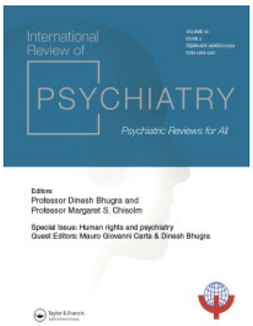

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REVIEW ARTICLE

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Human rights in mental healthcare; A review of current global situation

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ABSTRACT

The relationship between mental health and human rights is complex and bidirectional. Global mental health movements have been emphasizing the promotion of human rights in mental health care in accordance with the UN Convention on the Rights of Persons with Disabilities and the WHO QualityRights Initiative. The main objective of this review is to have an overview of the current global situation of human rights in mental health services by performing a review of scientific literature. The literature search and elimination process yielded a total of 26 articles focussing on human rights-related reports and tools. Further assessment of these articles clearly shows that despite significant improvements in mental health service delivery in the past decade, there is still substantial reporting of the continuing prominence of stigmatizing attitudes, and human rights violations and abuses in mental health settings. The human rights perspective requires society, particularly policymakers, to actively promote necessary conditions for all individuals to fully realize their rights. We suggest developing a more comprehensive model in mental health that integrates human rights into existing services and approaches. A model that recognizes that all people with mental health conditions and psychosocial disabilities are rights holders.

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Mental health; human rights; CRPD; QualityRights; autonomy

Introduction

Mental health is coming out from the shadows and recent reports from global health organizations identify mental health as a global priority (Chisholm, 2007; Eaton, 2019). There have been recommendations internationally focussed on increasing primary-care and community-based mental health service delivery, prevention, and promotion initiatives (Collins et al., 2011). Besides aiming at proximal low-stigma care, another motivator for a move of the locus of care from institutional to community-based has been to reduce the frequent human rights violations documented especially in institutional settings, violations described as a "global emergency" and an "unresolved crisis" across different countries (Porsdam Mann et al., 2016). Therefore, human rights have become a central consideration in revising mental health policies and plans (Herrman & Swartz, 2007; Marquez & Saxena, 2016; Patel, 2007).

There is high level of agreement between stakeholders about a need to invest substantially more in mental health services. Sustainable Development Goals and Agenda 2030 include promotion of mental health and prevention strategies (Patel et al., 2018; United Nations, 2021). In this regard it is of crucial importance to reach agreement whether increased investments in all elements of mental health services (promotion, prevention, treatment, recovery) should follow the "status quo" path, or maybe there is a need of change. And if there is a need of change – whether this change should be reaching the level of a paradigm shift. Mental health advocates call for reasonable funding of mental health care proportional to the impact of these conditions, aimed at reducing the treatment gap for people with mental health conditions (Wainberg et al., 2017). Within the key recommended components of what mental health service

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delivery should look like – including evidence-based, easily available, and accessible treatments as well as recovery-oriented services – human rights are a cross-cutting consideration (Puras & Gooding, 2019).

The relationship between mental health and human rights is complex and bidirectional. On the one hand, human rights violations can themselves negatively impact mental health, while protecting human rights can buttress or even improve mental health outcomes. The presence of a mental health condition is more likely to place an individual at risk for human rights abuses and people with mental health conditions are often at higher risk of human rights violations like discriminations, stigma and coercive measures than the general population (Hughes et al., 2012; Porsdam Mann et al., 2016). From a perspective of recovery-oriented care which focuses on mental and physical health beyond symptomatic treatment, an integration of human rights principles into mental health policy and law can promote autonomy, physical integrity, confidentiality and privacy, self-determination, legal capacity, liberty, and security of the person. This can be contrasted with how restrictions on patients' rights, together with stigma and discrimination (alienation, marginalization, loss of dignity and self-worth) in turn will reduce the potential for recovery (Passmore & Leung, 2003; Porsdam Mann et al., 2016).

Among the human rights advocates in mental health service contexts, there is particular concern around the use of involuntary psychiatric interventions such as involuntary preventive confinement, treatments, and other coercive measures. The position to adopt regarding such decisions may seem straightforward when taken from either a clinical or legal perspective but many challenges arise in integrating the two perspectives in specific situations and this has led to significant debate among proponents of involuntary practices and those who are against such measures (Sugiura et al., 2020). In fact, the many variants and subtleties of coercion and confinement in mental health services warrant further examination, discussion, and research.

The United Nations (UN) introduced an international law focussed on the human rights of persons with disabilities, and that includes persons with psychosocial, intellectual and cognitive disabilities almost 15 years ago; the "Convention on the Rights of Persons with Disabilities" (CRPD) adopted by the UN General Assembly in 2006 (Morrissey, 2012; United Nations, 2006). Ratifying states acknowledge that they are bound to apply the rights outlined in the Convention including the guiding principles of the CRPD (Table 1) into their national legislations. The CRPD aims at nothing short of social change and development in all areas of society through the respect of human rights of people with disabilities. To this goal the convention is intended as a human rights instrument with an explicit social development dimension. It reaffirms that all people with all types of disabilities including mental health conditions and psychosocial disabilities must enjoy all human rights and fundamental freedoms. It clarifies how all domains of rights apply to persons with disabilities on an equal basis with others. It also identifies areas where adaptations must be made for people with disabilities to effectively exercise their rights, and where protection of rights must be reinforced (Morrissey, 2012). Moreover, a key role of the Committee on the Rights of Persons with Disabilities – the body responsible for monitoring the implementation of the Convention as specified in article 35 – is to identify areas where human rights have been violated through the examination of periodic reports submitted by countries and individual communications.

Table 1. Eight guiding principles that underlie the CRPD.

1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

In the past 20 years, psychiatry has made good progress in claiming for parity between mental and physical health conditions given the impact of mental health conditions on the global burden of diseases (The World Health Report, 2001). Developing the Disability Adjusted Life Years measure which includes psychosocial disabilities has led to the greater understanding of the impact of mental health conditions (Gibney et al., 2013). But in so doing it has, to some extent, promoted the biomedical model which focuses primarily and sometimes solely on the person's diagnosis, impairments, and biological treatment. The biomedical model takes the individual as locus of analysis, separating out the role of environmental and societal influences (Deacon, 2013). The psychosocial model, on the other hand, was developed to take into account the role that social, political, spiritual, cultural and environmental factors play in the person's physical and mental health (Jenkins et al., 2011). Research

has revealed the extent to which social determinants of health actually impact on physical and mental health outcomes (Dean & Fenton, 2013). However,the strong emphasis on the psychological theories of mental health seemed to be a pendulum reaction to the inadequacies of the biomedical model. Therefore, two models have been combined into the "biopsychosocial model", formulated to better integrate various determinants of health and illness, and formulate accordingly comprehensive treatment or management plans. Although the widely accepted biopsychosocial model was first introduced in 1977 (Engel, 1977), the bipolarity in biological versus psychosocial approaches can still be seen in clinical practice (Kusnanto et al., 2018). Furthermore, the biopsychosocial model lacks a direct appreciation of other important factors such as cultural, spiritual and human rights factors, underscoring the need to specifically include human rights in our current models of mental health and services implementation.

Considering the interface between mental health services and human rights issues, and the important contribution human rights play in health outcomes, this paper will review the contemporary situation of implementing human rights in mental health service delivery around the world.

Methods

Our review aims to identify articles that are directly related to the human rights issues in mental health care services. For this purpose, a sequence of selection processes has been employed (Page & Moher, 2017). In order to identify potentially relevant articles, we used several search engines utilizing the broadest possible keywords. The search engines used included: Embase, MEDLINE via PubMed, and PsycINFO, limiting the time to articles published since Jan 2008 after CRPD came into force. The keywords used included: "human rights" or "rights-based approach" or "QualityRights" or "CRPD" or "rights", AND "Mental Health" or "psychiatry" or "psychiatric" on considering the possible national or local research in this field, no language restrictions were placed.

The main inclusion criterion was that the focus be on human rights. We excluded articles that did not contain human rights in their title, abstract or keywords. After screening, only the articles about human rights in mental health were retained. For the purpose of this review, we searched for any of the following terms in titles, abstracts or keywords: "mental health", "mental illness", "mental disorder", "psychiatry" or explicit mention of any diagnosis from the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" (DSM) V and "International Classification of Diseases" (ICD) 10. We selected all the articles directly focussing on human rights aspects of mental health, including those invoking the CRPD, the WHO QualityRights and other national and international human rights charters. The authors read title, keywords, and abstracts of the articles.

In the very first stage literature search, we identified more than 608 articles on the topic of "human rights" and "mental health" using the above-mentioned keywords. After excluding the duplicates, and applying the inclusion and exclusion criteria, 523 articles were excluded. We carefully read the titles and abstracts of the remaining 85 and retained those that were clearly focussing on human rights in mental health reading the full texts for assessment of the quality and relevance of the articles. This led to the removal of 64 articles from further evaluation. Then, we reviewed the references of the 21 retained articles to make sure that no important articles had been neglected. This resulted in identification of 5 additional articles. Each of the 26 articles was then read thoroughly to collect the relevant information and outcomes.

Table 2 summarizes the publications we found on human rights in mental health. We categorized the articles based on their major focus into three main categories:

1. Tools to assess compliance with human rights in mental health services.
2. Current status of human rights in mental health service delivery.
3. Coercive Measures in Psychiatry and Human Rights.

Results

Tools to assess compliance with human rights in mental health services

A growing number of healthcare services are becoming aware and interested in human rights aspects of mental health. To that end, multiple tools designed to assess compliance with human rights have been developed. Several of these tools evaluate services based on local and international human rights standards with concrete and tangible lists of factors that a healthcare establishment should consider when providing mental

Table 2. Summary of the bibliography on human rights in mental health.

Authors/Year	Title	Key focus	Findings
Byrne et al., 2018	A new tool to assess compliance of mental health laws with the convention on the rights of persons with disabilities	Analysis Instrument for Mental health (AIM)	AIM sets clear standards, giving legislators goals to aim for to reform MHAs. It also provides mechanism for society to measure legislative compliance against the CRPD.
Eiroa-Orosa & Liminana-Bravo, 2019	An Instrument to Measure Mental Health Professionals' Beliefs and Attitudes towards Service Users' Rights	Developing and validating a scale (BAMHS) on the attitudes of professionals towards users' rights	BAMHS can be used to measure the impact of recovery and anti-stigma methodology-based interventions with mental health professionals
Funk & Drew, 2017	WHO QualityRights: transforming mental health services	WHO QualityRights Initiative	improve the quality of care provided by mental health services and promote the human rights of people with psychosocial, intellectual, and cognitive disabilities
Bantjes et al., 2017	Human rights and mental health in post-apartheid South Africa: lessons from health care professionals working with suicidal inmates in the prison	Describe the experience of professionals in prisons regarding human rights	highlight the significant gap between current policies, which protect human rights, and every-day practices that is in the contrary
Rekhis et al., 2017	Rights of people with mental disorders: Realities in healthcare facilities in Tunisia	assess the rights of people with mental disorders in healthcare facilities	Significant improvements are needed to adapt the practice to comply with human rights, since the achievement level of the rights is lower than in a non-psychiatric hospital
Cooper et al., 2010)	Viewing Uganda's mental health system through a human rights lens	analysing mental health system via a survey of the systems using WHO AIMS	Uganda's mental health system inadequately promotes and protects, and frequently violates the human rights of people with mental disorders.
Mannan et al., 2013	Core concepts of human rights and inclusion of vulnerable groups in the mental health policies of Malawi, Namibia, and Sudan	Using EquiFrame, a novel policy analysis framework, to evaluate the mental health policies in terms of their coverage of human rights	The overall ranking for the Namibian Mental Health Policy was High; for the Sudanese Mental Health Policy was Moderate; and for the Malawian Mental Health Policy was Low.
Hoffman et al., 2016	Is the UN CRPD Impacting Mental Health Laws and Policies in High-Income Countries? A Case Study of Implementation in Canada	assesses the CRPD's impact on mental health systems and presents a legal and public policy analysis of implementation	Despite the lack of explicit implementation, CRPD has facilitated a larger shift in social and cultural paradigms of mental health. However, ratification and passive implementations are not enough
Minoletti et al., 2015	A survey about quality of care and users' rights in Chilean psychiatric services	baseline diagnosis of quality of care and respect for rights in public outpatient psychiatric services using WHO Quality Rights tools.	low level of achievement in user support to cope with community living, access to education or work and participation in community activities, respect for user treatment preferences and preventive measures to avoid maltreatment and cruelty
Zuniga-Fajuri & Zuniga-Fajuri, 2019	Mental health policies tackling violation of children's human rights in Chile	Reporting the violation of children's human rights in Chile	integrate child and adolescent mental health care into essential services, guaranteeing non-discriminatory access, opportunity, quality, and coverage
Abadi et al., 2012	Examining human rights and mental health among women in drug abuse treatment centres in Afghanistan	assesses the extent these women have experienced human rights violations and the risk factors	Half of the women experienced human rights violation, risk factors included marital status, ethnicity, literacy, employment, limited social functioning, and suicide attempts
Xiang, 2012	The proposed national mental health law in China: a landmark document for the protection of psychiatric patients' civil rights	Looking at human rights violations in psychiatric hospitals in China and National Mental Health Law	Despite its limitations, the latest draft of China's National Mental Health Law 2012 is a great step forward in the protection of psychiatric patients' civil rights.

(*continued*)

Table 2. Continued.

Authors/Year	Title	Key focus	Findings
Kelly, 2016	Mental health, mental illness, and human rights in India and elsewhere: What are we aiming for?	Looking at India's mental health laws and legislations in light of CRPD	focus not only on the right to liberty but also on rights to treatment, social care, social inclusion, and political empowerment of people with mental health conditions
Pathare, 2019	Systematic evaluation of the QualityRights program in public mental health facilities in Gujarat, India	describe the first large-scale implementation and evaluation of QualityRights as a scalable human rights-based approach	QualityRights can be effectively implemented even in resource-constrained settings and has a significant impact on the quality of mental health services
Kerbage et al., 2016	Mental health legislation in Lebanon: nonconformity to international standards and clinical dilemmas in psychiatric practice	review the existing legislation concerning treatment and legal protections, criminal laws, and laws regulating incapacity	Describing the clinical dilemmas that Lebanese psychiatrists encounter in practice, in the absence of a clear legislation that can orient their decisions and protect their patients from abuse
van Voren, 2017	Mental health and human rights in Russia—a flawed relationship	Looking at political abuse of psychiatry	gradual return of political abuse of psychiatry, particularly in Russia
Sugiura et al., 2020	An end to coercion: rights and decision-making in mental health care	reviewing the impact of historical trends and current mental health frameworks on human rights	developing a context-appropriate approach to implementing supported decision-making in mental health care
Ogunwale, 2019	Involuntary mental health treatment in England and Wales: A rights-based critique of current legal frameworks & recommendations	examining the legal frameworks for the involuntary treatments	The existing legal frameworks in mental health do not satisfactorily protect human rights or sustain ethical principles
Tingle, 2018	Monitoring the Mental Health Act: a need to protect patients' rights	Reviewing the mental health act of England	Mental health services are failing in many areas of human rights
Szmukler et al., 2014	The UN Convention on the Rights of Persons with Disabilities and UK mental health legislation	Reviewing the CRPD and UK mental health legislation	Discussing different ways of supported decision making
Kelly, 2014	Dignity, human rights and the limits of mental health legislation	Reviewing the human rights in Ireland mental health legislation	Dignity should become the over-arching principle of Ireland's mental health legislation
Maycraft Kall, 2014	Same law–same rights? Analysing why Sweden's disability legislation failed to create equal rights in mental health	Analysing disability rights in Sweden	Need for creation of enduring disability rights

health services. This section presents some of the most common tools available.

Stigma towards people with mental health conditions and psychosocial disabilities affects the importance given to complaints related to mental health, access to adequate mental health care, and the likelihood that treatment is initiated. In this way, stigma interacts with the right to adequate care (Corrigan et al., 2003). Several scales have been developed to measure stigma regarding mental health, applied to the general public, mental health service users, and professional audiences (Evans-Lacko et al., 2011; Taylor & Dear, 1981; van der Eijk, 2018). The first scale that measured beliefs and attitudes of mental health professionals towards service users was developed in the context of understanding mental health practices on a continuum from custodial to humanistic (Gilbert & Levinson, 1956). This scale made it possible to test the hypothesis that a custodial orientation is associated with an authoritarian attitude of the subject answering the questionnaire while a humanistic orientation is associated with an egalitarian attitude (Gilbert & Levinson, 1956).

Eiroa-Orosa et al (Eiroa-Orosa & Liminana-Bravo, 2019) validated the Beliefs and Attitudes towards Mental Health Service Users' Rights Scale (BAMHS) in 2019 to assess the impact of awareness and educational activities (e.g. recovery and anti-stigma based activities) on developing professionals' attitudes favourably towards the rights of people with mental health conditions and psychosocial disabilities. This scale assesses four dimensions which differentiate favourable vs unfavourable attitudes towards human rights: system criticism vs justifying beliefs, freedom vs coercion, empowerment vs paternalism, and tolerance vs discrimination.

Other relevant tools have been designed to assess how closely mental health legislations comply with human rights norms. One of these is the Rights Analysis Instrument (RAI) developed in late 90s (Watchirs, 2005). The pilot version of the RAI was later revised into an 'Audit Tool' to measure human rights compliance within mental health legislations. Byrne et al (Byrne et al., 2018) also proposed the Analysis Instrument for Mental Health (AIM) in 2018 with the goal of enabling countries and civil society to evaluate the compliance of non-forensic mental health laws with Article 12 of the CRPD. Article 12 reaffirms the equal recognition of rights to ensures appropriate measures to provide access to the support required by persons with disabilities to exercise their legal capacity (Balakrishnan et al., 2019).

WHO has officially withdrawn another tool called "WHO Resource Book on Mental Health, Human Rights and Legislation" (World Health Organization, 2005) because it was developed prior to CRPD and therefore did not align with current standards but they are currently working on developing new guidance around mental health related legislation, along with new guidance around mental health policy and planning, that will be finalized in 2022 (Johns et al., 2004). WHO QualityRights initiative was introduced in 2012 to address human rights violations and improve quality of care in line with the CRPD (Funk & Drew, 2017). QualityRights is a global initiative with several objectives that comprises many toolkits to improve the quality of care provided by mental health services and promote the human rights of people with mental health conditions and psychosocial disabilities. It is a global initiative to increase access to quality services based on best practices in mental health and related areas and to promote the human rights of people with psychosocial, intellectual and cognitive disabilities. It offers an innovative approach to mental health care which is rights-based and recovery-oriented. The core aspects of this initiative include freedom from coercive interventions, respect for the right to legal capacity, and promotion of autonomy, choice, and community inclusion (Funk & Drew, 2017). The five main objectives of the initiative are to: build capacity to combat stigma and discrimination and promote a person centred, rights based approach; improve the quality of care and human rights conditions in mental health and related services; create community-based and recovery-oriented services that respect and promote human rights; support efforts to strengthen a civil society movement, including persons with lived experience, in order to conduct advocacy and influence policy-making; reform national policies and legislations in line with the CRPD and international human rights standards. QualityRights has a number of tools that can be used to introduce and strengthen human rights in mental health care. Key tools from this initiative are: the QualityRights toolkit for assessing services and for transforming services and promoting human rights; the set of 13 QualityRights capacity building materials and guidance tools and the QualityRights e-training course: mental health and disability: Eliminating stigma and promoting human rights (Qualityrights Materials for Training, 2021), and new guidance on developing person-centred and rights-based community mental health services (Mental Health & Substance Use Department, 2021).

3.2. Current status of human rights in mental health services

This section intends to review the small and limited body of available literature about the human rights violations and achievements in the field of mental health. As revelatory as it is, it nevertheless indicates that little of the international experience on this topic is available in the medical and psychiatric literature. There are still many reports suggesting that many countries, regions and services around the world violate the rights of people with mental health conditions and psychosocial disabilities based on their current legislations (Puras & Gooding, 2019).

Bantjes et al in 2017 (Bantjes et al., 2017) looked at the human rights perspective of mental health professionals working in correctional facilities using semi-structured interviews and thematic content analysis. They described the challenges faced when attempting to provide psychological care in low-resource settings like prisons. Important challenges included lack of collaboration among mental health stakeholders, no integration of psychiatric services and healthcare system, and limited support and resources for people with mental health conditions. This highlights that a significant gap between current policies to protect human rights and specific facilities as this can occur. Another study carried out in 2017 using the WHO QualityRights toolkit to assess the respect for human rights in community healthcare facilities found an incomplete compliance to human rights conventions, identifying difficult living conditions for service users, poor hygiene of the clinical settings, and lack of decent bedding and privacy as major violations (Rekhis et al., 2017). In addition, there were several limitations to

free choice, deemed unnecessary by the authors of that paper: being forced to wear hospital uniforms, denied personal possessions, individual space, imposition of daily routines including waking, eating, and sleeping times. The authors concluded that such safeguarding of human rights should have been part of the role of mental health professionals, who require training and tools on assessing, respecting, protecting, and advocating for human rights. Other reports from around the world also describe major deficits on the inclusion of the human rights concepts within mental health laws, and in their applications in daily clinical practice (Kaiser, 2011; Mannan et al., 2013).

In an article by Cooper et al published in 2010 (Cooper et al., 2010), mental health systems are described like "inadequate protections and frequent violations of the human rights" of people with mental health conditions. They enumerate several shortcomings of the current legislations such as:

- Failure to distinguish between voluntary and involuntary admission and treatment.
- A strong focus on confinement and coercion.
- No provision for equitable mental health care.
- No special consideration of vulnerable groups.
- No provision for promoting and protecting the rights of people with mental health conditions and psychosocial disabilities, including right to humane treatment, right to privacy, autonomy, and confidentiality, right to non-discrimination, right to treatment and medications, and right to informed consent on admission.

During past decades media have also reported human rights violations in psychiatric hospitals particularly regarding involuntary admissions (Xiang et al., 2010). Situations of nonconformity of mental health legislations to CRPD or charters of human rights, and of significant violations of the human rights of people with mental health conditions and psychosocial disabilities, has been reported in several psychiatric establishments (Abadi et al., 2012; Kerbage et al., 2016). Kelly reported in 2016 that people with mental health conditions have increased rates of imprisonment, homelessness, social exclusion, untreated medical illnesses, and various other violations of human rights (Kelly, 2016). Surprisingly, there are still reports warning about the abuse of psychiatry by political regimes in some countries (van Voren, 2002). Van Voren reported dozens of cases in recent years where psychiatry has been misused by repressing the oppositions (van Voren, 2017). Such psychiatry makes use mainly of institutional care, does away with multidisciplinary teamwork or case management, and eschews the involvement of users and relatives in care provision.

Even in high-income countries with advanced human rights laws, experience has shown that ratifying the CRPD, though an important step forward, has not necessarily led to improved human rights conditions, the spirit of the convention, within mental health systems. The experience of persons with disabilities thus remain below the standards of the CRPD and human rights legislations (Hoffman et al., 2016).

One important area is concerning Article 12 of the CRPD on the legal capacity of persons with mental health conditions and psychosocial disabilities where the CRPD only allows for "supported decision-making", the vast majority if not all countries around the world maintain "substitute decision-making" regimes that in certain circumstances removes from people their legal right to make decisions related to their healthcare, housing, and finances far from respect for autonomy (Hoffman et al., 2016). In December 2018, an independent review of Mental Health Acts (MHA) of a high income country concluded that reforms were needed to reduce coercion in mental health care and promote supported decision-making (Sugiura et al., 2020). Similarly, in 2019, the Council of Europe's Commissioner for Human Rights reported that "historically, rejection and isolation have been the default response to persons with psychosocial disabilities". This ingrained fear is still very strong and is fuelling the prejudice that people with mental health conditions and psychosocial disabilities are automatically a danger to themselves and to society, against all available statistical evidence to the contrary (Szmukler, 2014).

Legal protections which attempt to uphold individual autonomy in the context of human rights while ensuring public safety do not, in many respects, satisfactorily align with the principles and requirements of the CRPD (Ogunwale, 2019). In addition, many mental health services often "fail badly" when it comes to human rights (Tingle, 2018). Most mental health legislations do not comply with requirements of the CRPD such as ensuring only voluntary admissions (article 14) and no coercive therapeutic measures (article 12) (Kelly, 2014). These deficits, it is suggested, should be addressed by replacing the principle of 'best interest' that justifies paternalism with principles that promotes dignity and the right to exercise full legal capacity, in order to enhance autonomy and person-

centred care. Such a change would help ensure that decisions made under the legislation actively facilitate, for individuals with mental health conditions and psychosocial disabilities, the exercise of their autonomy. Further analysis of disability rights demonstrate that while mental health laws may create some level of rights, focussing on the underlying ideology and culture are essential to embrace the 'spirit of the law' (Maycraft Kall, 2014). From the perspective of human rights, the key concepts of MHA should include an end to all coercive practices, improve access to health care and support in the community, ensure voluntary access to mental health services, and require informed consent to treatment and care. One other impediment to the application of such principles is the lack of awareness of human rights concepts among practicing psychiatrists and physicians. This might be because most postgraduate medical trainings focus on the clinically relevant acts rather than the broader principles of mental health law and human rights. This lack of training can result in a more risk-averse interpretation of MHAs less consistent with those aspects of the law which promote human rights (Wand & Wand, 2013).

All in all, despite the lack of full implementation of CRPD in most countries, the Convention might have helped to facilitate a paradigm shift towards better respecting human rights. Certain countries are moving in this direction and many MHAs have been or are in the process of being revised based on human rights' checklists (Mental Health & Substance Use Departmen, 2021; Ssebunnya et al., 2014). Such revisions are, at least on paper, a promising step forward in the protection of the rights of people with mental health conditions and psychosocial disabilities.

One example of such reforms has been adopting a "fusion legislation" – a single law which applies to everyone, including people with mental or physical health conditions (Sugiura et al., 2020). Fusion legislation though originally was introduced to potentially reduce the stigmatization of mental health conditions and discourage the overuse of substitute decision-making in people with limited decision-making capacity (Szmukler, 2020), do not fully align with the CRPD and human rights perspectives (Funk & Drew, 2019). Ratification and incomplete implementation of CRPD alone do not seem to be enough to produce notable achievements in offering discrimination-free health care, reducing abuse and neglect towards service users, and promoting dignity based on autonomy and consent (Kaiser, 2009).

Further efforts are needed in full application of human rights in health and social services, courtrooms, prisons, and other settings (Xiang, 2012). Improvements in including human rights principles in the mental health legislation should promote advances on cultivating community living, access to education or work, participation in community activities, respect for user treatment preferences and preventive measures to avoid maltreatment (Minoletti et al., 2015). Major recent advances in the quality of psychiatric services have been brought about by integrating CRPD and WHO QualityRights standards into mental health laws. Examples include introducing national policies centred on quality of care and rights of people with psychosocial disabilities, reinforcing and informing people about their rights and promoting research on interventions to improve the respect of their rights (Hoffman et al., 2016; Zuniga-Fajuri & Zuniga-Fajuri, 2019). Pathare et al. performed a pragmatic trial in 2019 (Pathare, 2019) comparing the implementation of WHO QualityRights at public mental health services. Their 12-month period observation concluded that the quality of services provided by those receiving the QualityRights intervention improved significantly. Staff showed substantial increase of attitudes favouring human rights, and service users reported feeling significantly more empowered and satisfied with the services offered (Pathare, 2019). This confirms that WHO QualityRights can effectively be implemented in community settings and has a significant impact on the quality of mental health care as well as compliance with human rights.

Coercive measures in psychiatry and human rights

Coercive measures are reportedly used in mental health services to protect "patients" from the risk of harm to themselves or to others. Literature indicates that the general public rarely questions the justification of the involuntary confinement and treatment of people with a mental health condition and psychosocial disabilities where there is any suspicion of a risk of harm (Mahomed et al., 2018; McKague, 1988; Sugiura et al., 2020). The simple combination of diagnosis of a mental health condition and risk to self or others has often been considered a sufficient legal and medical justification for coercion in psychiatry while there are in fact many other factors for consideration. Although, the processes – like who can authorize the confinement, for how long, how, the operation of appeals and reviews, and so on – have been subject to

modifications in several jurisdictions to address human rights aspects, the fundamental criteria and notions have rarely been challenged.

Even with specific processes for such removal of human rights from "patients", there is always a real danger that unfair discrimination and paternalistic attitudes against people with mental health conditions and psychosocial disabilities can too easily lead to coercive measures, which in turn can impact their mental health (Szmukler, 2020). Community Treatment Orders (CTO), for example, go against the CRPD and increasing voices are coming to the fore that CTOs are experienced as not only violations of the rights but also extremely distressing and disempowering for the patients (Patel, 2008). Although one study surveying the caregivers of people who were placed on CTOs reported that some carers might believe that the CTOs had been beneficial in reducing the caregiving burden (Vine & Komiti, 2015), it is the most important to consider the way CTOs are experienced by people having these orders placed upon them. Not only, there is a lack of solid body of evidence for efficacy of coercive involuntary measures for people with severe and persistent mental health conditions (Authors, 2006), there is some evidence of possible physical and emotional harm caused by compulsory measures in this vulnerable population (Kisely et al., 2005). In fact, there is mounting evidence indicating that noncoercive models of care such as recovery model community-based practices that aim to respect the will and preferences of service users, are equally effective if not more (Sugiura et al., 2020). Of course, respect of human rights within mental health services will require significant adaptations and increase in trained staffing and mechanisms that could enable full implementation of such practices.

One of key characteristics of current mental health laws, as mentioned, is the notion of substitute decision making, whereby the decision of a third party can legally supersede the preference of an individual if they are deemed to be incapable of making a proper decision due to a mental health condition (Szmukler et al., 2014). Although these provisions are meant to protect people with mental health conditions and psychosocial disabilities from causing harm to themselves or others, many people, including service-user advocates raise valid concerns that substitute decision-making can be considered, and is often experienced, as abuse and can potentially lead to a range of other abuses including but not limited to the misuse of psychiatric methods for political suppressions, sexual and physical abuse of mental health service users (Sugiura et al., 2020; van Voren, 2002, 2017).

Discussion

Our review of the literature yielded a relatively smaller number of articles than one may have anticipated in the field of human rights and mental health. It presents important factors to take into account in understanding the status of human rights in mental health services but is far from giving a full picture of the current situation globally. This is probably due to the limited relevant publications that can be found in the medical and psychiatric scientific literature regarding human rights issues. Nevertheless, we presented here some conclusions that can be drawn from the literature obtained.

Mental health care has undergone at least three significant transformations in the last few decades, namely deinstitutionalization, introduction of the recovery model, and the coming into force of the CRPD. These require significant legislative reform in countries and have been supported or driven by people with mental health conditions and psychosocial disabilities themselves, emphasising autonomy, freedom of choice, community living, social inclusion, and countering the emphasis on coercive approaches rooted in stigma against mental health conditions. These transformations have also made mental health professionals more aware of the rights of people with mental health conditions and psychosocial disabilities. This review depicts a glimpse of the status of human rights in mental health care that encourages international attempts for fundamental changes in this area, especially at reducing coercive measures and operating a paradigm shift from symptom reduction model to a more integrative rehabilitative and recovery model. Despite all the improvements, there are still too many reports of stigmatising approaches and human rights violations, sometimes profound, in mental health care. Human rights are of particular importance in mental health care given the bidirectional relationship to each other and the wide-ranging violations many people with mental health conditions and psychosocial disabilities are exposed to. Stereotypes portraying mental health service users as incompetent, incurable, violent, and dangerous are not justified and not based on any evidence, and lead to discrimination and coercive practices such as involuntary admissions and treatments, overmedicating,

restraints, seclusion, isolation, and arbitrary legal incapacitation and guardianship.

This review of the literature shows that the deep-rooted stigma around mental health conditions is still very prevalent and perpetuates itself by creating conditions for these people which reduce their access to social, educational, and occupational privileges. This societal bias is sufficiently embedded to infiltrate the decision-making of lawyers, policymakers, politicians, judges, juries, and even mental health professionals. The United Nation's Convention on the Rights of Persons with Disabilities is a big step forward in the support of human rights of people with disabilities including people with psychosocial conditions. The Convention emphasizes the right to equal recognition before the law and deems coercive measures and substitute decision-making inconsistent with this. It promotes supported decision-making, where the necessary accommodations and support are provided to ensure respect for individuals' will and preferences. It sets out key obligations on countries to end practices based on force, coercion and substitute decision making in mental health. The "status quo" mental health laws in almost all countries, despite their good intentions in many cases, reinforce discriminatory practices and vicious cycle of exclusion, discrimination, stigmatization, and disempowerment. This happens mostly because of provisions that override the rights of persons with mental health conditions and psychosocial disabilities allowing for the application of involuntary measures without informed consent when certain criteria are met. The improvement of mental health policies and legislations based on CRPD and WHO QualityRights, although necessary, do not ensure the end goal of promoting the applications of such tools and regulations in everyday practices. One way to enhance the applied integration of human rights thinking in practice is through the use of tools and instruments to advance rights-based care. Another way is to evaluate this application of human rights principles in mental health, and to use research and training to increase the awareness of mental health professionals about mental health law, human rights, and their day-to-day clinical implications.

WHO QualityRights Guidance and other technical packages on community mental health services support implementation of the CRPD by promoting services that respect and uphold human rights of people with mental health conditions and psychosocial disabilities (Qualityrights Materials for Training, 2021; Mental Health & Substance Use Departmen, 2021). It proposes evaluation, training, and guidance materials to enable countries to transform mental health services to comply with international human rights standards. Among its provisions are to ensure that people with lived experience be involved in decision making about mental health services at local, national, and global levels. Experiences with the WHO QualityRights indicate that the tools have a significant impact on the quality of mental health care and compliance with human rights (Pathare, 2019). In addition, independent global and national monitoring mechanisms such as CRPD Committee at a global level and CRPD implementation bodies at national levels are required as per article 33 of CRPD to ensure the application of these principles and foster continued improvements. Given the extent of the consequences of stigma and coercion towards people with mental health conditions and psychosocial disabilities, it is also essential to raise awareness and change the false assumptions about mental health in the public and in mental health professionals, to enhance empowering attitudes through frameworks such as recovery.

Finally, this paper contends that the already existing biopsychosocial model used to formulate the aetiology of, and treatment plans for mental health conditions should be enriched by fully integrating human rights into the model. This will structure our understanding that all people with mental health conditions and psychosocial disabilities are rights holders and serve policy makers in actively promoting services permitting complete realization of their rights. Human rights need to be entirely incorporated into mental health treatments, care, and approaches (a bio-psycho-socio-rights formulation).

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The authors report no financial conflicts of interest. The authors are either staff members or have been involved in policy documents with the WHO and/or UN. They affirm that they alone are responsible for the views expressed in this article, and it does not necessarily represent the decisions, policy or views of any organizations.

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References

Abadi, M. H., Shamblen, S. R., Johnson, K., Thompson, K., Young, L., Courser, M., Vanderhoff, J., & Browne, T. (2012). Examining human rights and mental health among women in drug abuse treatment centers in Afghanistan. *International Journal of Women's Health*, *4*, 155–165. https://doi.org/10.2147/IJWH.S28737

Authors. (2006). End human rights violations against people with mental health disorders. December 10: International Human Rights Day. *Annals of Saudi Medicine*, *26*(1), 77. https://www.ncbi.nlm.nih.gov/pubmed/16521888

Balakrishnan, A., Kulkarni, K., Moirangthem, S., Kumar, C. N., Math, S. B., & Murthy, P. (2019). The Rights of Persons with Disabilities Act 2016: Mental Health Implications. *Indian Journal of Psychological Medicine*, *41*(2), 119–125. https://doi.org/10.4103/IJPSYM.IJPSYM_364_18

Bantjes, J., Swartz, L., & Niewoudt, P. (2017). Human rights and mental health in post-apartheid South Africa: Lessons from health care professionals working with suicidal inmates in the prison system. *BMC International Health and Human Rights*, *17*(1), 29. https://doi.org/10.1186/s12914-017-0136-0

Byrne, M., White, B., & McDonald, F. (2018). A new tool to assess compliance of mental health laws with the convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry*, *58*, 122–142. https://doi.org/10.1016/j.ijlp.2018.04.001

Chisholm, D. (2007). Scale up services for mental disorders: A call for action. *Lancet*, *370*(9594), 1241–1252.

Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., Anderson, W., Dhansay, M. A., Phillips, A., Shurin, S., Walport, M., Ewart, W., Savill, S. J., Bordin, I. A., Costello, E. J., Durkin, M., Fairburn, C., Glass, R. I., Hall, W., … Stein, D. J. (2011). Grand challenges in global mental health. *Nature*, *475*(7354), 27–30. https://doi.org/10.1038/475027a

Cooper, S., Ssebunnya, J., Kigozi, F., Lund, C., & Flisher, A. (2010). Viewing Uganda's mental health system through a human rights lens. *International Review of Psychiatry*, *22*(6), 578–588. https://doi.org/10.3109/09540261.2010.536151

Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior*, *44*(2), 162–179. https://doi.org/10.2307/1519806

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, *33*(7), 846–861. https://doi.org/10.1016/j.cpr.2012.09.007

Dean, H. D., & Fenton, K. A. (2013). Integrating a social determinants of health approach into public health practice: A five-year perspective of actions implemented by Cdc's National Center for Hiv/Aids, Viral Hepatitis, Std, and Tb Prevention. *Public Health Reports*, 128(Suppl 3), 5–11. https://doi.org/10.1177/00333549131286S302

Eaton, J. (2019). Human rights-based approaches to mental health legislation and global mental health. *BJPsych International*, *16*(2), 37–40. https://doi.org/10.1192/bji.2018.5

Eiroa-Orosa, F. J., & Liminana-Bravo, L. (2019). An instrument to measure mental health professionals' beliefs and attitudes towards service users' rights. *International Journal of Environmental Research and Public Health.*, *16*(2), 510. https://www.ncbi.nlm.nih.gov/pubmed/30654510

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, *196*(4286), 129–136. https://doi.org/10.1126/science.847460

Evans-Lacko, S., Rose, D., Little, K., Flach, C., Rhydderch, D., Henderson, C., & Thornicroft, G. (2011). Development and psychometric properties of the Reported and Intended Behaviour Scale (Ribs): A stigma-related behaviour measure. *Epidemiology and Psychiatric Sciences*, *20*(3), 263–271. https://doi.org/10.1017/s2045796011000308

Funk, M., & Drew, N. (2017). Who Qualityrights: Transforming mental health services. *The Lancet. Psychiatry*, *4*(11), 826–827. https://doi.org/10.1016/S2215-0366(17)30271-7

Funk, M., & Drew, N. (2019). Practical strategies to end coercive practices in mental health services. *World Psychiatry*, *18*(1), 43–44. https://doi.org/10.1002/wps.20600

Gibney, K., Sinclair, M., O'Toole, J., & Leder, K. (2013). Using disability-adjusted life years to set health-based targets: A Novel use of an established burden of disease metric. *Journal of Public Health Policy*, *34*(3), 439–446. https://doi.org/10.1057/jphp.2013.22

Gilbert, D. C., & Levinson, D. J. (1956). Ideology, personality, and institutional policy in the mental hospital. *Journal of Abnormal Psychology*, *53*(3), 263–271. https://doi.org/10.1037/h0041987

Herrman, H., & Swartz, L. (2007). Promotion of mental health in poorly resourced countries. *The Lancet)*, *370*(9594), 1195–1197. https://doi.org/10.1016/S0140-6736(07)61244-6

Hoffman, S. J., Sritharan, L., & Tejpar, A. (2016). Is the un convention on the rights of persons with disabilities impacting mental health laws and policies in high-income Countries? A case study of implementation in Canada. *BMC International Health and Human Rights*, *16*(1), 28. https://doi.org/10.1186/s12914-016-0103-1

Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., & Officer, A. (2012). Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet*, *379*(9826), 1621–1629. https://doi.org/10.1016/S0140-6736(11)61851-5

Jenkins, R., Baingana, F., Ahmad, R., McDaid, D., & Atun, R. (2011). Social, economic, human rights and political challenges to global mental health. *Mental Health in Family Medicine*, *8*(2), 87–96. https://www.ncbi.nlm.nih.gov/pubmed/22654971

Johns, F., Crock, M., & Freeman, D. (2004). Migration, mental health, and human rights. *International Journal of*

Law and Psychiatry, *27*(6), 505–509. https://doi.org/10.1016/j.ijlp.2004.09.002

Kaiser, H. A. (2009). Canadian mental health law: The slow process of redirecting the ship of state. *Health Law Journal*, *17*, 139–194.

Kaiser, H. A. (2011). Canadian prisoners with mental health problems: The promise (and limits) of the convention on the rights of persons with disabilities. *Health Law in Canada*, *32*(1), 1–24. https://www.ncbi.nlm.nih.gov/pubmed/22128515

Kelly, B. D. (2014). Dignity, human rights and the limits of mental health legislation. *Irish Journal of Psychological Medicine*, *31*(2), 75–81. https://doi.org/10.1017/ipm.2014.22

Kelly, B. D. (2016). Mental health, mental illness, and human rights in india and elsewhere: What are we aiming for? *Indian Journal of Psychiatry*, *58*(Suppl 2), S168–S74. https://doi.org/10.4103/0019-5545.196822

Kerbage, H., El Chammay, R., & Richa, S. (2016). Mental health legislation in Lebanon: Nonconformity to international standards and clinical dilemmas in psychiatric practice. *International Journal of Law and Psychiatry*, *44*, 48–53. https://doi.org/10.1016/j.ijlp.2015.08.031

Kisely, S., Campbell, L. A., & Preston, N. (2005). 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Systematic Reviews*, (3), Cd004408.

Kusnanto, H., Agustian, D., & Hilmanto, D. (2018). Biopsychosocial model of illnesses in primary care: A hermeneutic literature review. *Journal of Family Medicine and Primary Care*, *7*(3), 497–500. https://doi.org/10.4103/jfmpc.jfmpc_145_17

Mahomed, F., Stein, M. A., & Patel, V. (2018). Involuntary mental health treatment in the era of the United Nations convention on the rights of persons with disabilities. *PLoS Medicine*, *15*(10), e1002679. https://doi.org/10.1371/journal.pmed.1002679

Mannan, H., Eltayeb, S., Maclachlan, M., Amin, M., McVeigh, J., Munthali, A., & Van Rooy, G. (2013). Core concepts of human rights and inclusion of vulnerable groups in the mental health policies of Malawi, Namibia, and Sudan. *International Journal of Mental Health Systems*, *7*(1), 7. https://doi.org/10.1186/1752-4458-7-7

Marquez, P. V., & Saxena, S. (2016). Making mental health a global priority. *Cerebrum*, *2016*. (accessed Jul-Aug).

Maycraft Kall, W. (2014). Same law-same rights? Analyzing why Sweden's disability legislation failed to create equal rights in mental health. *International Journal of Law and Psychiatry*, *37*(6), 609–618. https://doi.org/10.1016/j.ijlp.2014.02.035

McKague, C. (1988). Involuntary hospitalization: Are new mental health laws necessary? A patients' rights perspective. *Health Law in Canada*, *9*(1), 15–17. https://www.ncbi.nlm.nih.gov/pubmed/10312791

Mental Health and Substance Use Department. (2021). *Guidance on community mental health services: Promoting person-centred and rights-based approaches* (World Health Organization). https://www.who.int/publications/i/item/9789240025707

Minoletti, A., Toro, O., Alvarado, R., Carniglia, C., Guajardo, A., & Rayo, X. (2015). a Survey about quality of care and users' rights in chilean psychiatric services. *Revista Médica de Chile*, *143*(12), 1585–1592. https://doi.org/10.4067/S0034-98872015001200012

Morrissey, F. (2012). The United Nations convention on the rights of persons with disabilities: A new approach to decision-making in mental health law. *European Journal of Health Law*, *19*(5), 423–440. https://doi.org/10.1163/15718093-12341237

Ogunwale, A. (2019). Involuntary mental health treatment in england and wales: A rights-based critique of current legal frameworks and recommendations for reform. *International Journal of Law and Psychiatry*, *66*, 101451. https://doi.org/10.1016/j.ijlp.2019.101451

Page, M. J., & Moher, D. (2017). Evaluations of the uptake and impact of the preferred reporting items for systematic reviews and meta-analyses (Prisma) statement and extensions: A scoping review. *Systematic Reviews*, *6*(1), 263. https://doi.org/10.1186/s13643-017-0663-8

Passmore, K., & Leung, W. C. (2003). Psychiatrists' knowledge of the human rights act and its relevance to mental health practice: A questionnaire survey. *Medicine, Science and the Law*, *43*(2), 136–140. https://doi.org/10.1258/rsmmsl.43.2.136

Patel, G. (2008). Community treatment orders in Victoria: A clinico-ethical perspective. *Australas Psychiatry*, *16*(5), 340–343. https://doi.org/10.1080/10398560802233017

Patel, V. (2007). Mental health in low- and middle-income Countries. *British Medical Bulletin*, *81–82*(1), 81–96. https://doi.org/10.1093/bmb/ldm010

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., … UnÜtzer, JÜrgen. (2018). The lancet commission on global mental health and sustainable development. *Lancet*, *392*(10157), 1553–1598. accessed Oct 27). https://doi.org/10.1016/S0140-6736(18)31612-X

Pathare, S. (2019). Systematic evaluation of the qualityrights programme in public mental health facilities in Gujarat, India. *British Journal of Psychiatry*, *2019*, 1–8.

Porsdam Mann, S., Bradley, V. J., & Sahakian, B. J. (2016). Human rights-based approaches to mental health: A review of programs. *Health and Human Rights*, *18*(1), 263–276. https://www.ncbi.nlm.nih.gov/pubmed/27781015

Puras, D., & Gooding, P. (2019). Mental Health and Human Rights in the 21st Century. *World Psychiatry*, *18*(1), 42–43. https://doi.org/10.1002/wps.20599

'Qualityrights Materials for Training, Guidance and Transformation', World Health Organization. (2021). https://www.who.int/publications/i/item/who-quality-rights-guidance-and-training-tools)

Rekhis, M., Ben Hamouda, A., Ouanes, S., & Rafrafi, R. (2017). Rights of people with mental disorders: Realities in healthcare facilities in Tunisia. *International Journal of Social Psychiatry*, *63*(5), 439–447. https://doi.org/10.1177/0020764017712301

Ssebunnya, J., Ndyanabangi, S., & Kigozi, F. (2014). Mental Health Law Reforms in Uganda: Lessons learnt. *International Psychiatry*, *11*(2), 39–40. https://doi.org/10.1192/S1749367600004367

Sugiura, K., Mahomed, F., Saxena, S., & Patel, V. (2020). An end to coercion: Rights and decision-making in mental health Care. *Bulletin of the World Health Organization*, *98*(1), 52–58. https://doi.org/10.2471/BLT.19.234906

Szmukler, G. (2014). The Un convention on the rights of persons with disabilities and Uk Mental Health Legislation. *British Journal of Psychiatry*, *205*(1), 76. https://doi.org/10.1192/bjp.205.1.76

Szmukler, G. (2020). Involuntary detention and treatment: Are we edging toward a "Paradigm Shift"? *Schizophrenia Bulletin*, *46*(2), 231–235. https://doi.org/10.1093/schbul/sbz115

Szmukler, G., Daw, R., & Callard, F. (2014). Mental health law and the Un convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry*, *37*(3), 245–252. https://doi.org/10.1016/j.ijlp.2013.11.024

Taylor, S. M., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin*, *7*(2), 225–240. https://doi.org/10.1093/schbul/7.2.225

The World Health Report 2001 - Mental Health: New Understanding, New Hope. (2001). Retrieved June 14, 2020, from https://www.Who.Int/Whr/2001/En/Whr01_En.Pdf?Ua=1.',

Tingle, J. (2018). Monitoring the Mental Health Act: A need to protect patients' rights. *The British Journal of Nursing*, *27*(6), 344–345. https://doi.org/10.12968/bjon.2018.27.6.344

United Nations. (2006). 'Convention on the Rights of Persons with Disabilities. Retrieved December 3, 2021, from https://www.Refworld.Org/Docid/45f973632.Html',

United Nations. (2021). Sustainable Development Goals. Retrieved December 3, 2021, from https://www.Un.Org/Sustainabledevelopment/').

van der Eijk, Y. (2018). The convention on the rights of persons with disabilities as a Tobacco control tool in the mental health setting. *Tobacco Control*, *27*(6), 637–642. https://doi.org/10.1136/tobaccocontrol-2017-053954

van Voren, R. (2002). Comparing Soviet and Chinese Political Psychiatry. *The Journal of the American Academy of Psychiatry and the Law*, *30*(1), 131–135. https://www.ncbi.nlm.nih.gov/pubmed/11931361

van Voren, R. (2017). Mental health and human rights in Russia-a Flawed Relationship. *The Lancet*, *390*(10102), 1613–1615. https://doi.org/10.1016/S0140-6736(17)32402-9

Vine, R., & Komiti, A. (2015). Carer experience of community treatment orders: Implications for rights based/recovery-oriented mental health legislation. *Australasian Psychiatry*, *23*(2), 154–157. https://doi.org/10.1177/1039856214568216

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, J.-M E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and opportunities in global mental health: A research-to-practice perspective. *Current Psychiatry Reports*, *19*(5), 28. https://doi.org/10.1007/s11920-017-0780-z

Wand, A., & Wand, T. (2013). Admit voluntary, schedule if tries to leave: Placing Mental Health Acts in the context of mental health law and human rights. *Australasian Psychiatry*, *21*(2), 137–140. https://doi.org/10.1177/1039856212466923

Watchirs, H. (2005). Human rights audit of mental health legislation-results of an Australian pilot. *International Journal of Law and Psychiatry*, *28*(2), 99–125. https://doi.org/10.1016/j.ijlp.2005.03.001

World Health Organization. (2005). *Who resource book on mental health, human rights and legislation*. WHO Publishing.

Xiang, Y. (2012). The proposed national mental health law in China: A landmark document for the protection of psychiatric patients' civil rights. *Shanghai Arch Psychiatry*, *24*(1), 48–49. https://www.ncbi.nlm.nih.gov/pubmed/25324603

Xiang, Y. T., Yu, X., & Chiu, H. F. (2010). Compulsory admission to psychiatric hospitals in China. *The Lancet*, *376*(9747), 1145–1146. https://doi.org/10.1016/S0140-6736(10)61539-5

Zuniga-Fajuri, A., & Zuniga-Fajuri, M. (2019). 'Mental health policies tackling violation of children's human rights in chile. *Lancet Child Adolesc Health*, *3*(4), 210–211. https://www.ncbi.nlm.nih.gov/pubmed/30878110