legislation must be produced. Having easy-to-read versions of the bill is important to ensure that everyone, including persons with intellectual disabilities, has the opportunity to understand it and participate in the debates.

## The legislative process

Following revision of the new law on the basis of comments received during the consultation process, the legislation is submitted to the body designated to pass laws. This is potentially, though not necessarily, a time-consuming step, and a stage when proposed legislation risks being renegotiated. It requires persuading politicians and key members of the executive branch of government and the legislature of the demand for updated legislation, and therefore of the need to devote adequate legislative time to this process.

Even if government support for a new law was established prior to the formation of the drafting body, competing political priorities may cause delays in the process, in particular due to the fact that mental health continues to figure as a low political priority in many countries.

The legislative process for adopting new laws varies in different countries, depending on their legal traditions and political systems. What follows is a description of a general process and the difficulties that may arise at different stages.

### Responsibility for adopting legislation

Parliament or a sovereign law-making body is ultimately responsible for adopting legislation in the majority of countries. In most countries, the national parliament may be the sole legislative body, while in some countries with a federal political system, states or provinces within the country may be authorized to make laws in addition to the national legislature. In the latter case, depending on the locally determined jurisdiction, laws related to mental health may be subject to national or regional jurisdiction, or both.

While for most countries a law must be passed in the legislature and promulgated before it can be implemented, some countries’ constitutions make it possible to implement changes in laws through executive ordinances or decrees issued by the government. On some occasions, such orders must have prior authorization from parliament. The order would subsequently need to be ratified by the parliament within a specified time period. If not ratified, the order would lapse and the previous legislation would apply. Such a provision may occasionally be useful in bringing about speedy implementation of legislation on mental health.

### Debate of draft legislation and its adoption

Many legislatures have subcommittees that carefully examine the legislation before it is introduced into the main legislative body. These committees often wish to receive inputs from various perspectives to assist them in making their decisions. They may hold public hearings, request specific inputs or require clarification on different aspects of the law.

The debate and adoption stage of the legislative process can be long and labour-intensive. During this stage, legislators may propose amendments to the proposed draft legislation. Ultimately, the decision to include or reject proposed amendments is the prerogative of the sovereign body, but those responsible for submitting the legislation may have to provide substantial guidance to lawmakers about the effects of the proposed amendments. Again, active participation of persons with mental health and psychosocial disabilities is key to ensure a human rights-based approach.

After having considered the legislation and made amendments, the legislative body (which may consist of more than one level or house) will then pass or reject the legislation. In most countries, this is the end of the legislative process and the adopted law is ready to be sanctioned (see section 3.3.3). However, in many countries the executive branch has the power to reject or propose changes to an approved piece of legislation. If the head of State vetoes a proposal, it must be returned to the legislative body for reconsideration.

### Sanction, promulgation and publication of new legislation

The purpose of this stage of the legislative process is to make the adopted law publicly known, and to announce it officially.

The terms used here, such as ‘sanction’, ‘publication’ and ‘promulgation’, may be different across countries, but the functions are fairly common. Sanction of the adopted law is the prerogative of the head of State. Usually, the head of State signs the official text of the law and this act signifies validation of the law. Promulgation signifies the official announcement of the adopted law by the issuing of a special Act, for example, an order on official publication of the law. Usually, the government promulgates acts of legislation. Publication means printing of the text of the law in the official government gazette. This is a necessary stage before the adopted law can come into force. As a rule, legislation cannot come into force without its official publication. In many countries there are official sources for full and authentic texts of the laws.

Sometimes, the constitution or other legal provision may stipulate a period of time after publication before the new law can come into force, often between 10 and 20 days. A longer period of time may be established in the text of the law itself or be set by the executive branch to allow for a more comprehensive preparation process.

Delays can occur at all stages, from sanction to promulgation and publication, and those responsible for carrying the law forward will need to follow up with the relevant authorities to ensure that legislation which is passed by the sovereign body actually enters the statute books and thus becomes legally enforceable.

### Mobilizing public opinion and advocating for change

Mobilizing public opinion is critical for encouraging legislators to debate and pass proposed legislation. Obtaining the support of public opinion should be initiated as early as possible through public consultations, media strategies and other activities that could provide an opportunity to raise public awareness about the proposed legislation. Workshops and seminars for key groups and organisations can be organized, where main components of the new legislation can be explained and discussed.

Persons with lived experience should play an active role in these activities. The development of a new law is a valuable opportunity to empower organisations of persons with mental health conditions and psychosocial disabilities, and the legislative process can also serve as a vehicle to educate, influence social attitudes and facilitate social change.

Another important activity to stimulate the process of amending or adopting mental legislation on mental health is to contact and advocate with members of the executive branch of government and the legislature. Members of the legislature from the full spectrum of political parties need to be informed of the challenges and gaps in the existing legislation and the implications and restrictions for the enjoyment and exercise of rights. They need to understand the background to the development of the proposed law and the principal rationale on which the draft is based, including the concerns and demands of persons with mental health conditions and psychosocial disabilities, the human rights obligations and political commitments enshrined in the international human rights and sustainable development framework, and other issues pertinent to the legislation.

## Implementation

The process leading up to implementation effectively starts from the point of conception of the reform process. Many implementation difficulties can be identified, and corrective action taken, during the drafting and consultation phase of the proposed reform.

Once legislation has been passed through the legislative process, there is usually a short period before enactment of the legislation. In some countries, there may be also a longer period before enforcement, which gives the authorities time to put in place the necessary infrastructure to implement the law. This is a critical time, as it allows for procedures to be put in place, monitoring bodies to be set up, training to take place, and to make sure that all those involved are ready to implement the legislation once it is enacted. In countries which have regulations attached to legislation, these regulations must also be finalized and signed.

Governments should adequately evaluate the impact of any new legislation related to mental health in an existing policy and take corrective measures, so the policy complies with these new rules. This includes reviewing budget allocations needed for its proper implementation.

### Importance, role and composition of bodies responsible for implementation

As with the drafting of legislation, responsibility for overseeing implementation can take various forms. The implementation of legislation on mental health, as covered in chapter 2, is not only the responsibility of the health sector. Moreover, different functions of the legislation may be undertaken and monitored by different groups. For example, if a monitoring body has been established, it is likely to be compelled, through its given functions, to oversee certain legislative requirements (see section 2.7.1). This should not, however, preclude the government itself from setting norms, standards and indicators to establish whether the provisions of the legislation are being met. These need to be monitored and evaluated, and necessary steps taken if the legislation is not being implemented.

Whatever oversight agency is established, or whichever body is given this function, it should have a set timetable, measurable targets and the necessary administrative and financial powers to ensure effective and speedy implementation. The agency may require the mandate, authority and adequate financial resources to, for example:

develop regulations, rules and procedures for implementation;

prepare standardized documentation instruments for recording and monitoring implementation;

ensure a proper process for the training of mental health, social care and other professionals, introducing certification procedures if necessary;

address human resource issues; and

monitor implementation.

In addition, there must be speedy and effective implementation of complaints procedures as provided in legislation. In particular, mental health services should make persons with mental health conditions and psychosocial disabilities aware of their rights as recognised in legislation, and of the means for using the complaints procedures to obtain redress for their grievances, if any.

The oversight or implementation body should work in close consultation with organisations of people with lived experience, including in setting targets and measuring indicators that are key to monitoring implementation.

### Developing regulations and other guidance

In many countries, laws frequently require regulations to be effectively applied and operate in practice. Regulations are published by executive branch ministries or agencies and provide guidance on how to interpret and implement the law in real-life situations. While not all laws require regulations to be enforced, the lack of regulations may compromise the appropriate implementation of new legislation.

The process of adopting regulations varies across countries. Ideally, to ensure a transparent and participatory process, the ministry in charge publishes a proposed regulation for public comment giving the opportunity to any member of the public to provide input and suggest changes. Second, the ministry reaches out to key stakeholders, for example, persons with mental health conditions and psychosocial disabilities and their representative organisations, as well as service providers and others, to carry out consultation meetings to discuss the proposed regulation and receive feedback. Third, after the comment period closes, the ministry analyses the feedback received and makes changes to the proposal to address the comments submitted. Once those changes are made, the ministry or the executive branch publishes the final regulation in the official gazette.

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

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

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

### Public education and awareness

The general public as well as professionals, persons with lived experience, and advocacy organisations working on their behalf are frequently ill informed about the changes brought about by new legislation. In some instances, they may be well informed, but remain unconvinced about the reasons for these changes and hence do not act in accordance with the law. This is especially true when legislation require significant changes to customary practices related to mental health.

Stigma, myths and misconceptions associated with mental health can represent obstacles to effective implementation of rights-based legislation. Hence, changing public attitudes constitutes an important component in implementing legislation related to mental health. Disseminating information about mental health, including information about the rights provided in new legislation, can help to change public attitudes towards mental health. Public awareness programmes need to explain why a human rights-based approach is important and applies to everyone including persons with mental health conditions and psychosocial disabilities. The media can play a useful role in this process. They can highlight the importance of respecting the human rights of persons with lived experience and assist in educating the public about the new approaches to mental healthcare and support, particularly the importance of community-based approaches.

It is critical to inform and educate persons with mental health conditions and psychosocial disabilities about the new or reformed legislation. It is vital they are well versed on what the legislation says, and, specifically, to know their rights as provided for therein. While organisations of persons with mental health conditions and psychosocial disabilities should be actively involved through the whole process of drafting, consultation and adoption of legislation on mental health, not all persons with lived experience will have been part of these processes and all will need to be informed even after the law has been passed.

In addition, publications can be developed to provide information for key actors such as health practitioners and persons with mental health conditions and psychosocial disabilities. They could give particular information about aspects of the legislation that may be difficult to understand. It could also provide detail or guidance about interpretation. Diagrams could also be developed that clearly illustrate processes, such as complaint procedures.

All education and awareness-raising initiatives should be designed and implemented with the participation of persons with mental health conditions and psychosocial disabilities and their representative organisations. Budget allocation is needed for this purpose.

### Training of stakeholders in the mental health and social care system, other sectors and the community

Thorough knowledge of the new legislation by health and other professionals is extremely important for effective implementation. As carefully as legislation may be drafted, there are invariably clauses which may be ambiguous, or where the full intent and implications are not understood. Training may enable a full exploration of each provision of the legislation and a thorough discussion of its meaning and implications.

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

Education on ensuring rights-based approaches to mental health should be incorporated into human rights education programmes in schools as well as feature as compulsory core components of tertiary and vocational education and specialised training for health and legal professionals, the police and judiciary to combat discrimination and negative stereotypes.

Training of traditional healers and faith-based organizations is also needed where they play an important role in providing healthcare and support.

### Resource allocation

The speed and effectiveness of implementation is likely to depend on the availability of adequate financial resources. Many aspects of a rights-based legislation will need adequate budgetary provision for implementation activities. For example, funds are required for making the necessary changes to the mental health and social services as required by the legislation, for providing a holistic, rights-based approach that adequately address social determinants of health, for setting up and operationalizing monitoring bodies, and for training professionals and persons with mental health conditions and psychosocial disabilities in the use of the legislation. Negotiation for this should be carried out simultaneously with the process of drafting, reviewing or adopting legislation.

In addition, new legislation on mental health usually requires a shift from institutional to person-centred and rights-based community services, and this can require additional funding. While in the long run, reallocation of funds from institutions to community-based services is feasible, this will not happen ‘overnight’, and double running costs are needed until all resources currently tied up in institutions can be released *(21, 70)*.

Adequate human resources are of particular importance for the implementation of legislation in all countries. The workforce in health and social care sectors are key to the delivery of effective mental health care and support in the community. Without sufficient numbers of staff or adequate training, person-centred and rights-based approaches will fail. In addition, investment needs to be made in training all people who have a role to play in the implementation of the law (for example, the judiciary and the police) in order to ensure that they are familiar with all aspects of the legislation, and with their own roles and responsibilities in putting its provisions into practice.

The mental health budget would also need to ensure resources also based on the different needs of different groups, such as women, children, youth, or people living in remote areas. Ensuring people’s participation in budget decisions can help ensure the right holder’s views in relation to the services and resources needed for them.

Against this background, effective implementation of new legislation on mental health will generally require increased allocation of resources for mental health and social care. The Global Ministerial Mental Health Summit 2018 recommended the proportion of a country’s health budget that should be spent on mental health is five percent (5%) for low- and middle-income countries and ten percent (10%) for high-income countries *(262)*. It is important to ‘ring-fence’ or protect new funds for mental health and those released from institutions for community-based services. At the same time, efficient and effective execution of resources, with adequate transparency and monitoring and accountability mechanisms are needed.

The WHO Guidance on community mental health services: Promoting person-centred and rights-based approaches (2021) provides guidance on taking finance-related actions to this end *(21)*.

## Evaluation

Although complaints about the poor implementation of laws or their minimal impact are frequent, it is not standard practice for governments and parliaments to devote many efforts to evaluate the impact and outcomes emerging from the implementation of legislation. Most efforts are concentrated on the work of the monitoring bodies concerned about compliance with the obligations established in the law, or that of the legislative committees which are more concerned about the gaps and contradictions in the legal system. Beyond these activities, it is important to periodically evaluate if adopted or reformed legislation on mental health is effectively responding to the objectives and needs initially sought.

### Importance of evaluation

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

Post evaluation of legislation related to mental health can allow parliaments and governments – and society in general – to know if laws adopted are fit for purpose and are achieving the desired changes to mental health and social care services, and upholding the rights, and meeting the expectations, of persons with mental health conditions and psychosocial disabilities. While the legislative process can help to identify potential implementation problems or negative effects that can be prevented, evaluation ex post can identify and track faulty or malfunctioning provisions within the law, which may require modification or abolishment *(263)*. In addition, effective implementation may be impeded by other laws or regulations and evaluation can serve to pinpoint tensions which need to be resolved through harmonisation of other legislation. Such evaluation can also help parliaments and governments to determine the need for new legislation or regulations, or policy innovations or corrections.

### Systemic and regular review of legislation

A number of factors determine how often legislation is evaluated and the way in which it is evaluated. It has been suggested that legislation should be reviewed every 5 to 10 years, but if there are problems with the content or implementation of the current law, then it should be reviewed as soon as possible. In some countries the law includes a ‘power to remove difficulties’ that allows certain changes to be made – which are not fundamental in structure and effect, but which may be necessary to enable the legislation to better serve the purpose for which it was passed – without having to engage in a formal legislative process. The mental health law in India, for example, states, ‘If any difficulty arises in giving effect to the provisions of this Act, the Central Government may, by order, published in the Official Gazette, make such provisions, not inconsistent with the provisions of this Act, as may appear to be necessary or expedient for removing the difficulty’ *(264)*.

National legislation may provide for statutory procedures for the periodic evaluation of legislation. For example, in some countries, a law commission or similar body keeps legislation under review and recommends reform where deemed necessary. In other countries, post evaluation may be mandated by the law itself and entrusted to an existing authority or special committee. Such provisions can be included in legislation to ensure a participative evaluation of legislation on mental health after a fixed period, with the active engagement of organisations of persons with mental health conditions and psychosocial disabilities. National monitoring mechanisms created under article 33(2) of the CRPD could also be involved.

Authorities with the task of monitoring legislation on mental health can also contribute to evaluation by reporting whether the law functions well or not and to propose appropriate changes.

### Evaluation criteria and strategies

The evaluation can address different aspects of law implementation. A comprehensive evaluation of legislation on mental health could assess, among other aspects:

* Impact: what the results and effects of the law are
* Relevance: whether the law responds to people’ needs
* Effectiveness: whether the law is reaching its objectives
* Efficiency: what the costs and benefits are
* Coherence: how well it works with other actions
* Equity: whether the law reduces or increases inequality

Whichever the scope of the evaluation, health and social information systems are essential. With comprehensive data collection, information systems can provide important insights about needs and outcomes, the services and other actions or initiatives being provided, compliance with quality and human rights standards. They can also help inform improvements and future courses of action *(21)*. Hence, the importance of having adequate structural, process and outcome indicators to track progress of implementation and the impact of the law in the future (see section 2.7.4).

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

# **Annex**

**Checklist for rights-based legislation on mental health**

This checklist aims to provide a simple, direct and practical way to assess the rights-based compliance, in accordance with international human rights obligations, of a mental health-related piece of legislation or draft bill, as part of legal harmonisation efforts. It sets out a range of policy questions to assist stakeholders in identifying key issues that need to be addressed to ensure rights-based legislation. These questions are not exhaustive, and it is advisable to review the guidance put forward throughout the present publication.

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

1. Not at all
2. Little
3. Somewhat
4. Much
5. A great deal

Next to the rating, a comment box is provided to allow the user to add a justification or further information linked to the rating choice.

Countries and civil society organisations are encouraged to adapt this checklist to their national context and priorities.

1. **Legislative approach**

|  |  |  |
| --- | --- | --- |
| **Statement** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation promote a cross sectoral approach to mental health? |  |  |
| 1. Does the legislation challenge stigma and discrimination associated with mental health? |  |  |
| 1. Does the legislation enable access to quality care and support that is person-centred and rights-based approach? |  |  |
| 1. Does the legislation promote the transition towards community-based mental health care and support? |  |  |
| 1. Does the legislation promote the respect for legal capacity and informed consent and the elimination of coercion? |  |  |
| 1. Does the legislation promote community inclusion of persons using mental health services? |  |  |
| 1. Does the legislation promote the meaningful participation of service users in public decision-making related to mental health? |  |  |
| 1. Does the legislation increase the accountability of mental health services? |  |  |

1. **Legislative content**
2. **Provisions to ensure equality and non-discrimination**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation prohibit all forms of discrimination in health care, including mental health services? |  |  |
| 1. Does the legislation ensure the provision of reasonable accommodation in mental health services? |  |  |
| 1. Does the legislation prevent discrimination in obtaining adequate health insurance from public and private health insurance providers? |  |  |
| 1. Does the legislation prohibit health insurance companies to discriminate on the basis of pre-existing mental health conditions? |  |  |
| 1. Does the legislation repeal inappropriate, stigmatizing and outdated terminology related to mental health and marginalized groups? |  |  |
| 1. Does the legislation mandate awareness raising activities to combat stigma and discrimination associated with mental health? |  |  |
| 1. Does the legislation afford persons using mental health services the same rights as persons using general health services? |  |  |
| 1. Does the legislation guarantee persons using mental health services the right to access information about their diagnosis and treatment without discrimination? |  |  |
| 1. Does the legislation guarantee persons using mental health services the right of confidentiality of information about themselves and their diagnosis and treatment without discrimination? |  |  |
| 1. Does the legislation guarantee persons using mental health services the right to privacy within mental health services without discrimination? |  |  |
| 1. Does the legislation guarantee persons using mental health services the right to communicate with anyone they choose without discrimination? |  |  |
| 1. Does the legislation guarantee that persons using mental health services are given information about their rights in mental health services? |  |  |
| 1. Does the legislation guarantee the provision of safe, hygienic and comfortable mental health services? |  |  |

1. **Respecting personhood and legal capacity in mental health**

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

1. **Informed consent and eliminating coercive practices in mental health care**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation uphold the right to free and informed consent within mental health services so that all support and treatment is provided voluntarily? |  |  |
| 1. Does the legislation grant children and adolescents a right to consent to or refuse treatment in accordance with their age and maturity? |  |  |
| 1. Does the legislation provide for safeguards in the prescription of psychotropic drugs? |  |  |
| 1. Does the legislation provide for safeguards against abuses in the use of specific mental health interventions, such as electroconvulsive therapy, psychosurgeries and other irreversible interventions? |  |  |
| 1. Does the legislation prohibit medical or scientific research without informed consent? |  |  |
| 1. Does the legislation provide for advance planning options and ensure its accessibility within all relevant mental health services so they can be followed? |  |  |
| 1. Does the legislation make advance planning documents binding? |  |  |
| 1. Does the legislation establish a framework for supporting people experiencing mental health crises? |  |  |
| 1. Does the legislation mandate the availability of community-based crisis support services? |  |  |
| 1. Does the legislation mandate the financing of non-medical crisis support services (e.g., peer support services, crisis houses)? |  |  |
| 1. Does the legislation prohibit all forms of coercive practices within mental health services, including seclusion and restraint? |  |  |
| 1. Does the legislation ban all forms of coercion within the community, including community treatment orders and shackling? |  |  |
| 1. Does the legislation decriminalise suicide attempts? |  |  |

1. **Access to quality mental health services**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation provide for an enforceable right to mental health? |  |  |
| 1. Does the legislation put mental health on par with physical health in terms of coverage and quality of services? |  |  |
| 1. Does the legislation include or expand mental health coverage as part of national efforts towards UHC? |  |  |
| 1. Does the legislation establish criteria for needs-based allocation of services? |  |  |
| 1. Does the legislation institute earmarked funds for mental health, or progressive budget targets in their health budget aimed at increasing mental health investment? |  |  |
| 1. Does the legislation contribute to ensure mental health services are gender-responsive? |  |  |
| 1. Does the legislation contribute to ensure mental health services are age-appropriate? |  |  |
| 1. Does the legislation contribute to ensure mental health services are culturally appropriate? |  |  |
| 1. Does the legislation provide for the training of healthcare and social care providers? |  |  |

1. **Implementing mental health services in the community**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation provide for the integration of mental health in primary healthcare and general hospitals? |  |  |
| 1. Does the legislation improve the availability of a range of mental health goods and services at the primary care level? |  |  |
| 1. Does the legislation provide for the transformation of mental health service provision towards community-based, person-centered responses? |  |  |
| 1. Does the legislation promote the development a range of rights-based services in the community, including community mental health centres, crisis response services, community outreach services amongst others? |  |  |
| 1. Does the legislation provide for the development of peer support services? |  |  |
| 1. Does the legislation enable the creation of peer-led and peer-run services and their operations alongside mental health services? |  |  |
| 1. Does the legislation establish a de-institutionalization policy with a clear action plan? |  |  |
| 1. Does the legislation provide for the redistribution of financial and human resources from institutions to community services? |  |  |
| 1. Does the legislation ensure community-based mental health services and support are available in emergency situations and humanitarian contexts? |  |  |
| 1. Does the legislation stipulate that refuges, asylum-seekers and migrants are entitled to the same mental health care as citizens of the host country? |  |  |

1. **Ensuring full and effective participation in public decisions**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation ensure the full and equal involvement of persons with mental health conditions and psychosocial disabilities, as well as their representative organizations, in the development, implementation and monitoring of legislation and policies concerning mental health? |  |  |
| 1. Does the legislation grant organizations of persons with mental health conditions and psychosocial disabilities seats on mental health standing committees, temporary task forces, or monitoring bodies? |  |  |
| 1. Does the legislation regulate proper and transparent mechanisms and procedures to meaningfully consult persons with mental health conditions and psychosocial disabilities in decision-making processes related to mental health at the different branches and levels of government? |  |  |

1. **Ensuring accountability**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation recognize the right to request information or to consult or obtain a copy of documents concerning public mental health authorities, bodies or services? |  |  |
| 1. Does the legislation establish an independent monitoring framework to monitor the situation of the rights of persons using mental health services? |  |  |
| 1. Does the legislation grant persons using mental health services the right to report complaints and initiate legal proceedings concerning any aspect of mental health care? |  |  |
| 1. Does the legislation ensure complaint adjudicators, such as national human rights institutions or courts, provide remedies that are individually tailored and include redress and reparation? |  |  |
| 1. Does the legislation on professional liability provide for effective civil, administrative or criminal sanctions and reparations? |  |  |
| 1. Does the legislation mandate the adoption of indicators to measure, evaluate and review the performance and impact of mental health systems, as well as progress towards implementing human rights in the context of mental health? |  |  |

1. **Key cross-sectoral reform for holistic service provision**
   1. **Promoting community inclusion**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation recognize the right of persons with mental health conditions and psychosocial disabilities to live independently in the community? |  |  |
| 1. Does the legislation provide for access to community-based services and support? |  |  |
| 1. Does the legislation ensure mental health services facilitate and support service users to live, work and actively participate in the community? |  |  |
| 1. Does the legislation promote the integration of mental health into pertinent sectoral policies and programmes? |  |  |
| 1. Does the legislation create an enabling legal framework for the establishment and functioning of organizations of persons with mental health conditions and psychosocial disabilities? |  |  |
| 1. Does the legislation provide for access to information and services for families of persons with mental health conditions and psychosocial disabilities? |  |  |

* 1. **Access to justice**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Does the legislation recognize the full capacity of persons with mental health conditions and psychosocial disabilities to participate in all legal proceedings? |  |  |
| 1. Does the legislation establish a right to receive individually determined procedural accommodations in all legal proceedings? |  |  |
| 1. Does the legislation ensure that all substantive and procedural safeguards are equally afforded to persons with mental health conditions and psychosocial disabilities? |  |  |
| 1. Does the legislation ensure free or affordable legal assistance to persons with mental health conditions and psychosocial disabilities in all legal procedures related to their fundamental rights? |  |  |
| 1. Does the legislation limit police intervention in mental health crises and, when unavoidable, ensure it is free from discrimination and any use of force or coercion? |  |  |
| 1. Does the legislation support the reframing of the current criminal justice system to be responsive to the rights of persons with mental health conditions and psychosocial disabilities (e.g., restorative justice schemes)? |  |  |
| 1. Does the legislation recognize the obligation to provide prisoners with mental health conditions and psychosocial disabilities appropriate accommodations and support? |  |  |
| 1. Does the legislation provide for the training of all justice officials on rights-based approaches to mental health? |  |  |

1. **Drafting and legislative processes**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Do the drafting and legislative processes ensure the active involvement of persons with mental health conditions and psychosocial disabilities and their representative organisations? |  |  |
| 1. Do people involved in the drafting process clearly understand States’ obligations under international human rights law, including the CRPD obligations? |  |  |
| 1. Have all stakeholders involved in the drafting process been provided with information and training on human rights obligations? |  |  |
| 1. Do people involved in the drafting process have reliable information about the country’s situation and the barriers to implementing rights-based mental health responses? |  |  |
| 1. Has a rigorous and comprehensive review of national legislation in light of international human rights obligations been carried out? |  |  |
| 1. Has work been done to build consensus to pass a law that incorporates different perspectives, including persons with mental health conditions and psychosocial disabilities? |  |  |
| 1. Have broad, inclusive and accessible consultations been held to ensure that different stakeholders present comments and suggestions, particularly persons with mental health conditions and psychosocial disabilities? |  |  |
| 1. Have awareness-raising actions been carried out to ensure the support of public opinion? |  |  |

1. **Implementation and evaluation**

|  |  |  |
| --- | --- | --- |
| **Question** | **Rating from 1- 5** | **Comments** |
| 1. Has an overseeing agency been appointed to lead the implementation of legislation? |  |  |
| 1. Has regulation or other guidance been adopted to guide the implementation of legislation? |  |  |
| 1. Have awareness-raising actions been carried out to ensure knowledge and understanding around the legislation? |  |  |
| 1. Have adequate financial resources been allocated, to the maximum of the available resources, for implementation of legislation? |  |  |
| 1. Have trainings been provided to all stakeholders involved in the implementation of legislation? |  |  |
| 1. Have evaluations been conducted to assess the implementation of legislation? |  |  |

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