



**RESTORING DIGNITY AND AUTONOMY:**

**GLOBAL BEST PRACTICES AS  
ALTERNATIVES TO INVOLUNTARY  
HOSPITALIZATION AND TREATMENT AND  
PATHWAYS FOR REFORM IN ARMENIA**

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**Submitted to:  
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**This report was commissioned and funded by Helsinki Citizens' Assembly-Vanadzor Office (HCAV) as part of its ongoing efforts to promote rights-based mental health reforms in Armenia. It was prepared by Transforming Communities for Inclusion (TCI Global) team, in close consultation with national stakeholders and organisations of persons with psychosocial disabilities.**

The purpose of this report is to support legal and policy reform initiatives in Armenia, grounded in the principles and obligations of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The report reflects the movement's ongoing advocacy to end coercive practices, uphold legal capacity and promote community inclusion of persons with psychosocial disabilities.

*The information, views, and interpretations expressed in this report are those of the authors and do not necessarily reflect the views of HCAV or any other affiliated organisation.*

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The report was commissioned by **Helsinki Citizens' Assembly-Vanadzor (HCAV)** which is a non-governmental human rights organization that unites individuals who value democracy, tolerance, pluralism and principles of human rights supremacy. The Organization was founded in 1998 as an HCA Armenian Committee branch and has operated as a separate organization since 2001. The headquarters of the Organization is located in Vanadzor and it has a representative office in Yerevan. HCA Vanadzor provides free legal support to around 1000 citizens on the whole RA territory yearly, conducts strategic litigation within this framework, conducts monitoring in closed and semi-closed institutions, as well as state structures, local self-government bodies and electoral processes. The Organization analyzes legal acts and presents legislative recommendations, implements peacebuilding projects and provides international structures with information regarding the fulfilment of international obligations undertaken by the Republic of Armenia. (<https://hcav.am/en/>)



The report is prepared by **Transforming Communities for Inclusion (TCI Global)**. It is a post CRPD movement, and a membership based global organization of persons with psychosocial disabilities with members in 50+ countries. The identity of persons with psychosocial disabilities is derived from the Convention on the Rights of Persons with Disabilities (CRPD) description of the disability and is inclusive of persons who identify as 'users and survivors of psychiatry, 'mad' persons', persons who have been targeted as 'of unsound mind', autistic persons, persons with intersectional and neurodiverse identities, including persons with psychosocial disabilities. Empowered by the extraordinary vision and guidance of the Convention on the Rights of Persons with Disabilities (CRPD), TCI's purpose is to situate them at the centre of the cross-disability movements at the national, regional, and global levels, to reclaim their dignity and autonomy and experience independence to realize their right to live in the community. ([www.tci-global.org](http://www.tci-global.org))

## Executive Summary

The report offers an in-depth understanding of the mental health landscape in Armenia, along with a comprehensive plan for reform. It reveals significant issues within the mental health system, notably the regular use of coercive practices such as involuntary treatment and hospitalization, which are rooted in outdated legal frameworks inherited from the Soviet era and stereotypes associated with persons with psychosocial disabilities. The document emphasizes the damaging effects of forced treatments, which infringes upon fundamental human rights, and contrasts these practices with global best practices that promote non-coercive, rights-based services and support systems.

Involuntary hospitalization and treatment remain prevalent in Armenia, affecting approximately 10-12% of individuals within healthcare settings each year, primarily due to a lack of adequate community-based services and support systems. Legal and procedural gaps allow these practices to continue, often resulting in violations of the United Nations Convention on the Rights of Persons with Disabilities and other international human rights agreements, ratified by Armenia. Guardianship and legal incapacity persist under Civil Code, Criminal Code and other legislations regulating field of psychiatric care. Community based alternatives remain underfunded or non-existent, despite policy declarations. Engagement and meaningful participation of persons with psychosocial disabilities remain severely limited in decision making processes.

Armenia's obligations under various UN conventions require it to abolish involuntary treatment, institutionalization, and all forms of disability-based discrimination.

The report captures successful alternatives to forced treatment and forced hospitalization from various countries, focusing on supported decision making, legal reforms, rights based crisis support responses, practices to reduce or eliminate coercion for healthcare settings and mobilizing peer-support networks that uphold autonomy and dignity. These practices align with a human rights model of disability, advocating for inclusive services and the abolition of forced treatment.

The report proposes a six-pronged roadmap for transformation: **Legal Reform:** Repeal laws allowing coercion and guardianship; restore legal capacity; **Monitoring & Accountability:** Establish independent monitoring and complaint mechanisms; **Resource Reallocation:** Redirect funding from institutions to inclusive support services; **National Deinstitutionalization Strategy:** Develop an action plan, halt new admissions, and support transitions; **Public Awareness:** Combat stigma, educate professionals and communities, and promote cultural transformation and **Multisectoral Partnerships:** Engage OPDs, donors, and ministries in policy co-development.

To uphold human rights, Armenia must shift from a coercive, institutional model to a CRPD-compliant system rooted in autonomy, dignity, and inclusion of persons with psychosocial disabilities. This transition must be participatory, well-resourced, and time-bound, with leadership from persons with psychosocial disabilities and their organizations.

## TCI Global's positionality on alternatives to forced treatment and institutionalization

TCI Global, as an Organization of Persons with Psychosocial Disabilities (OPD), is firmly grounded in the CRPD and committed to the principles of inclusion and rights-based approaches. As a movement of persons with psychosocial disabilities, users and survivors of psychiatry, consumers, mad identity, persons with intersectional and neurodiverse identities, **we advocate for complete deinstitutionalization and promoting the right to living and being included in the community, on an equal basis with others.** We affirm that institutions (hospitals, care homes, social care institutions, small groups homes etc.) are not places of residence or care for us. **TCI has always opposed reformist moves** such as improving institutional infrastructure, encouraging better staff behaviour, promoting the principle of least restriction etc. **as it only provides remedial measures and does not address the mentality of bundling people for 'therapeutic care' using the power of law.** TCI has sustained its focus on the right to live independently in the community and be included (Article 19 of the CRPD) as a way to reclaim our dignity and autonomy and experience our independence to realize our rights.

Recognizing the contextual realities in Armenia and acknowledging the perspectives of the stakeholders engaged in this project, we have included recommendations for a few best practices (that are non-coercive, non violent and rights based) in the realm of mental health services. However, **we have also included the risks involved with such services and do not endorse these** alternatives as aligned with our values and the CRPD. **For us, there is no middle ground:** we remain committed to advocating for immediate deinstitutionalization, abolition of coercive practices, establishing of community support services and support systems and transforming communities and policies for true inclusion of persons with psychosocial disabilities.

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## Abbreviations

ALCE: Abolition of Punishment and Confinement Logics  
BET Unit: Basal Exposure Therapy  
CAT: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment  
CBHCs: Community-Based Mental Health Centres  
CBO: Community Based Organisation  
CCPR: Covenant on Civil and Political Rights  
CEDAW: Convention on the Elimination of all forms of Discrimination against Women  
CMHCs: Community Mental health Centres  
CPED: International Convention for the Protection of All Persons from Enforced Disappearance  
CRC: Convention on the Rights of the Child  
CRPD: Convention on the Rights of Persons with Disabilities  
CSOs: Civil Society Organisations  
CTOs: Community Treatment Orders  
DI: De-Institutionalization  
FGC: Family Group Conferencing  
FRESH: Finding Recovery Through Exercise Skills and Hope  
GCC: Gerstein Crisis Centre  
GPs: General Practitioners  
HCAV: Helsinki Citizens' Assembly's Vanadzor Office  
HIV: Human Immunodeficiency Virus  
ICCPR: International Covenant on Civil and Political Rights  
LGBQI: Lesbian, Gay, Bisexual, Queer, Intersex  
LMICs: Lower- and Middle-Income Countries  
MHCs: Mental health Centres  
MHMUs: The Mental Health Mobile Units  
MHPSS: Mental Health and Psychosocial Support  
NCS – CAF: Nidahas Chinthana Sansadaya – Consumer Action Forum  
NGO: Non-Governmental Organisation  
ODM: Open Dialogue Model  
OOPs: Out-of-Pocket Payments  
OPDs: Organizations of Persons with Disabilities  
OPGs: Judicial Psychiatric Hospitals  
PANUSP: Pan African Network of Users and Survivors of Psychiatry  
PHCs: Primary health Care  
PO: Personal Ombudsman  
PSWs: Peer Support Workers  
RCT: Randomized Controlled Trial  
REMS: Residence for Execution of Security Measures  
SAMHSA: Substance Abuse for Mental Health Services

SDM: Supported Decision Making  
SOAP: Speak out against Psychiatry Manifesto  
SPDCs: Servizi Psichiatrici di Diagnosi e Cura  
SR report: Special Rapporteur Report  
TCI: Transforming Communities for Inclusion  
UDHR: Universal Declaration of Human Rights  
UNCRPD/CRPD: United Nations Convention on the Rights of Persons with Disabilities  
UNGA: United Nations General Assembly  
UNICEF: United Nations Children's Fund  
UNSAI: The Uganda National Self Advocacy Initiative  
WHO: World Health Organization

## 1 | Introduction

Mental health systems and structures have traditionally leaned heavily on coercion, disregarding and violently taking away the right of individuals with psychosocial disabilities to make decisions about their lives, within health settings or in their own homes. These violations have been enshrined in legal frameworks, policy documents and government strategies often operating in a paternalistic framing of being done in their “best interests” resulting in withdrawing justice to deliver care.<sup>1</sup> This is also the result of the misconceptions and stereotyping of these individual’s as “dangerous”, “violent ones”, “lunatic”, “persons with unsound mind”, also the official language still being used in laws in some countries.<sup>2</sup>

Discriminatory legislations enable deprivation of liberty based on disability and officially allows them to be subjected to forced treatment, admission and procedures. Such an atmosphere is also conducive for guardianship systems and substituted decision-making further rendering persons with psychosocial disabilities as persons without any legal capacity or what OPDs term “civil death”.<sup>3</sup> With the advent of the UNCRPD, countries are legally bound to end these highly discriminatory and dehumanizing measures. Survivors of institutionalization, OPDs, scholars and activists have documented abuses of these legislations and substituted decision regime leading to human rights violations of persons with psychosocial disabilities.<sup>4,5,6</sup> Additionally, the use of forced psychiatry as a political tool to silence dissent and as personal means to settle disputes regarding inheritance, finances, property and relationships is well documented.<sup>7,8</sup> Coercive practices and involuntary institutionalization has frequently been applied despite limited clinical evidence

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<sup>1</sup> Delivering Justice, Withdrawing Care: The Norms and Etiquettes of 'Having' a Mental Illness. Available: <https://academic.oup.com/book/6389/chapter-abstract/150151729?redirectedFrom=fulltext>

<sup>2</sup> TCI Global. (2018). Bali Declaration 2018. Available: <https://whatweneed.tci-global.org/bali-declaration-2018/>

<sup>3</sup> Video: Legal Capacity Laws, Policies, and Practices, and Women with Intellectual and Psychosocial Disabilities. 2023. Available: <https://tci-global.org/inclusive-justice-leaving-no-one-behind/>

<sup>4</sup> Opinion Piece: House of Horrors, Tale of terror: Sadly, nothing new here. Available: [https://whatweneed.tci-global.org/wp-content/uploads/2023/01/WhatWENeed-submission\\_TCI\\_Final.pdf](https://whatweneed.tci-global.org/wp-content/uploads/2023/01/WhatWENeed-submission_TCI_Final.pdf)

<sup>5</sup> Lewis, J. (2019, November 8). On Admission To Wrekin. Recovery in the Bin. Accessed on December 22 at <https://recoveryinthebin.org/2019/11/08/on-admission-to-wrekin/>

<sup>6</sup> AM, A. D. (2013, April 24). Liberation Day...and I woke up singing... Asylum Magazine. Accessed on December 22 at <https://asylummagazine.org/2013/04/liberation-day-and-i-woke-up-singing-today/>

<sup>7</sup> van Voren R. Political abuse of psychiatry--an historical overview. Schizophr Bull. 2010 Jan;36(1):33-5. doi: 10.1093/schbul/sbp119. Epub 2009 Nov 5. PMID: 19892821; PMCID: PMC2800147. Available:<https://pmc.ncbi.nlm.nih.gov/articles/PMC2800147/>

<sup>8</sup> European Parliament: Directorate-General for External Policies of the Union and Van Voren, R., *Psychiatry as a tool for coercion in post-Soviet countries*, Publications Office, 2013, <https://data.europa.eu/doi/10.2861/28281>

supporting its effectiveness.<sup>9</sup> As reiterated by OPDs, “coercion is not care” and institutions cannot be considered as places of residence.<sup>10,11</sup>

Prevalent medical model of disability and its limitations, lack of community support services and support systems, insufficient resources and funding for community living, no availability or access to mainstream services, improper understanding of crisis situations and support plans, disabling legal frameworks and disregard of local and cultural ways of well-being and healing are some of the key pre-conditions for enabling forced admissions and forced treatments. A prevailing assumption that individuals with psychosocial disabilities lack decision-making capacity fuels a harmful cycle of marginalization, rights violation and mistreatment.

Armenia derives its legal frameworks from the Soviet Era laws and the country has moved in the direction of reforming its mental health system. The strong focus on psychiatric care and availability of services within institutions is a remnant of the Soviet era thinking of mental health “care”. Legal frameworks that enable forced procedures remain prevalent and in function. In Armenia, 10-12% of individuals receiving hospital treatment each year are subjected to involuntary care, with men aged 30-50 making up the majority<sup>12</sup>. People with psychosocial and intellectual disabilities represent a distinct group affected by involuntary treatment, often due to a lack of community-based care services, making psychiatric institutions the only option for extended care and stay.

In 2022, 123 applications were submitted to the courts for involuntary treatment, of which 103 were processed, with 69% being approved. While guardianship bodies are required to participate in court proceedings when the person lacks a representative, this involvement is often superficial, as representatives typically lack detailed information about the individual and cannot provide a substantive defence. Guardianship regimes are also in direct contradiction to the UNCRPD and often end up propagating substituted decision making.<sup>13</sup> Additionally, apart from the Syunik Region Neuropsychiatric Dispensary, individuals under involuntary treatment are not

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<sup>9</sup> Sashidharan SP, Mezzina R, Puras D. Reducing coercion in mental healthcare. *Epidemiol Psychiatry Sci.* 2019 Dec;28(6):605-612. doi: 10.1017/S2045796019000350. Epub 2019 Jul 9. PMID: 31284895; PMCID: PMC7032511.

<sup>10</sup> Wooley, S. (2020). “Coercion is not care”: A paradigm shift underway thanks to a perspective informed by human rights. *L'information psychiatrique*, 96(1), 27-34. Available: [https://www.ile.com/en/revues/ipe/e-docs/ce\\_nest\\_pas\\_du\\_soin\\_si\\_cest\\_contraint\\_un\\_changement\\_de\\_paradigme\\_en\\_route\\_grace\\_a\\_un\\_regard\\_eclairer\\_par\\_les\\_droits\\_humains\\_316139/article.phtml](https://www.ile.com/en/revues/ipe/e-docs/ce_nest_pas_du_soin_si_cest_contraint_un_changement_de_paradigme_en_route_grace_a_un_regard_eclairer_par_les_droits_humains_316139/article.phtml)

<sup>11</sup> Parliamentary Assembly. (2019, June 26). Ending coercion in mental health: the need for a human rights-based approach. Assembly debate. Strasbourg, France. Available: [PACE website](#)

<sup>12</sup> HCAV. (2023). Report on the practice of involuntary hospitalization and treatment in Armenia. Available at: Report on the practice of involuntary hospitalization and treatment in Armenia Read more <https://hcav.am/en/hospitalization-17-11-2023/>

<sup>13</sup> Davar, B. V. (2023, January 6). Statement of Expert Testimony on the topic of Legal Capacity and Guardianship of persons with disabilities, before the Hon. Constitutional Court of Indonesia. Transforming Communities for Inclusion [TCI] – Global. Available: <https://tci-global.org/wp-content/uploads/2024/02/Submission-Indonesia-Constitutional-Court-Expert-Testimony-TCI.pdf>

offered legal representation.<sup>14</sup> The lack of clear guidelines for appeal reviews in involuntary treatment cases further limits access to justice. Involuntarily treated individuals face high court fees, which have risen more than fourfold since 2021, and lack the right to challenge their hospitalization.<sup>15</sup>

Monitoring has shown that involuntary treatment does not prevent future hospitalization.<sup>16</sup> Community services, which could help reduce repeated hospitalizations and support better conditions for those with psychosocial disabilities, remain insufficiently developed.<sup>17</sup> There is the view that extending setting up of community support services will make institutions go away. “However, as long as legal barriers are provided as a solution and a “service”, exclusion will persist, and lives in the communities will always run the risk of having their lives interrupted and fragmented, exposing them to the risks and violations of inhuman, degrading, torturous treatments”.<sup>18</sup>

This report is designed to gather the necessary information through an in-depth desk review and qualitative approaches and documenting best practices led by OPDs implementing alternative practices to these forced procedures. The review includes an inventory of international best practices for alternatives to forced hospitalization and treatment, as well as recommendations for transforming Armenia’s current system of involuntary psychiatric hospitalization and treatment. The report is drafted for Helsinki Citizens' Assembly's Vanadzor Office (HCAV).

The troubling ease with which individuals in Armenia can be involuntarily hospitalized has been highlighted. People who consider themselves without any psychosocial disability may also find themselves institutionalized indefinitely based on a single complaint from relatives, neighbours, or others, with police and emergency doctors facilitating their admission.<sup>19</sup>

HCAV conducted a study of five Armenian psychiatric hospitals (four in Yerevan), gathering information from 316 individuals, including hospital staff, directors, and patients. The findings, which have been shared with the Ministry of Health, reveal systemic risks. The case of 53-year-old Zhulieta Amarikian at Yerevan’s Avan psychiatric hospital serves as a stark example: After a family dispute over inherited property, Amarikian’s brother allegedly threatened to have her committed, despite her

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<sup>14</sup> HCAV. (2023). Report on the practice of involuntary hospitalization and treatment in Armenia. Available at: Report on the practice of involuntary hospitalization and treatment in Armenia Read more <https://hcav.am/en/hospitalization-17-11-2023/>

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Transforming Communities for Inclusion (TCI). (2022, October 14). Report on “Re-Imagining Services in the 21st Century to give effect to the right to live independently and be included in the community for persons with disabilities”. Available: <https://tci-global.org/wp-content/uploads/2023/07/TCI-CFI-SRDisabilities-Re-Imagining-Services.pdf>

<sup>19</sup> Grigoryan, M. (2014, July 17). Armenia: Report Details Psychiatric Hospital Abuses. *Eurasianet*. Retrieved October 12, 2024, from <https://eurasianet.org/armenia-report-details-psychiatric-hospital-abuses>

having no history of mental health needs. Police reportedly arrived the next day, forcing her into an ambulance and transporting her to Avan psychiatric hospital.<sup>20</sup>

The report team confirmed that Amarian did not face any psychosocial disabilities. However, the clinic's environment caused her distress, and though she initially refused medication, doctors administered it forcibly. Supported by legal assistance from the HCAV, Amarian successfully petitioned for her release, later being declared mentally competent after a court-ordered psychiatric evaluation. She was discharged after over a month of involuntary confinement, expressing frustration over her detention despite leading a quiet, uneventful life.<sup>21</sup> Amarian continued to face attempts by her brother to have her legally declared mentally incompetent, a scenario made possible under Armenian law. This is just one case out of many, who have been subjected to the ramifications of having a disabling legal environment.

Many of those affected were elderly, unmarried, or lived alone, as seen in the Helsinki Assembly's study conducted a decade ago.<sup>22</sup> Deputy Ombudsman remarked at that time that Amarian's case was not unique; their office received frequent complaints from neighbours or letters from concerned individuals. According to them, conditions in psychiatric hospitals often worsened the patient's situation. Individuals with no mental health labels/diagnosis were reported being forcibly restrained, subjected to violence, and injected with sedatives.<sup>23</sup> Some patients were allegedly beaten with blankets over their faces to prevent visible bruising. The use of psychotropic drugs in these cases raised additional concerns as such medications can affect an individual's health significantly, making it challenging to assess their initial condition after extended treatment.<sup>24</sup> Armenian legislation had enabled such similar situations. The lack of clear statistics further prevented the ombudsman's office from accurately tracking how often individuals are institutionalized.<sup>25</sup> If this is the scenario for individuals without any history of psychosocial disability, one can only imagine the plight of those who have been "diagnosed" or labelled with a psychosocial disability. The very label takes away the personhood, subjecting them to forceful admissions and procedures. It has also been observed that psychiatric hospitals, as closed institutions, are also used as tools for resolving personal conflicts, such as those related to revenge, wills, inheritance, or housing.<sup>26</sup>

Armenia has made some advances toward mental health reform, including ratifying the CRPD in 2010, adopting a national disability rights law in 2021, and outlining commitments through the 2022–2026 Mental Health Action Plan. However, these efforts have yet to translate into systemic changes on the ground. The persistence of coercive practices, institutionalization, and disabling legal frameworks continues to

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<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.

<sup>26</sup> Ibid.

create an urgent need for rights-based transformation. This report therefore situates Armenia's reform journey as one in progress, marked by promising intent but challenged by deeply embedded legacies and operational gaps.

More recently, an investigation conducted in the Vardenis Neuropsychological Boarding House, which accommodated 450 individuals with psychosocial disabilities uncovered severe abuse and rights violations<sup>27</sup>. The Director and three staff of the centre were detained for offenses including not providing enough food and cigarettes for the individuals, labour being conducted by the patients rather than the staff, cleaning duties performed by the individuals for director's private property etc. One individual was found chained up with a metal chain and the other was tied by his hands and feet to the four corners of the bed. Although the Ministry of Labour and Social Affairs responded that it was closely following the case, the centre continues to operate as normal.

The 2007 UNCRPD marked a significant advancement in the rights of individuals with disabilities. Article 12 of the Convention affirms their right to equal recognition before the law, and in 2014, General Comment 1 on this article clarified that all individuals have decision-making capacity, rendering substitute decision-making incompatible with legal equality. Instead, the Convention and General Comment 1 advocate for supported decision-making, where accommodations and support enable individuals to express their own will and preferences. In rare cases where individuals cannot communicate their choices, practitioners and officials should strive to interpret the person's will as accurately as possible. The Convention has become one of the most widely ratified treaties, with 177 state parties as of today. By 2017, at least 32 countries had either reformed or were in the process of updating their mental health laws to align with the Convention's principles. Armenia ratified it in 2010. The biggest opposition by the critics of the Convention have been towards Article 12 and General Comment 1 wherein they elaborate upon "difficult" circumstances and question the wisdom of allowing an individual's right to autonomy to be protected at the expense of the right to life.<sup>28</sup> However, persons with psychosocial disabilities and OPDs have responded to this criticism by proposing pathways for supported decision making so that legal capacity can be exercised by everyone, with or without disability.<sup>29</sup>

Involuntary treatment and admission stand in clear opposition to the principle of autonomy, a core value upheld by the UNCRPD. The legitimacy and quality of coercive mental health care practices are increasingly scrutinized; evidence suggests that such treatments can inflict significant trauma, fail to provide sustained benefits, and create

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<sup>27</sup> amartikian. (2023, February 21). Torture and exploitation at a psychiatric care center in Armenia. *English Jamnews*. <https://jam-news.net/torture-at-varde-nis-care-center/>

<sup>28</sup> Appelbaum, P. S. (2019). Saving the UN Convention on the Rights of Persons with Disabilities—from itself. *World Psychiatry*, 18(1), 1. Available: <https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20583>

<sup>29</sup> Ombati, E. (2019). The Promise of the CRPD for persons with psychosocial disabilities. Blog. Available: [The Promise of the CRPD for persons with psychosocial disabilities | Elizabeth Ombati](#)

fear that deters individuals from seeking support. Critics of the Convention's autonomy-based approach argue that its universal application might undermine the right to health by limiting access to emergency treatment for those at risk of self-harm or harm to others, potentially leading to further impairment.<sup>30</sup>

Despite ongoing debate, growing evidence supports the effectiveness of non-coercive support models. These approaches, rooted in dignity and autonomy, prioritize individuals' rights and provide essential support. Community-based interventions, which emphasize individuals' will and preferences, illustrate these principles in action. Such practices not only protect the right to health but also reflect a more humane and acceptable form of care that supports equality, avoiding the negative implications of coercion. The entry point for the movement of persons with psychosocial disabilities has shifted to broader door of human rights and development.<sup>31</sup> The aspirations of persons with psychosocial disabilities is not just the right to health or good treatments or better conditions at the institutions, they aspire for fuller, richer lives, living in their communities, have access to support services and mainstream services, have robust support systems and social capital and opportunities for full and true inclusion.<sup>32</sup>

Coercive practices undermine equality by denying individuals an equal right to make decisions about their well-being. They also infringe on the right to living in the community, often leading to institutionalization and further isolation, despite research showing that community inclusion supports prevention, recovery and well-being. While managing high support needs situation need proper planning and mobilization of resources, arbitrary restrictions on rights and disability-based detention only deepen stigma and further exclude persons with psychosocial disabilities.

Concerns about coercive mental health practices also extend to the right to protection from cruel, inhumane, and degrading treatment. In 2013, the UN Special Rapporteur (SR) on torture urged states to ban all forced medical interventions, including non-consensual psychosurgery, electroshock, and restraint. Similarly, the 2017 report from the Special Rapporteur on health emphasized that involuntary treatment, despite its limited clinical benefit and rights concerns, remains widespread, calling for a substantial reduction in coercion and a shift away from forced psychiatric treatment and confinement.

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<sup>30</sup> Guernsey, K. (2018). Committee on the Rights of Persons with Disabilities. In *The UN Convention on the Rights of Persons with Disabilities: A Commentary* (pp. 1012-1037).

<sup>31</sup> TCI Asia Pacific (2020). 'Reframing the momentum: From "mental health" to "inclusion" of persons with psychosocial disabilities'. Report of the Classic Edition Plenary of Transforming Communities for Inclusion (TCI) Asia Pacific, Pune. [Plenary report]. Available: <https://tci-global.org/wp-content/uploads/2022/05/TCI-Asia-pacific-classic-edition-plenary-report.pdf>

<sup>32</sup> Guernsey, K. (2018). Committee on the Rights of Persons with Disabilities. In *The UN Convention on the Rights of Persons with Disabilities: A Commentary* (pp. 1012-1037).

This report aims to:

- Analyze the existing conditions, challenges, and key policy issues shaping Armenia's mental health system, providing a comprehensive overview of the current landscape.
- Collect and present evidence on the best international practices that offer alternatives to forced hospitalization and treatment, highlighting effective models that prioritize autonomy and patient rights.
- Aggregate globally recognized standards and recommendations from a policy perspective, offering a framework that could inform Armenia's approach to mental health care reform.

To conclude, this report is grounded in the recognition that Armenia is not starting from zero and there have been promising actions. However, without legal harmonization, robust oversight mechanisms, and a decisive shift toward rights-based community inclusion, the current system will continue to fall short. The next chapters will outline international best practices and recommend pathways for Armenia to move from isolated reforms to a comprehensive and humane system of support.

### **The report is structured with 6 chapters**

**1 | Introduction:** The chapter sets the context of the report with the objectives and defines overall structure of the report.

**2 | Methodology:** The chapter expands on the literature reviewed, data collection methods the inclusion and exclusion criteria, and the limitations of the study

**3 | Recap of Global Conventions, Guidelines, OPD Declarations and Reports by Special Rapporteurs:** This chapter is the recap on the global conversations advocating for the rights of persons with psychosocial disability. The chapter is a desk review of global conventions, strategies, guidelines and reports by Special Rapporteurs identifying the issues that persons with psychosocial disability are facing and reminding the global audience about their rights. This chapter also centers the Declarations and Manifestos developed by OPDs clearly laying down the advocacy stand of the movement along with suggesting practical approach to rights-based supports.

**4 | Compendium of Best Practices on Alternatives to Involuntary Hospitalization and Treatment:** This chapter includes the Best Practices for alternatives to involuntary hospitalization and treatment on a global scale. It is based on scoping reviews and interviews with organizations of persons with psychosocial disabilities working on creating and implementing alternatives to coercive practices.

**5 | Situational Analysis on Rights of Persons with Psychosocial Disability in Armenia:** This chapter offers a comprehensive analysis of Armenia's legal and policy

framework related to individuals with psychosocial disabilities. It delves into the country's domestic legislation, constitutional provisions, and international commitments, with a particular focus on the UNCRPD. Additionally, it conducts a comparative analysis, assessing the alignment of Armenian laws and policies with international standards, including UN Guidelines on De-institutionalization, global best practices led by OPDs, and policies promoting the rights of persons with psychosocial disabilities. This comparative analysis aims to identify strengths, weaknesses, and potential areas for reform in Armenia's mental health system, ultimately striving to ensure a human rights-based approach.

**6 | Recommendation:** This chapter presents a detailed list of actionable recommendations that the Government of Armenia should consider to reform policy and practice landscape for individuals with psychosocial disabilities. These recommendations are informed by international best practices, human rights principles, and the specific needs of the Armenian population.

## 2 | Methodology

This chapter outlines the research approach employed. The methodology adopts a rights-based and participatory approach by combining a comprehensive desk review with qualitative methods, such as interviewing key leaders of the OPDs to gather evidence and recommendations.

The search strategy was initiated by identifying relevant Conventions, Guidelines, and Special Rapporteur Reports focusing on the rights of persons with disabilities and persons with psychosocial disabilities. The search also involved reviewing UN agency reports focusing on ending, reducing and/or preventing coercion in mental health care (compulsory admission, involuntary treatment, involuntary medication, seclusion, restraint etc.). There was also a focus on declarations and manifestos developed by OPDs laying down the needs of persons with psychosocial disabilities along with documenting call for actions for stakeholders.

According to the Committee on the Rights of Persons with Disabilities, '[f]orced treatment is a common problem for persons with psychosocial disabilities, including children.' This review focuses on these groups.

Efforts were taken to consider practices, strategies, policy and laws from across low-, middle- and high-income countries. Due to time and language constraints, we excluded articles which were not available in English (unless the abstract contained sufficient useful information). The scope of the review was also limited by time constraints. A more exhaustive study would also draw in material from the bibliographies of each study, would cast a view further back than 1990 and would undertake more consultations and peer review from leading representatives in the field, including more organizations of persons with psychosocial disabilities, civil society groups and academics.

**Process:** A literature review is aimed at collecting, analyzing and presenting available research in each field of interest. This scoping review used strict, transparent methods of surveying the literature and re-iterating the rights-based approach which has been cited in peer-reviewed articles to “grey literature” and international reports.

The following key questions guided the review:

1. *What laws, policies and/or practices help to reduce and eliminate coercive practices in mental health settings?*
2. *What alternative strategies, laws, policies and/or practices exist which promote rights-based support in the mental health context?*
3. *What are the current practices of involuntary hospitalization and treatment in Armenia?*

4. *What are the challenges associated with involuntary hospitalization and treatment documented globally?*
5. *What are the international best practices for alternatives to involuntary hospitalisation and treatment?*
6. *What are the key components of successful de-institutionalization and community inclusion models?*
7. *What are the challenges and barriers to implementing de-institutionalization and community inclusion in Armenia?*
8. *What are the policy implications for reforming the involuntary hospitalization and treatment system in Armenia?*

For the academic and 'grey' literature, a rapid review method (streamlined literature review) was used. Numerous search strings in multiple combinations of the following words were used in keyword fields, or abstract and title fields (where available in each database). Examples of search strings used include, but were not limited to:

- *'human rights' AND (mental AND (ill\* OR health OR disab\* OR impair\*)) AND (coerci\* OR force\* OR civil commitment)*
- *(mental AND (ill\* OR health OR disab\* OR impair\*)) AND (coerci\* OR force\* OR civil commitment)*
- *(mental AND (ill\* OR disab\* OR impair\*)) AND (coerci\* OR force\*) AND (alternative\* OR advoca\*)*
- *(mental AND (ill\* OR disab\* OR impair\*)) AND (coerci\* OR force\*) AND (law OR legislat\*)*
- *(coerc\* OR forced OR compulsory OR involuntary) AND (mental (health OR ill\*))*
- *('mental health' OR 'mental\* ill' OR psychosocial) AND 'human rights'*
- *('mental health' OR 'mental\* ill') AND alternatives*
- *non-coercive\* AND psychiatry*
- *(alternative\* OR voluntary\*) AND 'mental health'*
- *right\* AND 'mental health'*
- *advoca\* AND 'mental health'*
- *psychiatr\* AND voluntary*
- *psychiatr\* AND alternative\**
- *reduc\* AND (seclusion OR restraint) AND (mental (health OR ill\* OR disability))*
- *'crisis respite'*

- *'recovery'*
- *'Armenia'*

A limit was placed on the date range for the search, from the year 2000 onwards and a language filter was applied to focus on English-language results.

### **Desk Review:**

1. Understanding the context: Understanding what is meant by institutions, how de-institutionalization is defined, what are the prevailing conditions, status, challenges and key policy points being practiced worldwide and in Armenia.
2. Gathering international best practices: Collecting evidence of successful alternatives to forced hospitalizations and forced treatment globally.
3. Collating standards and recommendations: Identifying internationally recognized standards and recommendations from a policy perspective.

A comprehensive literature review encompassed academic literature, policy documents, critical reports and articles, Special Rapporteur's reports, Human Rights Council resolutions, concluding observations, and grey literature. Key policy documents, such as national policies, guidelines, and legislations in Armenia were analyzed to identify key themes, challenges, loopholes and strategies for promoting alternative systems.

The materials collected through the systematic review and consultation were analysed using thematic content analysis. Themes were identified through a mix of deductive coding (based on CRPD articles and UN recommendations) and inductive analysis of interview narratives and documents. Attention was paid to materials authored by the CRPD Committee, the Human Rights Committee and other treaty bodies, as well as the Special Rapporteurs for the Rights of Persons with Disability, on the Right to Health, on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and other human rights agencies.

**Qualitative Methods and Documenting Best Practices:** Six interviews were conducted to understand the OPD-led initiatives on de-institutionalization, community inclusion models, and advocacy with the governments against coercive measures and policy reforms. Interviewees were purposively selected based on their engagement with CRPD-compliant community support practices across regions. A questionnaire and email consent form were drafted and shared with the interviewees in advance. The interviews provided insights into program components, community work, challenges faced, and successful strategies.

**Analysis:** The interviews were recorded and transcribed. The best practices suggested during the interviews were embedded into the best practices chapter based on the relevant themes and patterns across the collected data from the desk review,

policy analysis and best practices. This allowed the exploration of a wide range of themes, understanding nuances, and identification of underlying meanings, emerging themes and connections.

**Feedback Processes:** Touchbase and feedback calls were scheduled with the Helsinki Citizens' Assembly-Vanadzor on the ongoing process and to seek advice and sharing of learning to enhance the quality and relevance of the review work. HCAV served as a key national partner based on their advocacy experience and familiarity with the Armenian legal and policy context. Additionally, updates were provided to the group through emails.

### *Overview of the Literature Cited*

1. UN Conventions
2. Strategies and Guidelines by United Nation agencies, other global organizations and OPDs
3. UN General Assembly reports by Special Rapporteurs
4. Human Rights Commissioner reports
5. Academic literature
6. Policy documents in the Armenian and European context
7. Best Practices on alternatives to involuntary hospitalization and treatment
8. Reports and other resource documents by OPD and CSOs
9. Blogs, Campaign weblinks, Newspaper/Magazine articles
10. Websites of CSOs, OPDs, and other initiatives implementing practices to enhance the rights of persons with disabilities

### 3 | Recap of Global Conventions, Guidelines, OPD Declarations and Special Rapporteurs' Reports

#### Introduction

Persons with psychosocial disabilities are often presumed to be incapable of living independently, a belief rooted in stigma, stereotypes, and misconceptions. These harmful assumptions have long denied them equal opportunities for autonomy and inclusion. Article 19 of the UNCRPD asserts that all persons with disabilities have the right to live independently and be included in the community, on an equal basis with others. The Convention represents a transformative shift from a medical and charity model of disability to a human rights-based approach that centers persons with disabilities as rights holders and decision makers.

In the context of psychosocial disabilities, exclusion stems not only from individual or clinical factors but from deeply embedded legal, social, political, and cultural structures. Discriminatory laws, outdated governance systems, and inequitable policies contribute to institutionalization, coercion, and marginalization. OPDs have responded by broadening their advocacy from the narrow lens of mental health reform to a wider rights based and development focused agenda, engaging diverse stakeholders to advance their right to inclusion.

Armenia has ratified several international treaties that obligate it to uphold the rights of persons with psychosocial disabilities. These frameworks, alongside declarations led by OPDs and guidance from UN human rights mechanisms, create a compelling roadmap for ending coercive practices, dismantling institutional models, and building inclusive systems of community support.

This chapter draws on these instruments to underscore why forced treatment and hospitalization are discriminatory, and why Armenia must commit to rights-based reform.

#### UN Conventions

##### United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

The UNCRPD calls on States Parties to protect and uphold rights of persons with disabilities including psychosocial disabilities, and to prevent and end involuntary or coercive interventions.<sup>33</sup>

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<sup>33</sup> Gooding, P., McSherry, B., ROPER, C., & Grey, F. (2022). Alternatives to coercion in mental health settings: a literature review. Available: [https://figshare.unimelb.edu.au/articles/report/Alternatives to Coercion in Mental Health Settings A Literature Review/21128083?file=37478731](https://figshare.unimelb.edu.au/articles/report/Alternatives%20to%20Coercion%20in%20Mental%20Health%20Settings%20A%20Literature%20Review/21128083?file=37478731)

Article 12 of CRPD discusses the “equal recognition before the law”.<sup>34,35</sup> Article 12 (2) specifies that “persons with disabilities enjoy legal capacity on equal basis with others in all aspects of life”.<sup>36,37</sup> The legal capacity is described as the “ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency)”.<sup>38,39</sup> Article 12(3) requires States Parties to take appropriate measures to provide access and support to persons with disabilities they may require in exercising their legal capacity. This also includes “support to make decisions about medical treatment and care”.<sup>40,41</sup> Article 13 of CRPD elaborates on Access to Justice for persons with disabilities. Article 19, the very heart of the CRPD, enshrines to the Right to living independently in the community, and being included. Article 25 of the CRPD addresses health care and “promotes the rights of persons with disabilities to the highest attainable standard of health on an equal basis with others, without discrimination on the basis of disability”.<sup>42</sup> Article 25(d) requires health care professionals to provide care “on the basis of free and informed consent”.<sup>43</sup> The CRPD has also stated that disability based detention and forced treatment of persons with disabilities on any grounds violates Article 12 of the CRPD in conjunction with Article 14 (Liberty and security of the person).<sup>44,45</sup> Involuntary detention is also in contradiction to Article 15 on “Freedom of torture or cruel, inhuman or degrading treatment or punishment”, Article 16 on “Freedom from exploitation, violence and abuse”, Article 17 on “Protecting the integrity of the person”, and Article 19 on “Living independently and being included in the community”. The Committee has consistently urged States Parties to repeal provisions that allow for compulsory admissions and treatment of persons with disabilities in mental health institutions based on actual or perceived impairments.<sup>46</sup>

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<sup>34</sup> Ibid.

<sup>35</sup> United Nations. (2006). Convention on the Rights of Persons with Disabilities.

<https://www.ohchr.org/en/hrbodies/crpd/pages/conventionrightspersonswithdisabilities.aspx>

<sup>36</sup> Gooding, P., McSherry, B., ROPER, C., & Grey, F. (2022). Alternatives to coercion in mental health settings: a literature review.

<sup>37</sup> United Nations. (2006). Convention on the Rights of Persons with Disabilities.

<https://www.ohchr.org/en/hrbodies/crpd/pages/conventionrightspersonswithdisabilities.aspx>

<sup>38</sup> Committee on the Rights of Persons with Disabilities. (2014). General Comment No. 1: Article 12: Equal Recognition Before the Law. UN Doc. CRPD/C/GC/1.

<sup>39</sup> Committee on the Rights of Persons with Disabilities. (2015). Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities. 14th sess, para. 13

<sup>40</sup> Committee on the Rights of Persons with Disabilities. (2014). General Comment No. 1: Article 12: Equal Recognition Before the Law. UN Doc. CRPD/C/GC/1.

<sup>41</sup> Committee on the Rights of Persons with Disabilities. (2015). Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities. 14th sess, para. 13

<sup>42</sup> Ibid.

<sup>43</sup> United Nations. (2006). Convention on the Rights of Persons with Disabilities.

<https://www.ohchr.org/en/hrbodies/crpd/pages/conventionrightspersonswithdisabilities.aspx>

<sup>44</sup> Committee on the Rights of Persons with Disabilities. (2014). General Comment No. 1: Article 12: Equal Recognition Before the Law. UN Doc. CRPD/C/GC/1.

<sup>45</sup> Committee on the Rights of Persons with Disabilities. (2015). Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities. 14th session.

<sup>46</sup> Gooding, P., McSherry, B., ROPER, C., & Grey, F. (2022). Alternatives to coercion in mental health settings: a literature review. Available: [https://figshare.unimelb.edu.au/articles/report/Alternatives to Coercion in Mental Health Settings A Literature Review/21128083?file=37478731](https://figshare.unimelb.edu.au/articles/report/Alternatives%20to%20Coercion%20in%20Mental%20Health%20Settings%20A%20Literature%20Review/21128083?file=37478731)

This treaty is central to ending coercive practices and establishing supported decision-making and inclusive community living in Armenia.

### **International Covenant on Civil and Political Rights (ICCPR)<sup>47</sup>**

The ICCPR is a multilateral treaty that builds on the rights of the UNDHR. It aims to ensure the protection of civil and political rights and formally entered into force in 1976. Armenia ratified ICCPR in 1993. Forced treatment and forced hospitalization is in direct contravention to the Articles of International CCPR. It goes against:

- Article 7 (The freedom from inhuman or degrading treatment or punishment);
- Article 9 (The right to liberty and security of the person and freedom from arbitrary arrest or detention);
- Article 10 (All people deprived of their liberty must be treated with humanity and respect for their dignity);
- Article 12 (The right to liberty of movement and freedom to choose residence);
- Article 16 (The right to be recognised as a person before the law);
- Article 17 (The right to privacy and its protection by the law) and
- Article 26 (The right to equality before the law and equal protection).

Armenia's obligations under the ICCPR support urgent legal reform to ensure rights-respecting alternatives to detention and forced care.

### **Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)<sup>48</sup>**

The CAT was adopted by the UN General Assembly in 1984 and came into force in 1987. "The Convention absolutely prohibits torture and other acts of cruel, inhuman, or degrading treatment or punishment."<sup>49</sup> Armenia ratified it in 1993. Forced treatment and forced hospitalization is in direct contravention to the CAT. It goes against:

- Article 1 (Definition of torture),
- Article 2 (Prevention of torture and non-derogability),
- Article 12 (Prompt and impartial investigation),
- Article 13 (Complaint procedures),

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<sup>47</sup> United Nations, General Assembly. (1966). *International Covenant on Civil and Political Rights*. Treaty Series, 999, 171. Available: <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights>

<sup>48</sup> United Nations. (2008). Torture and other cruel, inhuman or degrading treatment or punishment (A/63/175). Available: [https://www.institut-fuer-menschenrechte.de/fileadmin/Redaktion/PDF/Sonstiges/Report\\_Special\\_Rapporteur\\_on\\_torture\\_and\\_other\\_cruel\\_inhuman\\_or\\_degrading\\_treatment\\_or\\_punishment.pdf](https://www.institut-fuer-menschenrechte.de/fileadmin/Redaktion/PDF/Sonstiges/Report_Special_Rapporteur_on_torture_and_other_cruel_inhuman_or_degrading_treatment_or_punishment.pdf)

<sup>49</sup> United Nations Secretary-General. (2008). Torture and other cruel, inhuman or degrading treatment or punishment (Note by the Secretary-General) [A/63/175]. Retrieved from: [https://www.institut-fuer-menschenrechte.de/fileadmin/Redaktion/PDF/Sonstiges/Report\\_Special\\_Rapporteur\\_on\\_torture\\_and\\_other\\_cruel\\_inhuman\\_or\\_degrading\\_treatment\\_or\\_punishment.pdf](https://www.institut-fuer-menschenrechte.de/fileadmin/Redaktion/PDF/Sonstiges/Report_Special_Rapporteur_on_torture_and_other_cruel_inhuman_or_degrading_treatment_or_punishment.pdf)

- Article 14 (Victims' right to redress and rehabilitation) and
- Article 16 (Prevention of cruel, inhuman or degrading treatment or punishment).<sup>50</sup>

Additionally, UN Subcommittee on Prevention of Torture published its General Comment 4 of the Optional Protocol to the Convention Against Torture (CAT/OP/GC/1)<sup>51</sup>. Suggestions were made to the State Parties to give access to National Preventive Mechanisms and SPT to visit a range of closed settings including psychiatric institutions, social care institutions, group homes, long stay hospitals, nursing homes etc. The General Comment also specified that if reasonable accommodation or supports are not made available for persons with disabilities to live independently in the community, then such places or settings or facilities should also be considered as places of deprivation of liberty.

CAT strengthens the argument that coercive mental health interventions may constitute torture and must be abolished in Armenian law and practice.

### **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**

CEDAW was adopted by the UN General Assembly in 1979 and came into force in 1981. It is the international bill of rights that focuses on human rights of women. Armenia ratified it in 1993. Forced treatment and forced hospitalization is in direct contravention to various articles of the Convention. It violates:

- Article 1 (Definition of discrimination against women),
- Article 2 (Obligations to eliminate discrimination),
- Article 5 (Elimination of stereotypes and harmful practices),
- Article 12 (Access to healthcare),
- Article 15 (Equality before law) and
- Article 16 (Equality in family and marriage).

As forced hospitalization means removing the person from their home, community and admitting them to a hospital, hence the process violates all the mentioned articles. CEDAW underscores the need to eliminate gendered forms of coercion in mental health and provide gender-sensitive support systems.

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<sup>50</sup> UNCAT- Article by Article (Easy to Read). (n.d.). *CTI - Convention Against Torture Initiative*. <https://cti2024.org/resource/uncat-article-by-article/>

<sup>51</sup> Subcommittee on Prevention of Torture. (2024). General comment No. 1 (2024) on article 4 of the Optional Protocol (places of deprivation of liberty) (CAT/OP/GC/1). United Nations Human Rights Office of the High Commissioner (OHCHR). Retrieved from <https://documents.un.org/doc/undoc/gen/q24/099/35/pdf/q2409935.pdf>

## **Convention on the Rights of the Child (CRC)<sup>52</sup>**

CRC was adopted by the UN General Assembly in 1989 and officially entered into force in 1990. Armenia ratified it in 1993. This is one of the most ratified treaties and enforces that children are not merely objects belonging to their parents or adults in training and for whom decisions are made. Rather, the Convention viewed children as human beings and individuals with their own rights and set to protect and uphold the rights of children. Forced treatment and forced hospitalization is in direct contravention to various articles of the Convention as children with disabilities are often found in care homes and subsequently transferred to mental health institutions. Coercive and forced procedures goes against:

- Article 2 (Non-discrimination);
- Article 3 (Best interests of the child);
- Article 6 (Right to life, survival and development);
- Article 12 (Respect for the views of the child);
- Article 13 (Freedom of expression);
- Article 19 (Protection from all forms of violence);
- Article 23 (Rights of children with disabilities);
- Article 24 (Right to health);
- Article 25 (Periodic review of treatment in care) and
- Article 28 (Right to education).

This treaty compels Armenia to protect children from harmful practices in psychiatric settings and ensure family- and community-based supports.

## **Universal Declaration of Human Rights (UDHR)<sup>53</sup>**

The UDHR was adopted in 1948 by the United Nations General Assembly (UNGA) and marks a historic commitment to establishing standards for human rights. The UDHR was drafted by representatives from diverse backgrounds and lists the human rights that need to be universally protected. Forced treatment, detention and forced hospitalization violate multiple Articles of the UDHR. It goes against:

- Article 1 (All human beings are born free and equal in dignity and rights);
- Article 3 (Everyone has the right to life, liberty and security of person);
- Article 5 (No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment);

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<sup>52</sup> United Nations, General Assembly. (1989, November 20). Convention on the Rights of the Child. United Nations. Available: <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child>

<sup>53</sup> United Nations General Assembly. (1948). Universal Declaration of Human Rights; Available: <https://www.un.org/en/about-us/universal-declaration-of-human-rights>.

- Article 9 (No one shall be subjected to arbitrary arrest, detention or exile) and
- Article 12 (No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation).

Though not a treaty, it sets the human rights standard for all legal frameworks. Referencing the UDHR roots Armenia's obligations in universal human rights principles and frames coercion as a global rights violation.

## **Guidelines on Deinstitutionalization and Community Living**

The movement from institutional care to community living requires more than legal recognition. It demands practical and system wide changes. A range of international tools support States in turning rights into reality, offering concrete guidance on how to build inclusive, rights-based services and supports for persons with disabilities. These instruments go beyond principle and provide frameworks for designing, resourcing, and monitoring deinstitutionalization.

### **Guidelines on de-institutionalization, including in emergencies (CRPD/C/5)<sup>54</sup>**

The adoption of the Guidelines on Deinstitutionalization, including in emergencies, by the UNCRPD Committee in 2022 marked a significant step toward safeguarding the rights of persons with disabilities, especially in light of the COVID-19 pandemic and laying down a practical approach for deinstitutionalization process. They were built upon the Committee's prior work, including General Comment No. 5 and were developed through a consultative process involving over 500 persons with disabilities.  
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The guidelines direct the states to “abolish all forms of institutionalization, refrain from investing in institutions, and emphasize that exercising these rights cannot be

<sup>54</sup> Committee on the Rights of Persons with Disabilities (2022). CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies. Geneva: United Nations.

Available: <https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>

<sup>55</sup> The general comment aims at assisting States parties in the implementation of Article 19 and fulfilling the obligations under the Convention. The committee has observed a gap between the goals and spirit of article 19 and highlights some barriers i.e.

a) Denial of legal capacity b) Inadequate social support and protection schemes ; c) Inadequate legal frameworks and budget d) Physical and regulatory institutionalization, including of children and forced treatment and individualized support; e) Lack of deinstitutionalization strategies and plans and continued investments in institutional care settings. ; f) Negative attitudes, stigma and stereotypes, preventing persons with disabilities from being included in community and g) Misconception about the rights to living independently within the community  
Read more: <https://documents.un.org/doc/undoc/gen/q17/328/87/pdf/q1732887.pdf>

<sup>56</sup> Guernsey, K. (2018). Committee on the Rights of Persons with Disabilities. In The UN Convention on the Rights of Persons with Disabilities: A Commentary (pp. 1012-1037).

<sup>57</sup> Committee on the Rights of Persons with Disabilities (2017). General comment no. 5 (2017) on living independently and being included in the community. Geneva: United Nations. Available:

<https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no5-article-19-right-live>

suspended in situations of emergency as well”.<sup>58</sup> The Guidelines also clarifies what are institutions and what features define them.<sup>59</sup> There is also a stress on the “importance of refraining from medicalization, forced intervention, and institutionalization of individuals in crisis or having high support needs”.<sup>60</sup> It states that a crisis should not be solely treated as a medical or social issue requiring forced medication or intervention. Instead, crisis support should be prioritized through support systems like peer networks and support services outside the health system with or without requiring mental health diagnoses or treatment.<sup>61</sup> It recommends allowing individuals to leave institutions, ending unauthorized detention, and avoiding new placements and construction of facilities. They also offer a comprehensive framework for transitioning individuals from institutions to community living while centring their rights, will, and preferences.<sup>62</sup>

For successful deinstitutionalization, States must establish and strengthen quality-driven community support systems and community support services catering to persons with disabilities. Support systems “include the relationships that an individual develops with family members, friends, neighbours or other trusted persons who provide the support that a person requires for decision-making or daily activities, in order that the person can exercise the right to live independently and to be included in the community. Support systems are important in enabling persons with disabilities to participate and be fully included in the community”.<sup>63</sup> Examples of support systems are “peer support, self-advocacy, circles of support and other support networks – including organizations of persons with disabilities, particularly those of survivors of institutionalization – and centres for independent living etc.”<sup>64</sup> Additionally, there should be provision of individualized support and inclusive mainstream services in the community. Support services include “personal assistance, supportive caregivers for children in family settings, crisis support, support for communication, support for mobility, the provision of assistive technology, support in securing housing and household help, and other community-based services.”<sup>65</sup> Guidelines also adds that support should be made available to access mainstream services such as education, employment, the justice system and health care. Community based support, based on their choices, that they may need to carry out daily tasks and engage with the

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<sup>58</sup> Minkowitz, T. (2024). Deinstitutionalization as Reparative Justice: A Commentary on the Guidelines on Deinstitutionalization, including in Emergencies. *Laws*, 13(2), 14.

<sup>59</sup> The elements listed are: “obligatory sharing of assistants with others and no or limited influence as to who provides the assistance; isolation and segregation from independent life in the community; lack of control over day-to-day decisions; lack of choice for the individuals concerned over whom they live; rigidity of routine irrespective of personal will and preferences; identical activities in the same place for a group of individuals under a certain authority; a paternalistic approach in service provision; supervision of living arrangements; and a disproportionate number of persons with disabilities in the same environment”.<sup>59</sup>

<sup>60</sup> *Ibid.*

<sup>61</sup> *Ibid.*

<sup>62</sup> *Ibid.*

<sup>63</sup> *Ibid.* (para 69, Page 10)

<sup>64</sup> *Ibid.* (para 70, Page 10)

<sup>65</sup> *Ibid.* (para 26, page 4)

community is a core component of living independently and being included in the community.

Highlighting a reparations framework, the guidelines call for mechanisms and processes for institutionalization survivors, provisions of income support aimed at repairing the harm caused, guidance for family members, and emphasis on the immediate cessation of violations and the restitution of liberty, including economic assistance for resettlement.<sup>66</sup>

To operationalize these recommendations, States are encouraged to:

- Create flexible funding mechanisms to support independent living in the community
- Ensure accessible housing and service inclusion on an equal basis
- Involve persons with disabilities in deinstitutionalization planning
- Build capacity among service providers, policymakers, and communities
- Establish legal reforms and monitoring systems
- Explore innovative models like peer support, individualized funding, and use of technology for accessibility
- Create inclusive and robust community support systems and networks catering to diverse needs

These Guidelines serve as a foundational tool for States to build inclusive, community based systems that uphold the rights and autonomy of persons with disabilities. The guidelines offer Armenia an authoritative, CRPD-compliant blueprint to build inclusive community services, eliminate coercive settings and protect the liberty and dignity of persons with psychosocial disabilities, especially as the country plans system reforms.

### **Incheon Strategy for Persons with Disabilities in Asia and the Pacific<sup>67</sup>**

The Incheon Strategy to “Make the Right Real” for Persons with Disabilities in Asia and the Pacific was adopted during an Intergovernmental Meeting in Incheon, Republic of Korea, from 29th October to 2 November 2012. It outlines a comprehensive set of 10 goals, 27 targets and 62 indicators aiming to promote the rights and inclusion of persons with disabilities in the region. The strategy is built upon the UNCRPD mandate and seeks to address challenges faced by individuals with disabilities, particularly in areas such as accessibility, participation, and non-discrimination. It is a guiding document for governments, civil society and stakeholders to work collaboratively towards creating an inclusive society that upholds the dignity and rights of all persons with disabilities throughout the new Asian and Pacific Decade of Persons with Disabilities from 2013-2022.

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<sup>66</sup> Minkowitz, T. (2024). Deinstitutionalization as Reparative Justice: A Commentary on the Guidelines on Deinstitutionalization, including in Emergencies. *Laws*, 13(2), 14.

<sup>67</sup> ESCAP, U. (2012). Incheon strategy to "Make the Right Real" for persons with disabilities in Asia and the Pacific.

The Strategy recognizes that “mental health is integral to overall health and well-being and *advocates for de-institutionalization and alternative models of community based and rights based supports*. It calls for adoption of rights-based approach that respects the dignity and autonomy of individuals.<sup>68</sup> It recognizes the need for community-based services that support individuals with psychosocial disabilities, promoting their rights to live independently and participate fully in society. “*Deinstitutionalization in the strategy is seen to enhance the quality of life for individuals with disabilities, allowing them to access support services in their communities and engage with family and friends*”.<sup>69</sup>

On alternative options, “*the strategy promotes the provision of support for individuals with disabilities, particularly those with psychosocial disabilities and mental health conditions, in a manner that respects their rights and preferences*”.<sup>70</sup> It emphasizes the need for community-based rehabilitation programs and services that empower individuals to live independently and participate fully in society. Community based rehabilitation is a strategy for “*general community development that provides rehabilitation, poverty reduction, equalisation of opportunities and social inclusion for persons with disabilities and this is done at community level through utilization of local resources*”.<sup>71,72</sup>

The strategy encourages the government to develop policies and programs that provide support and resources for persons with disabilities, including those with psychosocial disabilities and mental health conditions, to ensure that they receive appropriate care and support in inclusive environments. It calls for the establishment of support systems that include personal assistance, peer counselling, and other resources that enable individuals to thrive in their communities.<sup>73</sup> It also highlights the importance of family support and involvement in caring for individuals with disabilities, recognizing that families play a crucial role in their well-being.

**NOTE:** While CBR has played a key role in bringing services closer to people with disabilities, especially in low-resource settings, it has often been critiqued for its medical and charity-based roots. The approach sometimes reinforces paternalistic attitudes by viewing persons with disabilities as passive recipients of care rather than active rights-holders. CBR programs have also tended to focus narrowly on rehabilitation and individual functioning, rather than tackling structural barriers to

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<sup>68</sup> Ibid.

<sup>69</sup> Ibid.

<sup>70</sup> Ibid.

<sup>71</sup> Lemmi V, Kuper H, Blanchet K, Gibson L, Kumar KS, Rath S, Hartley S, Murthy GVS, Patel V and Weber J. (2016). Community based rehabilitation for persons with disabilities. 3 ie Systematic Review Summary 4. London. Available at: [https://www.3ieimpact.org/sites/default/files/2019-05/srs4-commbasedrehab\\_0.pdf](https://www.3ieimpact.org/sites/default/files/2019-05/srs4-commbasedrehab_0.pdf)

<sup>72</sup> Butura, A.-M., Ryan, G. K., Shakespeare, T., Ogunmola, O., Omobowale, O., Greenley, R., & Eaton, J. (2024). Community-based rehabilitation for people with psychosocial disabilities in low- and middle-income countries: A systematic review of the grey literature. *International Journal of Mental Health Systems*, 18(1), 13. <https://doi.org/10.1186/s13033-024-00630-0>

<sup>73</sup> Ibid.

inclusion or promoting systemic change. In many contexts, CBR has lacked genuine participation of persons with disabilities in leadership and decision-making, limiting its alignment with the CRPD's rights-based framework. Community Based Inclusive Development (CBID) emerged as an evolution of CBR in response to these critiques and the growing global momentum around disability rights, especially following the adoption of CRPD. While CBR laid the groundwork by bringing support into local communities, CBID builds on the foundation and shifts the focus from rehabilitation and service provision to inclusion, participation, and empowerment. It aligns more closely with CRPD principles by ensuring that persons with disabilities lead and shape development processes, and that disability is addressed not just as a health or social issue, but as a human rights concern integrated across all sectors of community life.<sup>74</sup>

## Movement Led Declarations and OPD Advocacy

These declarations are movement manifestos, created by and for persons with psychosocial disabilities. They reflect grassroots demands for justice, dignity, and freedom from coercion, grounded in lived realities. Unlike technical or legal texts, these declarations express the urgent realities and visions of communities who have long been excluded from decision-making. For Armenia, they offer not only moral clarity but a compass for reform, reminding us that any changes must be shaped by those most affected.

While these declarations are not binding on States, they reflect the collective demands and priorities of persons with psychosocial disabilities globally. They serve as a crucial interpretive and normative resource for States like Armenia seeking to implement the CRPD meaningfully and inclusively.

### The Bali Declaration (2018) & Addis Declaration (2022)

Besides the UN conventions and guidelines, various OPD-led movements are growing worldwide, creating awareness and advocating for the rights of individuals following the adoption of the CRPD. **The Bali Declaration, 2018<sup>75,76</sup> and Addis Declaration, 2022<sup>77,78</sup>** aligned their commitment to deinstitutionalization, human rights, and social

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<sup>74</sup> IDDC. (2012). *CBR Guidelines as a Tool for Community Based Inclusive Development*.

[https://www.iddcconsortium.net/wp-content/uploads/2019/11/2012-CBRTG-CBR-Guidelines-as-a-Tool-for-Community-Based-Inclusive-Development\\_EN.pdf](https://www.iddcconsortium.net/wp-content/uploads/2019/11/2012-CBRTG-CBR-Guidelines-as-a-Tool-for-Community-Based-Inclusive-Development_EN.pdf)

<sup>75</sup> TCI Global. (2018). Bali Declaration 2018. Available: <https://whatweneed.tci-global.org/bali-declaration-2018/>

<sup>76</sup> The Bali Declaration was adopted on August 29, 2018, during the 5th “Classic Edition” Plenary of Transforming Communities for Inclusion (TCI) Asia Pacific, held in Bali, Indonesia. It was developed by a gathering of persons with psychosocial disabilities and their supporters from 21 nations across the Asia Pacific region. The declaration stems from the acknowledgement of widespread and systemic human rights violations against persons with psychosocial disabilities in the Asia Pacific region in healthcare settings and communities.

<sup>77</sup> Transforming Communities for Inclusion – Global. (2022). Addis Declaration. Available: <https://tci-global.org/wp-content/uploads/2023/11/Addis-Declaration-2023.pdf>

<sup>78</sup> The Addis Declaration was developed during a significant gathering of persons with psychosocial disabilities from five East African countries, i.e. Ethiopia, Kenya, Malawi, Rwanda, and Uganda, held in Addis Ababa on 26th July 2022. TCI Global organized the consultation in partnership with several local organizations, including CIC-Kenya, TRIUMPH, Rights for Disability Development Foundation (RDDF), and Uganda National Self Advocacy Initiative (UNSAI). In September 2023, the declaration gained further recognition when Tanzania Users and

inclusion for individuals with psychosocial disabilities and were developed by persons with psychosocial disabilities, many with their own experiences of coercive and violent treatments. To advocate for the full inclusion of persons with psychosocial disabilities into communities and policies, the declarations drew attention to issues such as disability-based discrimination, disability specific deprivation of liberty, exclusion, and inhumane treatment within mental health systems. Both declarations call out for:

1. Immediate deinstitutionalization of persons with psychosocial disabilities, emphasizing the importance of community-based living and support systems.<sup>79,80</sup>
2. Uphold the human rights of individuals, including their right to live independently, participate in society, and access essential services.
3. Remove barriers to social inclusion, provide reasonable accommodation, and implement social protection schemes that respect the dignity and autonomy of individuals with psychosocial disabilities.<sup>81,82</sup>
4. Prioritize community-based support services to promote independent living and prevent institutionalization.

**The Bali Declaration also** reiterates the importance of the rights and well-being of persons with psychosocial disabilities with the key points i.e.<sup>83</sup>

1. Persons with psychosocial disabilities have the “Right to Live Independently” and be included in society. This consists of choosing their place of residence and who they live with.
2. There is a need for a range of in-home, residential, and “community support services” that are accessible and responsive to individuals’ needs. The shift from institutional care to community-based support is crucial for promoting autonomy, upholding rights and respecting the inherent dignity of persons with psychosocial disabilities.
3. To put in place measures that “prevent the institutionalization”, especially those who are more vulnerable to being institutionalized of individuals or are currently detained or shackled. It highlights the importance of providing adequate housing and social protection measures to ensure that persons with psychosocial disabilities can live in their communities rather than in institutions.
4. The “underlying social, economic, and environmental determinants of health” need to be addressed.

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Survivors of Psychiatric Organization (TUSPO) adopted it, expanding its reach and impact within the East Africa Region.

<sup>79</sup> Transforming Communities for Inclusion – Global. (2022). Addis Declaration. Available: <https://tci-global.org/wp-content/uploads/2023/11/Addis-Declaration-2023.pdf>

<sup>80</sup> TCI Global. (2018). Bali Declaration 2018. Available: <https://whatweneed.tci-global.org/bali-declaration-2018/>

<sup>81</sup> Ibid.

<sup>82</sup> Ibid.

<sup>83</sup> Ibid.

**Addis Declaration**<sup>84</sup> calls for immediate deinstitutionalization efforts, particularly in risk and humanitarian emergencies. It stresses that institutions should not be built with the idea of “building back better” and that persons with psychosocial disabilities should be engaged in the preparation and execution of disaster management plans. The emphasis is also on the need for political participation and the realization of rights related to adequate living standards, housing, social protection, work, and education for persons with psychosocial disabilities. It also emphasizes the importance of informed consent in healthcare and the availability of cultural ways of well-being and healing. The declaration is valid for all persons who self-identify as having psychosocial disabilities, including users and survivors of psychiatry, individuals facing discrimination based on their intersectional and neurodiverse identities, and those from Commonwealth nations in Africa who are still legally labelled as being of “unsound mind” or “lunatic”.

### **The Cape Town Declaration**<sup>85</sup>

This Declaration was put forward by the Pan African Network of Users and Survivors of Psychiatry (PANUSP) in 2011. PANUSP was a collective voice to promote and protect the rights and dignity of people with psychosocial disabilities on the African continent. This Declaration confirmed and reiterated the issues faced by persons with psychosocial disabilities ranging from derogatory terms used for them, to people taking decisions on their behalf. They also affirmed that persons with psychosocial disabilities are the experts of their lives and their voices, opinions and decisions should be upheld and respected. The Declaration also drew attention to the horrors of psychiatry that continue to affect persons with psychosocial disabilities, the issues of poverty and human rights violations and condition of those shackled or chained within institutions. The Declaration strongly proclaimed that medicines or western technology cannot restore their dignity or eradicate poverty. It shared this powerful message of acknowledging the barriers that disrupt their participation in their communities, engaging them in all processes and wishing for a world where human rights belong to everyone.

### **Speak Out Against Psychiatry (SOAP) Manifesto**<sup>86</sup>

SOAP, UK, is a group composed of former patients, carers, mental health professionals and concerned citizens who are advocating for humane treatment for people experiencing distress<sup>87</sup>. SOAP are opposed to forced treatment, electro-shock therapy and the psychiatric drugging of children. SOAP also promotes humane

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<sup>84</sup> Transforming Communities for Inclusion – Global. (2022). Addis Declaration. Available: <https://tci-global.org/wp-content/uploads/2023/11/Addis-Declaration-2023.pdf>

<sup>85</sup> PANUSP. (2011). Cape Town Declaration. Available at: <https://dqsjournal.org/wp-content/uploads/2012/06/dqs-01-02-10.pdf>

<sup>86</sup> SOAP. (2023). Speak Out Against Psychiatry Manifesto. Available at: <https://whatweneed.tci-global.org/wp-content/uploads/2023/12/Speak-Out-Against-Psychiatry-Manifesto.pdf>

<sup>87</sup> Ibid.

alternative ways of helping people in distress. They developed this Manifesto based on their personal experiences of the mental health systems and associated oppression. The Manifesto speaks clearly against medicalizing of human responses to stressors and instead calls for humane social support systems and understanding to be offered for persons experiencing distress. It criticizes the system of psychiatric diagnosis and labelling, chemical imbalance theories that offers legitimacy to medicalization and psychiatrization. The Manifesto calls out for ending forced treatment and interventions as they clearly deny choice, is a damaging experience for the individuals and violates their rights and dignity. They reaffirm that hospitals are not healing spaces and anybody with a mental health 'diagnosis' can be deprived of their liberty, as per current legislations. They suggest that the mental health personnel should clearly inform the individuals regarding the side effects of medications and their withdrawal symptoms, and they should also end psychiatric drugging of children, on account of increasing labelling using ADHD, childhood bipolar disorder etc. The Manifesto clearly calls for ban on ECT, lobotomy, psychosurgery, and Community Treatment Orders (CTOs) while also emphasizing that measures should be put in place to stop pharmaceutical companies from influencing practice of psychiatry.

### **Petition by Stop Forced Treatment, France<sup>88</sup>**

The "Stop Forced Treatment" Collective is an informal organization of French-speaking Users and Ex-users of Psychiatry. Their goal is the abolition of forced psychiatry in France and globally. They started a petition calling for the abolition of forced treatment and forced institutionalization, in line with the CRPD. They clearly state that persons with psychosocial disabilities need a human rights model of disability, and not solely a medical model. They also call for repeal of any legislation instrument that repeal the legal capacity of persons based on their diagnosis or labelling.

Together, these global voices express a clear and consistent demand: to end coercive practices, uphold legal capacity, dismantle institutional and psychiatric dominance, and build inclusive systems grounded in rights and dignity. From Bali to Cape Town to Paris, persons with psychosocial disabilities are asserting their power and reframing what meaningful support and care look like.

While Armenia may not be legally bound by these declarations, they represent the lived realities, priorities, and wisdom of those historically oppressed and marginalized. Any genuine reform must be guided by this movement-led vision and not merely by formal obligations. These declarations are not peripheral, rather, they are central to realizing CRPD compliant change.

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<sup>88</sup> Petition: <https://www.change.org/p/abolir-l-hospitalisation-forc%C3%A9e-et-le-traitement-forc%C3%A9>

## Special Rapporteur's Reports

The above stated Mandates, Guidelines, Declarations and Petitions, serve as a fundamental framework for reforming the practices surrounding involuntary hospitalization and treatment of individuals with disabilities. This section is a deep dive into the global reports provided by Special Rapporteurs who have consistently urged a reassessment of existing models and practices that have led to the mistreatment of persons with disabilities, particularly those with psychosocial disabilities.

These reports underscore the urgency of addressing human rights violations faced by persons with psychosocial disabilities that deny their fundamental right to live independently and with dignity. The emphasis continues to be on the intersection of human rights, mental health, and the social factors that influence well-being. There is a need to adopt a rights-based approach that recognizes importance of legal, social, cultural, economic, and political conditions in shaping well-being and healing responses. Additionally, this section also discusses the gaps highlighted in the reports and suggests alternative approaches to amend the practices of forced institutionalization. It advocates for adopting holistic, community-led and based actions to promote well-being and address the challenges posed by coercive practices in mental health systems.

The section recognizes the need to implement alternatives to involuntary hospitalization, including de-institutionalization.<sup>89</sup>

### Understanding Deprivation of Liberty of Persons with Disabilities

Deprivation of liberty of persons with disabilities is a major global human rights concern rooted in the medical model of disability.<sup>90</sup> Common forms of disability-specific deprivation of liberty include “*involuntary hospitalization in mental health facilities, placement into institutions, detention as a result of diversion from the criminal justice system, forced treatment in “prayer camps”, and home confinement.*” Unfortunately, institutionalization is yet to be abolished; instead, legislation is put in place to define the criteria for the detention and procedural safeguards, with most countries regulating it through mental health laws. Often these institutions are justified as need for

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<sup>89</sup> United Nations Human Rights Council. (2019). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.(A/HRC/41/34). Geneva: United Nations. Available: <https://www.ohchr.org/en/documents/thematic-reports/ahrc4134-right-everyone-enjoyment-highest-attainable-standard-physical>

<sup>90</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54). <https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights>

“specialized care” and it has been estimated that 1.2 million persons with disabilities live in institutions in 25 European countries.<sup>91,92</sup>

Though these institutions differ in size, name and set up but share common defining elements.<sup>93</sup> These practices are not limited to low-income settings but are practiced in many parts of the world. These practices are derived from stigmatization, misconceptions and prejudice particularly against persons with psychosocial disabilities.

Placing persons with disabilities in these institutions without their free and informed consent, puts them at risk of systemic and individual human rights violations and they may experience physical, mental and sexual violence, depriving them from right to liberty and overall violations of their fundamental rights.<sup>94,95</sup> Children with disabilities are vulnerable to institutionalization, and in some countries, forced separation from families or guardians are permitted.<sup>96</sup> The interplay between disability and intersectional identities further produces inequalities and prohibits persons with disability to personal liberty. For example, women with disabilities are at risk of being viewed as “burden”, older persons with disabilities being confined to home because of age and disability, and interplay of poverty, homelessness and disability is also well recognized. The COVID-19 pandemic has highlighted the disproportionate impact in the time of crisis, where persons with disability living in institutions were exposed to serious health risk, unmet support needs.<sup>97,98</sup>

In this context, Article 14 of UNCRPD on right to liberty of persons with disabilities stresses that “*persons with disabilities must enjoy the right to personal liberty on an equal basis with others and, cannot be deprived of their liberty unlawfully or arbitrary*”.<sup>99</sup> This article bans the practices *on deprivation of liberty based on disability*

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<sup>91</sup> Ibid

<sup>92</sup> de Bruijn-Wezeman, R. (2021). De-institutionalisation of persons with disabilities. Council of Europe. Available: <https://assembly.coe.int/LifeRay/SOC/Pdf/DocsAndDecs/2021/AS-SOC-2021-46-EN.pdf>

<sup>93</sup> “isolation and segregation from independent life within the community; lack of control over day-to-day decisions; lack of choice over whom to live with; daily schedule and routine irrespective of personal will and preferences; identical activities in the same place for a group of persons under a certain authority; a paternalistic approach in service provision; supervision of living arrangements; obligatory sharing of assistants with others”.

<sup>94</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54). <https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights>

<sup>95</sup> de Bruijn-Wezeman, R. (2021). De-institutionalisation of persons with disabilities. Council of Europe. Available: <https://assembly.coe.int/LifeRay/SOC/Pdf/DocsAndDecs/2021/AS-SOC-2021-46-EN.pdf>

<sup>96</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54). <https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights> (para.19, p.6)

<sup>97</sup> de Bruijn-Wezeman, R. (2021). De-institutionalisation of persons with disabilities. Council of Europe. Available: <https://assembly.coe.int/LifeRay/SOC/Pdf/DocsAndDecs/2021/AS-SOC-2021-46-EN.pdf>

<sup>98</sup> Disability Rights Monitor. (2021). Disability rights during the pandemic: A global report on findings of the COVID-19 Disability Rights Monitor. Retrieved November 11, 2024, from <https://www.disabilityrightsmonitor.org/disability-rights-during-the-pandemic/>

<sup>99</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54).

and UNCRPD committee further specified that the ban applies even when additional factors are used to justify the deprivation on “danger to self or to others’ or in need of treatment or care.” Depriving individuals of their liberty due to disability is discriminatory and denies them the fundamental human rights outlined in convention, including equality and non-discrimination (Art. 5), freedom from torture or cruel inhuman or degrading treatment or punishment (Art. 15), freedom from exploitation, violation and abuse (Art. 16) and among others.<sup>100</sup>

## Deprivation of Liberty and Disability Based Discrimination in Healthcare Settings

The Special Rapporteurs have critically examined the intersection between healthcare and human rights.<sup>101</sup> They have emphasized that the analysis of abuse in health-care settings must be framed through the lens of torture and ill-treatment, in accordance with the definitions and interpretations provided by the CAT.<sup>102,103</sup>

Article 1 of the CAT affirms that abuse becomes torture when a person is discriminated against based on disability. This is relevant in the context of medical treatment, “where serious violations and discrimination against person with disabilities may be defended as “well intended” on the part of health-care professionals”.<sup>104</sup> When informed consent is commonly protected in the legal framework at the national level, it is frequently compromised in health care settings through structural inequalities such as power imbalance between doctors and patients, worsened by stigma and discrimination, resulting in compromise of informed consent with marginalized groups. This has been frequently emphasized by the CRPD Committee and in other reports from Special Rapporteur on Torture. The common examples are “*medical treatments of an intrusive and irreversible nature, non-consensual medication, involuntary sterilization, discriminatory practices such as forced psychiatric intervention justified as “good intentions” by medical professionals, camps, secular and religious-based therapeutic*

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<https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights> (para 44 & 45, p.11)

<sup>100</sup> Ibid.

<sup>101</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights.

[https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

<sup>102</sup> United Nations. (1984, December 10). Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading>

<sup>103</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights.

[https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

<sup>104</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights.

[https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

*boarding schools, boot camps, private residential treatment centers or traditional healing centers”*.<sup>105</sup>

Additionally, people with psychosocial disabilities and people with intellectual disabilities in health-care settings continue to face severe abuses, such as neglect, mental and physical abuse and sexual violence.<sup>106</sup> In this context, it has been reiterated that “*detention of persons with disabilities based on “danger to self or others”, “need of care” or “medical necessity” is unlawful and arbitrary*”. It is discriminatory and disproportionately applies to persons with actual or perceived disability particularly persons with intellectual disabilities, psychosocial disabilities, persons with autism and persons with dementia.<sup>107</sup> The denial of the person’s legal capacity to decide about care, treatment and admission to a hospital, institutions, violates their right to personal integrity and freedom from torture and ill treatment, hinders their recovery and re-traumatize them.<sup>108</sup> Forced institutionalization has also been recognized as a form of violence.<sup>109</sup> Countries continue to “practice detention based on disability or impairment<sup>110</sup> ; involuntarily admit them in psychiatric facilities<sup>111</sup>; use harmful and forced practices such as shackling, seclusion, restraints in institutions<sup>112</sup>; use legislative provisions that deprive them of liberty on the basis of disability<sup>113</sup>; are subjected to forced treatments, gender based and sexual violence<sup>114,115,116</sup>;forced sterilizations<sup>117</sup>and; abortions<sup>118</sup>.

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<sup>105</sup> Ibid.

<sup>106</sup> Ibid.

<sup>107</sup> Ibid.

<sup>108</sup> Ibid.

<sup>109</sup> Human Rights Council. (2021). Accelerating efforts to eliminate all forms of violence against women and girls: preventing and responding to all forms of violence against women and girls with disabilities.

(A/HRC/47/L.18/Rev.1). United Nations. Available:

<https://documents.un.org/doc/undoc/ltid/g21/176/46/pdf/g2117646.pdf>

<sup>110</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of India. CRPD/C/IND/CO/1.United Nations.

<sup>111</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of Japan. CRPD/C/JPN/CO/1.United Nations.

<sup>112</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of Indonesia. CRPD/C/IDN/CO/1.United Nations.

<sup>113</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of Korea. CRPD/C/KOR/CO/1.United Nations.

<sup>114</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of Croatia. CRPD/C/HRV /CO/1.United Nations.

<sup>115</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of European Union. CRPD/C/EU/CO/1.United Nations.

<sup>116</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of Germany. CRPD/C/DEU /CO/1.United Nations.

<sup>117</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of Canada. CRPD/C/CAN /CO/1.United Nations.

<sup>118</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of France. CRPD/C/FRA /CO/1.United Nations.

## Measures suggested by Special Rapporteurs to address deprivation of liberty and human rights violation of persons with disabilities

The areas in which Special Rapporteurs suggest steps beyond what has been proposed in the mandate to promote CRPD as the new paradigm and call for measures on:

### Enabling Legal and Policy Frameworks

People with disabilities, especially persons with psychosocial disabilities are denied of their legal capacity worldwide, due to “stereotypes, colonial legal frameworks, assumptions and discrimination, through judicial declaration of incompetency or merely by a doctor’s decision that the person lacks capacity to make a decision”.<sup>119</sup> When denied of legal capacity, “people are assigned a guardian or other substitute decision maker, whose consent is then considered sufficient to justify forced treatment or any forced process”.<sup>120</sup> The right to personhood, as reinforced by having legal capacity, on an equal basis with others, is the “right to have rights”.<sup>121</sup> It is a requisite for the exercise and enjoyment of economic, political, social and cultural rights and is referred to as the “key to accessing meaningful participation in society.”<sup>122</sup>

When incapacity provisions applied in law gets entrenched into the daily lives of persons with psychosocial disabilities, there is a cascading and compounding loss of rights and entitlements, such as: vote and participate in public life; access to justice and seek legal remedy; own and manage property or a bank account; have a family and custody over children; exercise contractual capacity; and, allowing proxy consent, guardianship, and institutionalization. The denial of rights is often referred to as “civil death” by organizations of persons with disabilities: their personhood is not recognized nor validated.<sup>123</sup>

Informed consent is not simply accepting medical intervention but making a voluntary and sufficiently informed decision.<sup>124</sup> It is fundamental aspect of respecting an

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<sup>119</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights. [https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

<sup>120</sup> Ibid.

<sup>121</sup> United Nations Human Rights Council. (2017). Report of the Special Rapporteur on the rights of persons with disabilities. (A/HRC/37/56). United Nations. Available: <https://documents.un.org/doc/undoc/gen/q17/360/32/pdf/q1736032.pdf>

<sup>122</sup> Committee on the Rights of Persons with Disabilities. (2014). General Comment No. 1: Article 12: Equal Recognition Before the Law. UN Doc. CRPD/C/GC/1.

<sup>123</sup> Statement of Expert Testimony on the topic of Legal Capacity and Guardianship of persons with disabilities, before the Hon. Constitutional Court of Indonesia. Available at: <https://tci-global.org/wp-content/uploads/2024/02/Submission-Indonesia-Constitutional-Court-Expert-Testimony-TCI.pdf>

<sup>124</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights. [https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

individual's autonomy, self-determination and human dignity.<sup>125</sup> This aligns with the core principles of the CRPD “respect for inherent dignity, individual autonomy including the freedom to make one's own choices and independence of persons” (art 3(a)).<sup>126</sup>

The CRPD instructs States parties to “repeal laws and regulations and modify or abolish customs and practices that prevent persons with disabilities from living independently and being included in the community”.<sup>127</sup> Additionally, the guidelines stresses that legal criteria for overseeing treatment in the absence of free and informed consent should be clearly defined in the law, and no difference between persons with or without disabilities should be made.<sup>128</sup> This ensures that will and preferences of persons with disabilities are respected, allowing them to exercise free and informed consent on matters such as acceptance or rejection of treatment, institutionalization or other life-affecting interventions. Several states have reformed their legal frameworks in line with Article 12, such as Peru, where full legal capacity of persons with disabilities was recognized by the Government in its General law on Persons with Disabilities of 2012.<sup>129</sup>

There is also an emphasis on supported decision making to address discrimination and the denial of legal capacity to persons with disabilities. Various forms of supported decision making exist, for example, in Argentina, there is an inclusion of the provision through the civil code<sup>130</sup> and in Ireland through “Assisted Decision-Making (Capacity) Bill”.<sup>131</sup> Despite these developments, largely States have given third parties the right to make decisions in the form of common schemes such as guardianship, often denying individuals the right to appeal against imposed guardianship, and involuntary medical treatment.<sup>132</sup> Such substitute decision making is the violation of Article 12 and impacts persons with disabilities. The CRPD Committee suggests replacing the substituted decision-making regime by supported decision making, which respects the

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<sup>125</sup> Ibid. (para. 18)

<sup>126</sup> Ibid.

<sup>127</sup> Ibid. (para. 64, p.15)

<sup>128</sup> Ibid.

<sup>129</sup> United Nations High Commissioner for Human Rights. (2014, December 12). *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights* (A/HRC/28/37). Geneva: United Nations. Available: <https://documents.un.org/doc/undoc/gen/q14/241/66/pdf/q1424166.pdf>

<sup>130</sup> Ibid.

<sup>131</sup> Assisted Decision Making Capacity Act. Ireland. Available at: <https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>

<sup>132</sup> United Nations High Commissioner for Human Rights. (2014, December 12). *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights* (A/HRC/28/37). Geneva: United Nations. Available: <https://documents.un.org/doc/undoc/gen/q14/241/66/pdf/q1424166.pdf>

person's autonomy, will and preferences.<sup>133,134,135</sup> This means that legislation must protect and support persons with disabilities to live in the community with dignity and must be aligned with UNCRPD.<sup>136</sup>

The denial of legal capacity originates from medical understanding on mental health legislation, resulting in persons with intellectual disabilities or psychosocial disabilities being denied the right to choose their living arrangements or any other decision of their life.<sup>137,138</sup> In this context, Article 19(a) of UNCRPD urges "States to ensure that persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement".<sup>139</sup> The reports suggest that the legal and policy frameworks should enable full inclusion of persons with disabilities and guide deinstitutionalization process towards the closure of institutions.<sup>140</sup> Special Rapporteurs have urged for revision of "domestic legislation allowing for forced interventions".<sup>141</sup>

In many countries, despite the existing mental health policies and laws, the focus is on restriction of people with psychosocial disabilities in psychiatric institutions, and have failed to protect their human rights.<sup>142</sup> The CRPD Committee has been clearly

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<sup>133</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights.  
[https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

<sup>134</sup> Committee on the Rights of Persons with Disabilities. (2014). General Comment No. 1: Article 12: Equal Recognition Before the Law. UN Doc. CRPD/C/GC/1.

<sup>135</sup> ESCAP, U. (2012). Incheon strategy to "Make the Right Real" for persons with disabilities in Asia and the Pacific.

<sup>136</sup> Ibid.

<sup>137</sup> United Nations High Commissioner for Human Rights. (2014, December 12). *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights* (A/HRC/28/37). Geneva: United Nations. Available:

<https://documents.un.org/doc/undoc/gen/q14/241/66/pdf/q1424166.pdf>

<sup>138</sup> Davar, B. (2012). *Legal Frameworks for and against People with Psychosocial Disabilities*. 47(52).

<https://www.epw.in/journal/2012/52/special-articles/legal-frameworks-and-against-people-psychosocial-disabilities.html>

<sup>139</sup> United Nations High Commissioner for Human Rights. (2014, December 12). *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights* (A/HRC/28/37). Geneva: United Nations. Available:

<https://documents.un.org/doc/undoc/gen/q14/241/66/pdf/q1424166.pdf>

<sup>140</sup> Committee on the Rights of Persons with Disabilities (2022). CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies. Geneva: United Nations. Available: <https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including> (para. 55, p.8)

<sup>141</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights.

[https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

<sup>142</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights.

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calling to prohibit detention based on disability, which includes civil commitment and compulsory institutionalization based on disability.<sup>143</sup> It asserts that living within the community with well-established support systems, is no longer an option but an internationally recognized right. Laws that permit the “institutionalization of persons with disabilities on the grounds of their disability for their care and treatment without their free and informed consent” or “likelihood of them posing a danger to themselves or others” must be abolished.<sup>144</sup>

Acknowledging each person’s legal capacity is a crucial initial step in the prevention of torture and ill-treatment. This includes legislative recognition, for all persons with disabilities, of the right to live independently and be integrated in the community, including a right to personal assistance.<sup>145,146</sup> States must guarantee that “all persons with disabilities who have experienced any form of arbitrary deprivation of liberty and/or exploitation, violence or abuse in the context of such practices have access to adequate redress and reparations, including institution compensation, satisfaction and guarantees of non-repetition”.<sup>147</sup>

This requires development of a national action plan that outlines specific goals, timelines and responsibilities for transition to community-based support services and community living arrangements. These plans should be regularly reviewed and updated based on feedback from stakeholders and must evolve based on the needs of the population.<sup>148</sup> These must lay emphasis on “proper mapping of existing laws, regulatory frameworks, policies, budgets and both formal and informal community-based support.”<sup>149</sup> This understanding is essential to inform comprehensive reforms.<sup>150</sup> States must also repeal “disability-neutral legislation that has disproportionate and adverse impact on the right to liberty of persons with disabilities, mental health legislations that authorizes and regulates the involuntary deprivation of liberty and forced treatment of persons with disabilities”.<sup>151</sup>

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<sup>143</sup> Ibid.

<sup>144</sup> Ibid.

<sup>145</sup> Committee on the Rights of Persons with Disabilities (2022). CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies. Geneva: United Nations. Available: <https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including> (paras. 55-60, p.7-10)

<sup>146</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54). <https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights>

<sup>147</sup> Ibid. (para.74, p.17)

<sup>148</sup> ESCAP, U. (2012). Incheon strategy to " Make the Right Real" for persons with disabilities in Asia and the Pacific.

<sup>149</sup> Committee on the Rights of Persons with Disabilities (2022). CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies. Geneva: United Nations. Available: <https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>

<sup>150</sup> Ibid. (para.60, p.9)

<sup>151</sup> Méndez, J. E. (2013, February 1). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/22/53). Geneva: United Nations Office of the High Commissioner for Human Rights.

Lastly, the Special Rapporteur notes that “the prohibition against torture relates not only to public officials, such as law enforcement agents in the strictest sense, but may apply to doctors, health professionals and social workers, including those working in private hospitals, other institutions and detention centres”.<sup>152</sup> As underlined by the CAT in its general comment No. 2 (2008), “the prohibition of torture must be enforced in all sorts of institutions and States have to exercise due diligence to prevent, investigate, prosecute and punish such non-State officials or private actors”.<sup>153</sup>

## **Exploring and developing inclusive community support services and community support systems**

The medical model of disability has led to interpretation of community support services and support systems through a clinical lens where all support needs are defined within the clinical or medical paradigm. It has also resulted in the narrow framing of the rights of the constituency towards the right to health, rather than discussing the right to inclusion, in alignment with the CRPD. This has further limited the discourse around support services and support systems to symptom reduction, consent to treatments, peer led services in a service delivery model etc. Persons with psychosocial disability have support needs that entail living independently in the community. “The provision of appropriate support is necessary to the realization of the full spectrum of human rights and enables persons with disabilities to achieve their full potential, thus contributing to the overall well-being and diversity of the communities in which they live.”<sup>154</sup> A wider, more encompassing definition of support needs was highlighted “Support for persons with disabilities includes a wide range of formal and informal interventions, including live assistance and intermediaries, mobility aids and assistive devices and technologies. It also includes personal assistance; support in decision making; communication support, such as sign language interpreters and alternative and augmentative communication; mobility support, such as assistive technology or service animals; living arrangements services for securing housing and household help; and community services. Persons with disabilities may also need support in accessing and using general services, such as health, education and justice.”<sup>155</sup>

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[https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf)

<sup>152</sup> United Nations Secretary-General. (2008). Torture and other cruel, inhuman or degrading treatment or punishment (Note by the Secretary-General) [A/63/175]. Retrieved from

[https://www.institut-fuer-menschenrechte.de/fileadmin/Redaktion/PDF/Sonstiges/Report\\_Special\\_Rapporteur\\_on\\_torture\\_and\\_other\\_cruel\\_inhuman\\_or\\_degrading\\_treatment\\_or\\_punishment.pdf](https://www.institut-fuer-menschenrechte.de/fileadmin/Redaktion/PDF/Sonstiges/Report_Special_Rapporteur_on_torture_and_other_cruel_inhuman_or_degrading_treatment_or_punishment.pdf)

<sup>153</sup> Ibid.

<sup>154</sup> United Nations Special Rapporteur on the rights of persons with disabilities. (2017). Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/34/58).

<https://documents.un.org/doc/undoc/gen/q16/436/64/pdf/q1643664.pdf>

<sup>155</sup> Ibid.

Community support systems, depending on the local contexts, may include a wide spectrum of humane exchanges and processes: Neighbourhood support systems, simple befriending actions, altruistic actions, foster support, neighbourhood supports for homeless persons with psychosocial disabilities, group support, peer to peer support, support for exercising legal capacity, contributions to peaceful communities, support to negotiate family, conflict reduction in the household and community, reducing gender violence, enabling community negotiation processes to prevent institutionalization (using community justice systems), promoting “bystander ethics” in neighbourhoods, access to play, sport and recreation groups, etc.<sup>156</sup>

It is essential to think beyond the medical paradigm to ensure that support services and support systems for persons with psychosocial disabilities enable a life of dignity, uphold their rights and facilitate independent living in the community. Availability of support services itself may not ensure that persons with psychosocial disabilities are able to access them. For enabling access, it is imperative to build and strengthen support systems around them by actively engaging communities and families, stronger community networks, strengthening peer support networks and informal support systems. In many instances, social protection benefits (for example pensions, disability benefits) hardly reach person with psychosocial disability due to family’s own perception of legal incapacity of the individual.<sup>157</sup>

“Article 19 (b) of UNCRPD is an important guideline and requires the states parties to prioritize the development of a range of high-quality individualized support and inclusive mainstream services within the community.<sup>158</sup> No single option of support fits all contexts and article 19 (b) suggests a reference to a range of services that can involve different providers. To do so, there are certain criteria that are necessary to meet based on the principle that “support” in article 19 implies shifting from “care” to “rights”.<sup>159</sup> This includes provisioning for persons with disabilities to live independently and have support, based on their choices.<sup>160,161</sup> It is necessary that all persons with disabilities should have equal access and equal choice of, and control over support

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<sup>156</sup> TCI (2022). TCI positionality on Community Inclusion. TCI Global, Geneva. Available at: <https://tci-global.org/wp-content/uploads/2024/07/TCI-Positionality-on-Community-Inclusion-2022.pdf>

<sup>157</sup> TCI. (2023). Working Group on Community Inclusion (WG-CI) Strategy Meeting: A Learning Report. <https://tci-global.org/wp-content/uploads/2023/10/WGCI-Strategy-Meeting-Learning-Report.pdf>

<sup>158</sup> Committee on the Rights of Persons with Disabilities (2022). *CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies*. Geneva: United Nations.

Available: <https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>

<sup>159</sup> United Nations High Commissioner for Human Rights (OHCHR). (2014). Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37)

<sup>160</sup> Committee on the Rights of Persons with Disabilities (2022). *CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies*. Geneva: United Nations.

Available: <https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>

<sup>161</sup> United Nations High Commissioner for Human Rights (OHCHR). (2014). Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37).

services that respect their inherent dignity and individual autonomy and aim to achieve effective participation and inclusion in society.<sup>162</sup>

It is imperative for the States to consider a paradigm shift towards community-based practices, promoting social inclusion and offering a range of rights-based psychosocial support at all levels.<sup>163</sup> Outdated biomedical approaches to treatment that have failed to address contexts and relationships can no longer be considered a viable option.<sup>164</sup>

To ensure community-based support services, such as in-home assistance and other personal assistance, states should work to eliminate and prevent new segregated services. This includes group housing - including small group homes, sheltered workshops, facilities for respite care, transit homes, day care centres, or forced interventions, which are not community-based services.<sup>165</sup> General mainstream services and programs, including education, healthcare, employment and housing must be inclusive and accessible for persons with disabilities.<sup>166</sup> Children with disabilities and their families must be provided with different types of information and support services including, day care, education, child protection and social services, to avoid family separation and institutionalization.<sup>167</sup> Families must also be provided with assistance to understand disability and how to provide support. It is important that children are placed in appropriate family based alternative care arrangements that meet their best interests.<sup>168</sup> For example in Cuba, persons with disabilities living independently can have access to the state funded domestic social assistant service, which provides personal and domestic support.<sup>169</sup>

Mainstreaming support for psychosocial needs is also essential which means that psychosocial support is brought closer to persons with psychosocial disabilities living in their communities.

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<sup>162</sup> Ibid.

<sup>163</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21). <https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>164</sup> Ibid.

<sup>165</sup> United Nations High Commissioner for Human Rights (OHCHR). (2014). Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37) (para. 28, p.4)

<sup>166</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54). <https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights> (para. 77, p.17)

<sup>167</sup> Ibid. (para. 77, p.17)

<sup>168</sup> Ibid.

<sup>169</sup> United Nations High Commissioner for Human Rights (OHCHR). (2014). Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37)

It is crucial for health care professionals - including nurses, general practitioners, midwives, social workers and community health workers to be equipped with psychosocial skills and be aware of the rights of persons with psychosocial disabilities to ensure accessibility, integration and sustainability.<sup>170</sup>

While the paradigm shift requires a move towards integrated and population-based support services, distress will still occur and rights-based responses will be required.<sup>171,172</sup> Coercion, medicalization and exclusion, which are inherent to traditional psychiatric care relationships, must be replaced with a rights-based understanding of recovery and healing that restore dignity and support individuals to return to their families and communities.<sup>173</sup> States must work towards transforming these mental health systems to ensure rights based approach and well-funded community based interventions, including peer-led services.<sup>174</sup> “Psychosocial interventions, not medication, should be the first-line response for the majority of people who experience high support needs. There is no single definition of recovery, it is often described as a personal journey towards regaining a meaningful life and becoming more resilient. The recovery approach, when implemented with human rights approach, will help and allow them to break down power asymmetries, empowering individuals and making them agents of change rather than passive recipients of care”.<sup>175</sup>

For example, peer support is an important part of recovery-based services. Establishing peer support networks can empower individuals with disabilities by connecting them with others who have similar experiences. These programs can provide emotional support, practical advice, and a sense of community.<sup>176</sup> The various

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<sup>170</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21).

<https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>171</sup> Ibid.

<sup>172</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54).

<https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights>

<sup>173</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21).

<https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>174</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54).

<https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights> (para.71, p.16)

<sup>175</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21).

<https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>176</sup> ESCAP, U. (2012). Incheon strategy to " Make the Right Real" for persons with disabilities in Asia and the Pacific.

peer support models have provided hope and empowered people to learn from each other, including through peer support networks, recovery colleges, club houses and peer-led crisis houses.<sup>177</sup> Open Dialogue, a successful practice, has entirely replaced emergency, medicalized treatment in Lapland.

Community-based services should also be tailored to the specific needs and preferences of individuals. This may involve creating personalized support plans that outline the types of assistance required, such as personal care, therapy, or vocational training.<sup>178</sup> Families and caregivers play a crucial role in supporting individuals with disabilities. Governments should provide training programs and resources to equip them with the skills to offer effective support in a community setting.<sup>179</sup> Offering respite care services can alleviate the burden on families and caregivers, allowing them to take breaks while ensuring that individuals with disabilities receive quality care.

Other non-coercive models include mental health crisis units, respite houses, community development models for social inclusion, personal ombudsmen, and family support conferencing.<sup>180</sup> The Soteria House project is a long-standing recovery-based model, which has been recreated in many countries. The increasing availability of alternatives and education and training on the use of non-consensual measures are critical indicators for measuring overall progress towards compliance with upholding of human rights.<sup>181</sup>

The larger goal is to provide “*a shift in living arrangements for persons with disabilities, from institutional and other segregating settings to a system enabling social participation where services are provided in community according to individual will and preference*”, also referred as de-institutionalization.<sup>182</sup> The Special Rapporteur report emphasizes on the need for a systematic approach to ensure that individuals with disabilities can live independently and be included in society.<sup>183</sup>

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<sup>177</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21). <https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>178</sup> ESCAP, U. (2012). Incheon strategy to "Make the Right Real" for persons with disabilities in Asia and the Pacific.

<sup>179</sup> Ibid.

<sup>180</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21). <https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>181</sup> Ibid.

<sup>182</sup> United Nations High Commissioner for Human Rights. (2014, December 12). *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37)*. Geneva: United Nations.

<sup>183</sup> de Bruijn-Wezeman, R. (2021). De-institutionalization of persons with disabilities. Council of Europe. Available: <https://assembly.coe.int/LifeRay/SOC/Pdf/DocsAndDecs/2021/AS-SOC-2021-46-EN.pdf>

Beyond this “transformation of residential institutional services, the wider areas such as healthcare, rehabilitation, support services, education and employment, as well as in the societal perception of disability”.<sup>184</sup>

States must eradicate all forms of institutionalization of persons with disabilities and set up clear deinstitutionalization processes, which includes:

- Adoption of action plan with clear timelines and concrete benchmarks
- Redistribution of public funds from institutions to community services and the development of adequate community support such as housing assistance, home support, peer support and respite services.<sup>185,186</sup>
- The strategies must not be simply relocating individuals to smaller institutions, group homes or different congregated settings.
- For children with disabilities, it is important that investment is made into family support systems, provision of child services, family-based alternative care
- States must take immediate actions for all kinds of institutions such as psychiatric facilities, faith-based institutions such as orphanages, small group homes, rehabilitation centres and prayer camps and new admissions must be stopped.

Initiatives by States such as the government of Finland have been implementing programs providing individual housing and community support services.<sup>187</sup> The program “I, just Like you” in Croatia has been providing individual planning and skills development support to persons with psychosocial disability in institutions.<sup>188</sup> The Republic of Korea has been providing re-settlement benefits to help persons with disabilities discharged from institutions to live independently in local communities.

Policy reforms must be complemented with capacity building and awareness raising activities for authorities, public officials, service providers, the private sector, media, persons with disabilities on the CRPD, related Conventions and rights of persons with psychosocial disabilities.<sup>189</sup> Health settings must empower users as rights holders to exercise autonomy and participate meaningfully and actively in all matters concerning them, to make their own choices about their health, including sexual and reproductive

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<sup>184</sup> United Nations High Commissioner for Human Rights. (2014, December 12). *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37)*. Geneva: United Nations.

<sup>185</sup> de Bruijn-Wezeman, R. (2021). De-institutionalization of persons with disabilities. Council of Europe. Available: <https://assembly.coe.int/LifeRay/SOC/Pdf/DocsAndDecs/2021/AS-SOC-2021-46-EN.pdf>

<sup>186</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54). <https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights>

<sup>187</sup> United Nations High Commissioner for Human Rights. (2014, December 12). *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37)*. Geneva: United Nations.

<sup>188</sup> Ibid.

<sup>189</sup> Ibid.

health, and their treatment, with appropriate support where needed.<sup>190</sup> It is important to support individuals through the support of self-advocacy initiatives, peer support networks, dialogues and other user-led advocacy initiatives, as well as new working methods, such as co-production, which ensure representative and meaningful participation in health-service development and provision.<sup>191</sup>

In that regard, creating space for OPDs, civil society and supporting the activities of non-governmental organizations is crucial to restoring trust between service providers and rights holders using services. The focus should be on integrated service delivery where community-based services are designed to address the diverse needs of individuals with disabilities, including health care, education, employment and social services. This is to ensure that individuals receive comprehensive support and promote overall well-being.<sup>192</sup> This also means effective coordination among various government sectors (health, education, social services) is also crucial for the successful implementation of community-based services. This may involve establishing ministerial committees or task forces to facilitate collaboration and resource sharing.<sup>193</sup>

## Re-distribution of Funds and Resource Mobilization

“The guidelines highlight that investments in institutions should be prohibited. The allocation of public funds for the construction and renovation of institutions should be stopped, including those from international cooperation.<sup>194</sup> These funds should be directed towards providing all appropriate support for living independently for persons with disabilities.<sup>195</sup> States must make full use of available resources including those made available through international cooperation.<sup>196</sup> It is necessary that States must incorporate funding for disability specific support services, mainstream services as well as monitoring while planning budgets.<sup>197</sup> It is important that States parties refrain from suggesting that persons with disabilities “choose” to live in institutions and justify

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<sup>190</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21).

<https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>191</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21).

<https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>192</sup> ESCAP, U. (2012). Incheon strategy to "Make the Right Real" for persons with disabilities in Asia and the Pacific.

<sup>193</sup> Ibid.

<sup>194</sup> Committee on the Rights of Persons with Disabilities (2022). *CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies*. Geneva: United Nations.

Available: <https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>

<sup>195</sup> Ibid.

<sup>196</sup> United Nations Human Rights Council. (2019). Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities (A/HRC/40/54).

<https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights>

<sup>197</sup> Ibid.

the maintenance of this argument.<sup>198</sup> A comprehensive compensatory package comprising of goods, daily living cash, food is also suggested.<sup>199</sup>

Special Rapporteurs, in their various reports have also called out for ending complete financial support for segregated mental health institutions and large psychiatric hospitals (A/HRC/35/21); Refrain from allocating funding to services infringing the right to liberty and security of persons with disabilities (A/HRC/40/54); refrain from funding programs that are in direct contradiction to the rights of persons with disabilities (A/75/186); redistribute the current funds that are supporting detention and confinement for persons with disabilities (A/HRC/38/36).

## Monitoring and Accountability

Accountability for the enjoyment of an inclusive rights-based services depends on three elements: “(a) monitoring; (b) independent and non-independent review, such as by judicial, quasi-judicial, political and administrative bodies, as well as by social accountability mechanisms; and (c) remedies and redress”.<sup>200</sup> This is important to understand how the administration has implemented the laws and to question wherever there are gaps. At the international level, the adoption of the CRPD and the countries ratifying and reporting on it will provide an important new opportunity to amend the gaps and promote the rights of persons with psychosocial, cognitive and intellectual disabilities.<sup>201</sup>

By contrast, at the national level, accountability mechanisms for the right to health are often not in place. There is a growing concern that to address mental health field related challenges, instead of providing a mechanism for accountability, legitimize coercion and further isolate people within mental health systems from access to justice.<sup>202</sup>

Individuals often have limited access to justice, including independent accountability mechanisms. That may arise because they are deemed to lack legal capacity and have limited knowledge of their rights, legal aid cannot be accessed, or simply because oversight of complaints bodies does not exist.<sup>203</sup> The Convention establishes that all mental health services designed for persons with disabilities are to be effectively monitored by independent authorities (art. 16.3).

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<sup>198</sup> Committee on the Rights of Persons with Disabilities (2022). *CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies*. Geneva: United Nations.

Available: <https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpd5-guidelines-deinstitutionalization-including>

<sup>199</sup> Ibid.

<sup>200</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21).

<https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>201</sup> Ibid.

<sup>202</sup> Ibid.

<sup>203</sup> Ibid.

This also means governments should implement accountability mechanisms to ensure that policies and programs are effectively implemented and may include regular reporting, independent evaluations, and feedback mechanisms for individuals with disabilities and their families.<sup>204</sup> To do so establishing systems for collecting and analysing data on the experiences of individuals with disabilities in community-based settings for informed policymaking is also necessary so that through the use of data gaps in services and areas for improvement can be identified.<sup>205</sup>

Additionally, human rights must be incorporated into the framework of reference for all monitoring and review procedures in the field of mental health.<sup>206</sup> The Special Rapporteurs specifically encourage national human rights institutions to pay attention to the right to health in their monitoring and promotion activities.<sup>207</sup> Persons with lived experience, their families and civil society should be engaged in the development and implementation of monitoring and accountability arrangements.<sup>208 209</sup>

### **Guidance on National Implementation**

The Concluding Observations on Armenia, published by the CRPD Committee listed down several recommendations for CRPD implementation<sup>210</sup>. The observations recommended State Party to repeal discriminatory legislations, restoring full legal capacity of persons with disabilities along with ensuring supported decision-making regimes. It strongly calls out for prohibiting detention including involuntary hospitalization and forced institutionalization on grounds of disability or impairment. State Party was also directed to ensure provision and accessibility of Reasonable Accommodation to those still languishing in institutions, including advocacy support. Immediate implementation of the deinstitutionalization process was another firm recommendation of the Committee along with allocating sufficient resources for development of community support services, to enable independent living in the community. Persons with psychosocial disabilities, and their representative organizations must be engaged in all stages of the deinstitutionalization processes.

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<sup>204</sup> ESCAP, U. (2012). Incheon strategy to "Make the Right Real" for persons with disabilities in Asia and the Pacific.

<sup>205</sup> Ibid.

<sup>206</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2017). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/35/21).

<https://documents.un.org/doc/undoc/gen/q17/076/04/pdf/q1707604.pdf>

<sup>207</sup> Ibid.

<sup>208</sup> Ibid.

<sup>209</sup> United Nations General Assembly. (2016). Report of the Special Rapporteur on the rights of persons with disabilities. (A/HRC/31/62). United Nations.

<https://documents.un.org/doc/undoc/gen/q16/004/48/pdf/q1600448.pdf>

<sup>210</sup> Committee on the Rights of Persons with Disabilities. (2019). Concluding observations on the initial report of Armenia. CRPD/C/ARM/CO/1. United Nations.

The report by the Special Rapporteur (A/HRC/38/36/Add. 2)<sup>211</sup> on the right to health following his visit to Armenia outlines the country's progress and ongoing challenges in realizing the right to health. The report highlights that Armenia has taken considerable steps in reforming healthcare since gaining independence in 1991. But there is a need for structural reforms in the health system, including increased funding and improved access to services across regions.<sup>212</sup> It emphasizes the importance of transitioning from reliance on large psychiatric hospitals to community-based health services.

The Special Rapporteur (A/HRC/38/36/Add. 2)<sup>213</sup> highlights the necessity for reforms, advocating for inclusive education and community services. He visited various institutions and found that many still operate under outdated practices, such as long-term confinement and overmedication. The report discusses the concept of de-institutionalization in the context of Armenia's mental health system, emphasizing the need to move away from outdated practices reliant on large psychiatric hospitals and long-term care institutions.<sup>214</sup> Many individuals with psychosocial disabilities are frequently hospitalized, often for extended periods, not necessarily due to their medical needs but because of the lack of adequate community care structures. It points out that many residents of psychiatric institutions have been confined for long periods, sometimes up to 10-15 years, not because they require hospitalization, but due to the absence of community-living options.<sup>215</sup> This prolonged confinement can lead to a deterioration in their health, exacerbated by discriminatory and stigmatizing attitudes prevalent in the current system.

The report discusses alternative practices in Armenia, particularly in the context of mental health and social services for individuals with psychosocial and intellectual disabilities. The Armenian government approved an "Action Plan of the concept on the provision of alternative care and social services to persons with mental health problems" for the period 2013–2017, which aimed to introduce community-based services.<sup>216</sup> Additionally, the "Strategy on Preserving and Improving Mental Health in the Republic of Armenia" for 2014–2019 was adopted, focusing on normative and institutional activities to align with international standards, including the UNCRPD.<sup>217</sup>

The report also acknowledges some positive pilot initiatives aimed at providing alternative care and social services for individuals with mental health issues. However,

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<sup>211</sup> Puras, D. (2018, June 18 - July 6). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Armenia. *Human Rights Council, 38th Session*. Available: <https://documents.un.org/doc/undoc/gen/q18/116/45/pdf/q1811645.pdf>

<sup>212</sup> Ibid.

<sup>213</sup> Puras, D. (2018, June 18 - July 6). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Armenia. *Human Rights Council, 38th Session*. Available: <https://documents.un.org/doc/undoc/gen/q18/116/45/pdf/q1811645.pdf>

<sup>214</sup> Ibid.

<sup>215</sup> Ibid.

<sup>216</sup> Ibid.

<sup>217</sup> Ibid.

these initiatives remain exceptions rather than the norm. The Special Rapporteur stresses that strong political will is essential to replicate and expand these community-based services nationwide.<sup>218</sup> The Special Rapporteur emphasizes the importance of developing community-based services that empower individuals with psychosocial or intellectual disabilities. These services should focus on including individuals into their communities, supporting their needs, and ensuring their right to live independently. The Special Rapporteur urges Armenia to integrate a human rights perspective into its mental health policies and community services fully. This includes adopting, implementing, and monitoring laws and practices that eliminate discrimination, stigma, violence, and social exclusion related to mental health.<sup>219</sup> The Special Rapporteur recommends that Armenia should implement the good practices and recommendations provided by international organizations, including the Committee on the Rights of Persons with Disabilities. This includes promoting prevention and training programs for relevant professionals and ensuring that community-based services protect and respect the rights of individuals with psychosocial disabilities.<sup>220</sup>

This chapter has outlined the global legal and normative frameworks that call for the abolition of coercive practices and institutionalization of persons with psychosocial disabilities. From binding international treaties to expert guidance and movement-led declarations, a clear message emerges: states must move away from paternalistic, medicalized systems and build rights-based, inclusive models rooted in legal capacity, community living, and dignity. Armenia's reform efforts must be grounded in these international obligations and lived experiences, ensuring that future actions reflect not just policy goals, but the human rights of all.

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<sup>218</sup> Ibid.

<sup>219</sup> Ibid.

<sup>220</sup> Ibid.

## 4 | Compendium of Best Practices on Alternatives to Involuntary Hospitalization and Treatment

This chapter outlines global best practices for alternatives to involuntary hospitalization and treatment. It is based on scoping reviews and interviews with OPDs working on creating and implementing alternatives to coercive practices. The best practices in this chapter are explained in the context of key themes as derived from the UN Guidelines on Deinstitutionalization, including in emergencies. **These key themes highlight the underlying reasons that lead to forced institutionalization and forced treatment of persons with psychosocial disabilities and are used in this chapter to structure the presentation of best practices that serve as viable, rights based alternatives.**

### 4.1 Best Practices for Crisis Support

In line with CRPD, a crisis is understood as the high restriction of participation of persons with psychosocial disabilities leading to custodial mentality and coercive practices that overwhelms person with disabilities.

Crisis, within the traditional or mental health frame of reference, is attributed to the result of an individual's negative perception of the situation and hence the solutions proposed are directed at "treating" the individual. For instance, a person getting violent, abusing loudly, or causing harm to others etc.

In contrast, a rights-based understanding of the crisis refers to the violation of fundamental rights of persons with disabilities. For instance, violation of a person's rights to liberty (article 14), their legal capacity (article 12), to make their own choice in terms of their daily living, support and treatment, to be excluded in communities, forcefully given treatment, institutionalized in psychiatric facilities, being beaten up by others, being discriminated by community etc. would be seen as a crisis.

Crisis situations are often viewed as the most justifiable moments for involuntary interventions. Families, communities, service providers, and at times, even OPDs have expressed the absence of known alternatives to support individuals experiencing high support needs during crises. Through this section, a list of best practices that provide rights based, CRPD compliant support during crisis situations has been described.

## Grassroots OPD-Led Crisis Support Models

### Crisis intervention strategy by Bapu Trust (India)<sup>221</sup>

Bapu Trust for Research on Mind and Discourse is an organization of persons with psychosocial disabilities located in India. The organization creates, pilots and monitors community inclusion programs that enable autonomy and independence of persons living with psycho-social disabilities.<sup>222</sup>

In its crisis intervention strategies, it outlines specific approaches and techniques used to address crisis situations that persons with psychosocial disabilities may experience within their communities. The strategies are designed to provide immediate support and assistance to prevent further deterioration of the individual's situation and to promote safety and well-being, while upholding the rights, will and preferences of the individual. The key strategies employed to provide support during crisis are:

1. Immediate response prioritizes a prompt response to situations that require urgent attention. This may involve mobilizing trained staff or community members to provide support when a crisis is identified.<sup>223</sup>
2. Assessing the nature and severity of the crisis. This includes understanding the individual's immediate needs, the context of the situation, and any potential risks to their safety or well-being.
3. Use of de-escalation techniques to help calm the individual and reduce tension. This may include using active listening, validating feelings, and employing calming communication methods to create a safe space for dialogue.
4. Collaboration with community resources, such as healthcare providers, social services, and community organizations, ensures that individuals have access to a comprehensive support network during a crisis.
5. Developing individualized crisis support plans is an essential part of the intervention process. These plans outline specific steps during a crisis, including who to contact, what resources are available, and how to ensure the individual's safety.<sup>224</sup>
6. Emphasis must be on empowering individuals to make choices about their care and support. This aligns with supported decision-making (SDM) principles and respects the person's autonomy in crisis.
7. After the immediate crisis has been addressed, follow-up support is crucial. This may involve ongoing check-ins, counseling, or connecting the individual with additional resources to help them stabilize and recover.

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<sup>221</sup> Davar, B. V., Pillai, K., & LaCroix, K. (2021). Seher's "Circle of Care" Model in Advancing Supported Decision Making in India. In *Mental Health, Legal Capacity, and Human Rights*. Cambridge University Press

<sup>222</sup> Baput Trust: <https://bapustrust.com/>

<sup>223</sup> Ibid.

<sup>224</sup> Ibid.

8. Crisis intervention strategies often include training community members and service providers to recognize and respond to crises effectively. This education helps build a community's capacity to support individuals in distress.
9. Other strategies may involve preventive measures, such as identifying early warning signs of crises and developing community resources to address potential issues before they escalate.
10. Crisis intervention strategies should be culturally sensitive and tailored to the community's needs and values. This ensures that interventions are respectful and relevant to the individuals being served.

One of Bapu Trust's key strategies is understanding and identifying 'when' does forced hospitalization and treatment occurs and then proactively addressing the situation by working with persons with psychosocial disabilities, their families and community people. These strategies are a part of the broader program of Bapu Trust, Seher, which focuses on community mental health and inclusion of persons with psychosocial disabilities.<sup>225</sup> This model has been supported by national and global donor agencies, and is implemented in partnership with local government departments to ensure sustainability.

### **Uganda National Self Advocacy Initiative (UNSAI) | Uganda<sup>226</sup>**

UNSAI is an organization of persons with psychosocial disabilities, committed to advocating for their rights and promoting non-institutional, community-based support systems.

A key initiative, "Support My Choice", has supported approximately 200 individuals with psychosocial disabilities to live independently and avoid institutionalization.<sup>227</sup> It brings together peers, community people, local organizations, associations, and informal groups to assist people with psychosocial disabilities in areas such as crisis support, access to housing, nutrition, public security, employment, finance, and social protection. This program provides a crisis support response and community-based support model by mobilizing peer and family support when individuals face distress or heightened support needs. Following crisis situations peers carry out daily check-ins, support individuals in familiar environments, and enable resettlement within communities. The program also works with peers, families, local organizations, and informal groups that respond swiftly in times of crisis and can facilitate supported decision making of persons with psychosocial disabilities. This rights-based peer support has prevented over 50 individuals returning to institutions during moments of crisis. Simultaneously, UNSAI builds broader community awareness about psychosocial disability, the right to community living, and how to respond to crisis

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<sup>225</sup> <https://bapustrust.com/seher-inclusion-program/>

<sup>226</sup> Nakato, D. (n.d.). Fellowship Report. TCI. Available: <https://tci-global.org/wp-content/uploads/2023/08/Dorothy-TCI-Fellowship-Report.pdf>

<sup>227</sup> UNSAI Website: <https://www.mhinnovation.net/organisations/uganda-national-self-advocacy-initiativeunsai>

without coercion or hospitalization. Families and caregivers form an essential part of this ecosystem and are actively supported to create enabling environments for inclusion.

The program has received funding from global donor agencies and continues to demonstrate scalable models of crisis response and long-term community inclusion.

## Respite Houses

Respite houses, also known as crisis houses or therapeutic community residences, provide temporary support for individuals experiencing crises.<sup>228</sup> They are designed to offer a safe, supportive environment to prevent hospitalization and support recovery. The concept of respite houses has gained international recognition, leading to the development of various models to meet diverse crisis needs.

### Key Features

- 1. Crisis Intervention:** They provide immediate support and a calming environment, which can help de-escalate crises and prevent the need for more intensive interventions, such as hospitalization.
- 2. Non-Coercive Environment:** Unlike traditional psychiatric hospitals, respite houses are committed to non-coercive practices. They focus on voluntary participation and respect for individual autonomy, fostering a sense of safety and trust and encouraging individuals to actively engage in their recovery process.
- 3. Peer Support:** Many respite houses are staffed by individuals with lived experience of mental health support needs. This peer support model is particularly effective, as staff members can relate to the challenges faced by residents and provide empathetic, understanding care, demonstrating that recovery is possible.
- 4. Holistic Care:** Respite houses often adopt a holistic approach to support, addressing not only the immediate support needs of residents but also their physical, emotional, and social well-being. This may include access to therapeutic activities, life skills training, and support for reintegration and inclusion into the community.
- 5. Community Integration:** Respite houses are typically located within the community, allowing residents to maintain connections with their social networks and support systems. This community-based approach helps to reduce stigma and promotes a sense of belonging, which is crucial for recovery.
- 6. Short-Term Stay:** Respite house stays are usually short-term, ranging from a few days to a couple of weeks. This time-limited approach encourages residents to focus

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<sup>228</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

on immediate coping strategies and recovery while planning for their next steps, whether returning home, engaging in outpatient services, or accessing further support.

### International Models of Respite Houses:

- 1. Soteria House (Sweden and International):** The Soteria model provides a home-like environment for individuals experiencing psychosis, emphasizing the importance of social support and therapeutic relationships. These are community residences established for the prevention of hospitalization for individuals experiencing extreme distress.<sup>229,230,231</sup> Soteria in Switzerland has the legal status of public psychiatric hospital financed by Swiss health system and health insurance. Soteria is allocated US\$ 740 for each person using the service, 55% from the Canton of Berne and 45% from the insurance providers.<sup>232</sup> In 2020, the cost of a stay at Soteria was reported to be 6-8% lower than comparable psychiatric hospitals in the city.<sup>233</sup>
- 2. Bochum Crisis Rooms (Germany)<sup>234</sup>:** These facilities offer a respite care model that prioritizes safety and support for individuals in crisis, providing a comfortable, non-institutional environment. The Bochum crisis respite project in Germany is a long-standing, self-advocacy-based initiative that offers non-medical, community-rooted crisis support. Operating for over 25 years, it de-professionalizes crisis response by emphasizing peer relationships, flexible roles, and collective responsibility. Its approach is grounded in social justice and offers an alternative to clinical mental health interventions.
- 3. Weglaufhaus<sup>235</sup> (Germany):** The Weglaufhaus “Villa Stöckle” in Berlin is a crisis respite and self-help house for people experiencing psychosocial crises who wish to avoid forced treatment and psychiatric intervention. It offers a protected, non-violent space based on self-determination, peer support, and community living. The project promotes alternatives to coercion and fosters recovery through solidarity and shared experience. The social welfare offices in Germany covers the costs.

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<sup>229</sup> Ingle, M., PhD. (2019, September 11). How Does the Soteria House Heal? Mad in America.

<https://www.madinamerica.com/2019/09/soteria-house-heal/>

<sup>230</sup> Spiro, L. (2023, March 28). Emotional crisis response: The peer-run respite/soteria house approach compared to the conventional approach. *Mad in America*. <https://www.madinamerica.com/2023/03/peer-run-respite-soteria-house-approach/>

<sup>231</sup> Soteria Summit: <https://www.peerrespite-soteria.org/>

<sup>232</sup> Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available:

<https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y>.

<sup>233</sup> Ibid.

<sup>234</sup> Russo, J., & von Peter, S. (2022). Politicising crisis support: Learning from autonomous self-organising in Bochum, Germany. *Advances in Mental Health*, 20(1), 64–73. <https://doi.org/10.1080/18387357.2021.2000337>

<sup>235</sup> Website: <https://weglaufhaus.de/en/>

- 4. Afiya Peer Respite - Crisis Respite Services (USA)**<sup>236</sup>: Crisis respite services in Massachusetts provide short-term residential support of up to 7 days for individuals in crisis, incorporating paid peer support and community integration. Their philosophy is that everyone at the house has the capacity to give and receive support, whether they are paid to be there or staying<sup>237</sup>. Team members support residents at the house in setting up a wellness plan, maintaining existing clinical relationships in the community, or making change to the clinical service they receive. Afiya also emphasizes choice and self-determination in providing trauma-informed peer support.<sup>238</sup> When entering the respite, people are briefed on human rights issues and provided access to Afiya's human rights officer and third-party contacts. A period of residence is completely voluntary and is initiated by the person who wishes to stay. Core principles are respect for legal capacity, non-coercive practices, community inclusion, participation, and recovery approach.

There were 174 stays at Afiya House between 1<sup>st</sup> July 2016 and 30 June 2017. Approx. 43% of the respondents reported of having prior experience in a traditional respite program and 57% reported also using other mental health services. There were total of 1344 contacts that did not result in a stay at Afiya House, out of which 74% of which were due to lack of space. In 2017 reports, results of anonymous evaluations completed by people prior to their departure indicated that users of Afiya House preferred the environment at Afiya and experienced better outcomes. Most reported that Afiya had a positive impact on their life.

The Afiya House was fully funded by the State of Massachusetts Department of Mental health, and the services provided were free of charge to people who stay, and no insurance is required. In 2015, Afiya accommodated 250 separate stays and it was reported that on 125 of those occasions, the individual would likely have been hospitalized who had no peer respite available. In 2015, the estimated average cost per person per day in Afiya was US\$ 1460 compared with US\$ 2695 per person per day in hospital. The total annual running cost for Afiya in 2019 was US\$ 443,928, of which personnel expenditure comprises the largest component.

- 5. Berlin runaway house:** This is a unique crisis facility that provides refuge and support to individuals affected by homelessness and severe personal crises, especially those who are survivors of psychiatric practices. Developed with a philosophy rooted in anti-psychiatry and self-determination, the Runaway House prioritizes the agency of its residents, allowing them to lead lives without the constraints of diagnosis-based treatment or traditional psychiatric approaches. Its

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<sup>236</sup> Wildflower Alliance. (2024). Afiya Peer Respite [Wildflower Alliance]. Retrieved from <https://wildfloweralliance.org/afiya/>

<sup>237</sup> Video on Afiya: <https://www.youtube.com/watch?v=Q9EQQp6XbVw>

<sup>238</sup> Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available: <https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y> .

inclusive approach brings together ex-users, survivors of psychiatry, and staff members who may not have been patients but share experiences of major life disruptions. Funded through homelessness assistance programs rather than medical or mental health services, the facility operates independently of diagnostic criteria, making it an innovative model of holistic, community-driven support<sup>239,240</sup>.

By providing immediate support in a non-coercive environment, respite houses have effectively prevented the need for hospitalization and reducing instances of forced and coercive processes. These are alternative facilities intended to offer temporary support to individuals undergoing crises. Their primary objective is to provide a secure and supportive environment to prevent hospitalization and facilitate recovery. The concept of respite houses has gained international prominence, leading to diverse models tailored to the specific needs of individuals in crisis.<sup>241</sup>

Respite Houses face challenges as they rely on public financing, which can be inconsistent. Ensuring adequate resources for staffing, training, and facility maintenance is crucial for the success of these programs. Moreover, individuals in crisis and their families may not be aware of the availability of respite houses. Increasing visibility and accessibility of these services is essential for maximizing their impact.<sup>242</sup>

Respite houses represent an important component of the support continuum, offering individuals in crisis a safe, supportive environment to facilitate recovery. By prioritizing non-coercive practices, community inclusion, and holistic approach, these facilities provide an alternative to traditional psychiatric hospitalization.

## Dialogic Models

### The Open Dialogue Model (ODM), Finland<sup>243</sup>

The ODM, developed in Finland, is a therapeutic approach primarily focused on treating high-support needs. It emphasizes the importance of dialogue and collaboration among distressed individuals, their families, and a network of healthcare professionals.

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<sup>239</sup> Burstow, B., & Burstow, B. (2019). On Berlin Runaway House: Dialogue with Wichera. *The Revolt Against Psychiatry: A Counterhegemonic Dialogue*, 83-91.

<sup>240</sup> Interview with Kim Wichera: <https://whatweneed.tci-global.org/spotlight-interview-of-kim-wichera/>

<sup>241</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

<sup>242</sup> Ibid.

<sup>243</sup> Developing Open Dialogue (n.d.). Open Dialogue Finland. Retrieved from <https://developingopendialogue.com/open-dialogue-finland/>

## Core Principles<sup>244</sup>

1. **Network Meetings:** Regular "network meetings" involving the individual, their family, and clinical team members facilitate open communication and ensure that all voices are heard, promoting a collaborative decision-making environment.
2. **Respect for Individual Preferences:** The model emphasizes respecting the individual's wishes and preferences regarding treatment, aiming to empower the person to make informed decisions about their care.
3. **Transparency:** Transparency in treatment planning and decision-making processes ensures that individuals understand the rationale behind treatment options and are not subjected to undue influence.
4. **Therapeutic Dialogue:** Psychotherapeutic techniques foster dialogue between the individual and their support network, serving as both a therapeutic intervention and a means of understanding the individual's experience of distress.
5. **Community-Based Care:** Open Dialogue is often practiced in community settings, including the individual's home, to keep individuals connected to their social networks and support systems.
6. **Open-Ended Questions:** Therapists use open-ended questions to encourage dialogue and exploration of the individual's thoughts and feelings, fostering a deeper understanding of the person's experiences.
7. **Eliciting Multiple Viewpoints:** The model emphasizes the importance of hearing multiple perspectives during discussions to understand the individual's situation better and promote collaborative problem-solving.
8. **Relational Focus:** The dialogue is centered around relationships and the meanings individuals attribute to their experiences, helping build trust and rapport between the individual and their support network.

## The Intervention<sup>245</sup>

1. **Crisis Intervention:** The ODM is particularly effective in crisis situations where immediate support is needed. The approach allows for rapid mobilization of resources and support networks, which can be crucial in preventing crises from escalating.
2. **Training and Supervision:** Professionals implementing the ODM undergo specific training to develop the necessary skills for facilitating network meetings and engaging in dialogic practice. Ongoing supervision and peer support are also integral to maintaining fidelity to the model.
3. **Cultural Adaptation:** While the core principles of Open Dialogue remain consistent, the model has been adapted to fit various cultural contexts in different

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<sup>244</sup> Kłapciński, M. M., & Rymaszewska, J. (2015). Open Dialogue Approach – about the phenomenon of Scandinavian Psychiatry. *Psychiatria Polska*, 49(6), 1179–1190. <https://doi.org/10.12740/PP/36677>

<sup>245</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

countries. This adaptability has allowed its successful implementation in diverse settings, from urban centres to rural communities.

One significant outcome of the ODM is reducing the use of involuntary treatment measures. By promoting a collaborative environment, individuals are more likely to engage in services of their choice. The success of the ODM in Finland has led to its dissemination in other countries, where it has been integrated into various mental health systems. This international network of practitioners shares experiences and best practices through seminars and conferences. The ODM aligns with human rights principles in mental health care, emphasizing the importance of individual autonomy, informed consent, and the right to participate in one's healthcare decisions. By promoting community-based care and support networks, the ODM contributes to the broader movement towards community services, which aim to provide support in less restrictive environments and reduce the stigma associated with psychosocial disabilities.<sup>246,247</sup> The ODM represents a transformative approach prioritizing dialogue, collaboration, and respect for individual preferences. Its emphasis on community involvement and relational understanding addresses crises and fosters a supportive environment conducive to long-term recovery.<sup>248, 249, 250</sup>

In 2018, Open Dialogue was evaluated in comparison with a large Finland-wide control group, covering about 19 years. The duration of hospital care, disability allowances and the need for neuroleptic remained significantly lower for the Open Dialogue cohort. This cohort also reported to have better employment outcomes.

The services are free of charge for those using it, but it has been estimated that one dialogical network meeting of 60-120 minutes costs US\$155-475.<sup>251</sup> National health insurance covers the costs of some medication and private psychotherapy and other services are state funded via the health sector.<sup>252,253</sup>

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<sup>246</sup> Institute For Dialogic Practice. (n.d.). About Open Dialogue. Retrieved from <https://www.dialogicpractice.net/open-dialogue/about-open-dialogue/>

<sup>247</sup> Kłapciński, M. M., & Rymaszewska, J. (2015). Open Dialogue Approach – about the phenomenon of Scandinavian Psychiatry. *Psychiatria Polska*, 49(6), 1179–1190. <https://doi.org/10.12740/PP/36677>

<sup>248</sup> Institute For Dialogic Practice. (n.d.). About Open Dialogue. Retrieved from <https://www.dialogicpractice.net/open-dialogue/about-open-dialogue/>

<sup>249</sup> Razzaque, R., & Stockmann, T. (2018). An introduction to peer-supported open dialogue in mental healthcare. *BJPsych Advances*, 24(1), 40-45. Available at: <https://www.cambridge.org/core/journals/bjpsych-advances/article/an-introduction-to-peersupported-open-dialogue-in-mental-healthcare/E7A34021A8266DF280BD12FD2C0FAB8B>

<sup>250</sup> Seikkula, J., & Olson, M. E. (2003). The Open Dialogue Approach to Acute Psychosis: Its Poetics and Micropolitics [PDF document]. Retrieved from <https://revlyon.wordpress.com/wp-content/uploads/2019/07/the-open-dialogue-approach-to-acute-psychosis-its-poetics-and-micropolitics-2003.pdf>

<sup>251</sup> Conversion as of March 2021

<sup>252</sup> Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available: <https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y>

<sup>253</sup> Website: <http://developingopendialogue.com/>

Videos: Jaakko Seikkula - Challenges in Developing Open Dialogue Practice <https://www.youtube.com/watch?v=VQoRGfskKUA>

Open Dialogue, An Alternative, Finnish approach to Healing Psychosis <http://wildtruth.net/films-english/opendialogue>

The models above demonstrate that a wide range of community-rooted, non-coercive crisis responses are already being practiced across regions. Whether led by peers, community actors, or hybrid teams, these examples show that alternatives to institutionalization and forced treatment are both viable and scalable.

## 4.2 Best Practices on Strengthening Community Support Systems

Community support systems are essential for enabling persons with disabilities to live independently and be included in the community and are indispensable elements of deinstitutionalization.<sup>254</sup> Article 19 (b) of the CRPD requires state parties to ensure that persons with disabilities have access to a range of in-home, residential, and other community support systems that are available to prevent isolation or segregation from community support.<sup>255</sup> And yet, many persons with psychosocial disabilities continue to be institutionalized because community-based responses remain weak or missing. Families often express that they do not have alternatives and mental health systems emphasize individual treatment over community based support. Strengthening peer networks, neighborhood support, and social capital, especially in low-resource settings, can prevent crisis escalation and forced interventions.

**Defining community support systems:** Community support systems are locally rooted, humane networks that enable people with psychosocial disabilities to live with dignity and inclusion. These systems may include inclusive neighbourhoods, befriending, peer-to-peer support, informal support for decision making, community-based conflict resolution, support for the homeless persons, and inclusive cultural or recreational spaces. While social protection and formal services are essential, they are not enough. Real inclusion requires strengthening informal networks, peer-led initiatives, and community-based responses. Social capital in the form of trust, reciprocity, and relationships plays a key role. In many cases, individuals cannot access entitlements like disability pensions because families or systems deny their legal capacity. Around the world, persons with psychosocial disabilities, their peers and families have independently built circles of care, hearing voices groups, intentional peer zones, and spiritual or creative collectives, often without government support. These grassroots models must be recognized, supported, and scaled.

Community support can take many forms: respite for families, support groups, inclusive arts, “just being” spaces, mindful listening hubs, yoga or nature retreats,

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<sup>254</sup> United Nations High Commissioner for Human Rights (OHCHR). (2014). Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37). <https://documents.un.org/doc/undoc/gen/q14/241/66/pdf/q1424166.pdf>

<sup>255</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

digital helplines, and more.<sup>256</sup> These are “ways of life” in many cultures; however, the genuine support function of “community” may have to be redefined and reclaimed in several cultural and geographic contexts.

One of the most effective forms of community support is peer support, relationships built on shared lived experience, mutual respect, and collective strength. Organically occurring peer support is non-hierarchical, informal, unstructured and rooted in informal self-help promoted by the ex-patients / survivor movement in the 1970s<sup>257</sup>.

Peer support can take multiple forms, depending on the context and level of formalization:

- a. **Informal Peer Support** is formed when two or more peers with similar lived experiences come together to encourage and support each other. The supporters operate in an informal, independent role without structures or organizational affiliation.
- b. **Formal Peer Support** is often organized by government or non-government organizations that train and recruit peers to provide support. Often, peer supporters are referred to as “Peer Support Workers” (PSW), who can be paid or volunteer their time and are connected with mental health or social services.
- c. **Peer Delivered Self-help**: It is offered informally and voluntarily to another peer to assist each other mutually and is delivered in a group format, often defined as “voluntary small group structures”<sup>258</sup> This is the fastest-growing peer support service in low and middle-income countries and has gained relevance in the context of deinstitutionalization. These services are more acceptable, feasible and accessible to people with psychosocial disabilities and cover support needs and co-morbid physical and social health challenges (e.g. loneliness). These are also expanding on digital platforms such as helplines, WhatsApp, and YouTube channels (offering individual services, group services and tools to navigate through crisis).
- d. **Peer Run Services**: These are administered and led by peers. These services and programs are legally independent entities and are embedded within larger non-profit organizations.<sup>259</sup> Peers control the operations, as these have emerged as an alternative to traditional mental health services. Some examples are peer-respite<sup>260</sup> (a voluntary, short-term, overnight program providing community-based and non-clinical crisis support), WarmLine<sup>261</sup> (24/7 non-emergency telephone lines

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<sup>256</sup> TCI (2022). TCI positionality on Community Inclusion. TCI Global, Geneva. Available: <https://tci-global.org/wp-content/uploads/2024/07/TCI-Positionality-on-Community-Inclusion-2022.pdf>

<sup>257</sup> Penney, D. (2018). Defining “Peer Support”: Implications for Policy, Practice, and Research. Available: [https://www.ahpnet.com/AHPNet/media/AHPNetMediaLibrary/White%20Papers/DPenney\\_Defining\\_peer\\_support\\_2018\\_Final.pdf](https://www.ahpnet.com/AHPNet/media/AHPNetMediaLibrary/White%20Papers/DPenney_Defining_peer_support_2018_Final.pdf)

<sup>258</sup> Ibid.

<sup>259</sup> Ibid.

<sup>260</sup> National Empowerment Center. (n.d.). Directory of Peer Respite. Available: <https://power2u.org/directory-of-peer-respite/>

<sup>261</sup> Mental Health Association of San Francisco. (n.d.). Mission. Available: <https://www.mentalhealthsf.org/mission/>

providing accessible emotional support), and drop-in centres such as BRIDGES<sup>262</sup>. Some of these organizations have expanded to include social-entrepreneurial organizations. Example: Common ground, Dr. Patricia Deegan<sup>263,264,265</sup>

- e. **Peer Partnership:** These are the organizations where responsibilities lie with non-peers and administrative and operational duties are mutually shared by both peers and non-peers, but primary control is with peers.<sup>266</sup>
- f. **Peers in Recovery as Employees:** Individuals hired into designated peer positions or traditional mental health positions and self-identify as peers and service users themselves as persons with psychosocial disabilities.<sup>267</sup> Commonly certified peer support specialists work in conjunction with conventional psychiatric treatment care and are integrated within medical and psychiatric treatment settings. Example: Substance Abuse for Mental Health Services (SAMHSA)<sup>268</sup> defined peer support competencies (2015) and delineated core competencies based on recovery-oriented and person-centered care principles.

### What Makes Peer Support Work

1. **Ownership by members:** Ownership over meetings and activities is an important component; while an organization may assist in establishing groups, the members themselves take charge to ensure that commitment, equality, and mutual support exist within the group.<sup>269</sup>
2. **Shared problem solving:** The group brings together individuals with similar concerns, allowing them to explore solutions to shared challenges. These sharing help members to feel understood and supported by others who have faced similar situations.<sup>270</sup>
3. **Emotional safety:** The peer support group provides a safe space for members to share their feelings and experiences in a confidential and empathetic setting. This environment is crucial for fostering trust and openness among members.<sup>271</sup>

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<sup>262</sup> Bridges Connecticut. (n.d.). About. Available: <https://bridgesct.org/about/>

<sup>263</sup> Summer Institute for Informed Patient Choice at Dartmouth. (2012, July 27). Pat Deegan-Common Ground [Video]. YouTube. Retrieved from <https://www.youtube.com/1>

<sup>264</sup> Bonfils, K. A., Dreison, K. C., Luther, L., Fukui, S., Dempsey, A. E., Rapp, C. A., & Salyers, M. P. (2018). Implementing CommonGround in a community mental health center: Lessons in a computerized decision support system. *Psychiatric Rehabilitation Journal*, 41(3), 216.

<sup>265</sup> Pat Deegan (n.d.). CommonGround Software - Pat Deegan. Available: <https://www.patdeegan.com/software>

<sup>266</sup> Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric rehabilitation journal*, 27(4), 392. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8855026/#:~:text=Thus%2C%20they%20wanted%20to%20maintain,using%20Personal%20Medicine%20in%20recovery.>

<sup>267</sup> Ibid.

<sup>268</sup> U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (n.d.). About Us. Available: <https://www.samhsa.gov/data/about-us>

<sup>269</sup> U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (n.d.). About Us. Available: <https://www.samhsa.gov/data/about-us>

<sup>270</sup> CBM. (n.d.). Community mental health good practice guide: Peer support. Available: <https://cbm-global.org/wp-content/uploads/2021/06/Good-Practice-Guide-CBM-Peer-support.pdf>

<sup>271</sup> Ibid.

4. **Digital continuity:** With the advancement in technology, these groups often provide online support groups through WhatsApp or other channels, ensuring the continued support is offered.<sup>272</sup>

These components build resilience, prevent isolation, and reduce the reliance on coercive mental health interventions. To support replication and scale-up of peer support practices, the following guides are recommended.<sup>273,274</sup> The following section presents best practice models from across the globe that demonstrate how community support systems, especially peer-led ones, are already preventing involuntary hospitalization and supporting inclusion in meaningful, localized, and sustainable ways.

### **Peer-Led Community Support Models**

These initiatives are led by persons with psychosocial disabilities, centered on mutual support, solidarity, and culturally grounded models of support.

#### ***Hugarafli, Iceland***<sup>275</sup>

Hugarafli, which means "Mindpower" in Icelandic, is a non-profit organization in Reykjavík, Iceland. It was established in 2003 by individuals with personal and professional knowledge of mental healthcare systems. The organization's goal is to empower individuals experiencing emotional distress by offering various services that promote mental health, recovery, and community engagement. Hugarafli operates on the principles of peer support, empowerment, and inclusivity, which makes it a unique model in Iceland's mental health landscape. The mission is to enhance the participation of individuals with lived experience of emotional distress in Icelandic society. The organization aims to create a supportive environment where individuals can share their experiences, access resources, and engage in activities that promote mental well-being. Hugarafli envisions a mental health system that values the voices of those with lived experience and fosters a culture of recovery and empowerment.

Hugarafli draws inspiration from the Empowerment Paradigm of Recovery, Healing, and Development developed by Daniel Fisher and from Judi Chamberlin's ideology of empowerment, grounding its work in a rights-based and participatory approach. The organization avoids clinical labels such as "mental illness" and instead uses the term "mental challenges," framing distress as shaped by a person's life experiences and social environment rather than as an individual pathology. Its services are co-created

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<sup>272</sup> Ibid.

<sup>273</sup> Practical guide for setting up a peer support group: <https://www.limbs4life.org.au/uploads/resources/A-Practical-Guide-for-Setting-up-a-Peer-Support-Group.pdf>

<sup>274</sup> Community Mental Health Good Practice Guide: Peer Support : [https://cbm-global.org/wp-content/uploads/2021/06/Good-Practice-Guide\\_CBM\\_Peer-support.pdf](https://cbm-global.org/wp-content/uploads/2021/06/Good-Practice-Guide_CBM_Peer-support.pdf)

<sup>275</sup> Hugarafli. (2024, February 1). About Hugarafli [Website]. Available: <https://hugarafli.is/about-hugarafli/>

through equal collaboration between peers and professionals, ensuring mutual respect and shared decision-making.

Participation in Hugarafll's programs is free, and individuals do not need a formal diagnosis or referral to access services. This open-door policy encourages individuals to seek support on their terms and fosters a sense of belonging within the community.

Hugarafll provides a variety of services and activities designed to support individuals in their well being journeys:

1. **Peer-Led Self-Help Groups:** Regular self-help groups are hosted and led by individuals with lived experience.<sup>276</sup> These groups provide a safe space for participants to share their experiences, discuss coping strategies, and offer mutual support.
2. **Peer Support:** The organization offers one-on-one peer support, where trained peer supporters guide and encourage individuals navigating their support needs and challenges. This support is grounded in empathy and shared experience, helping individuals feel understood and less isolated.
3. **Counselling Services:** Hugarafll provides access to professional counselling services, including therapy and psychological support. These services complement peer support and empower individuals to work through their needs in a supportive environment.
4. **Activism and Advocacy:** Hugarafll is actively involved in mental health advocacy, working to raise awareness about the rights and needs of individuals with lived experience. The organization engages in community outreach and collaborates with other mental health organizations to promote systemic change and improve mental health services in Iceland.
5. **Mental Health Promotion in Education:** Hugarafll is committed to promoting mental health awareness and education within the community. The organisation conducts workshops and training sessions to educate the public about psychosocial health issues, reduce stigma, and foster a culture of understanding and support.
6. **Community Activities:** Hugarafll organizes various community activities, including social events, workshops, and recreational outings. These activities aim to build community among participants and encourage social interaction, which is vital for well-being.
7. **Vocational Rehabilitation:** Hugarafll provides robust vocational rehabilitation services for individuals.

By prioritizing peer support and empowerment, the organization has helped many individuals regain control over their lives and well being. Participants often reported feeling more connected to their community, experiencing reduced isolation, and

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<sup>276</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

developing effective coping strategies<sup>277</sup>. Hugarafi's efforts to raise awareness about the importance of lived experience in mental health care have influenced policy discussions and encouraged the integration of peer support into mainstream mental health services.

While Hugarafi has achieved significant success, it faces challenges typical of non-profit organizations, including funding constraints and the need for ongoing community engagement. To address these challenges, Hugarafi is exploring opportunities for partnerships with other organizations, seeking grants, and expanding its outreach efforts to raise awareness about its services.

Hugarafi represents a pioneering peer-led psychosocial support model in Iceland, emphasizing empowerment, community, and the importance of lived experience.

### **IMHA (Indonesian Mental Health Association- IMHA), Indonesia**<sup>278,279</sup>

IMHA, officially *Perhimpunan Jiwa Sehat*, is a national OPD of persons with psychosocial disabilities in Indonesia, founded in 2008–2009. It is founded and led by survivors of coercive psychiatric treatment and forced hospitalization and promotes rights-based inclusion, human rights, and deinstitutionalization through peer-led advocacy. One of its key strategies is the development of peer support groups across the country that function as both solidarity spaces and platforms for rights-based self-determination.

Peer support groups, across Indonesia, have been established for collective advocacy efforts to build capacity on how to support themselves, address local issues, advocate for their rights and provide a safe space for individuals to share their experiences, challenges and successes. The meetings are organized once every week and are structured as per the needs of the members. These groups also connect through WhatsApp, ensuring continued mutual support. IMHA also engages with families and care givers to listen to them, provide the needed support and restore hope. These group interactions are also helpful to understand the context and reasons of why persons with psychosocial disabilities are put into institutions. They strongly advocate for supported decision making of persons with psychosocial disabilities. This also informs the advocacy and work of IMHA around addressing these causes and proposing alternatives. Through these efforts, IMHA transforms peer groups from basic support mechanisms into empowerment structures that challenge institutional norms and promote collective alternatives to coercive systems. IMHA's peer support activities are funded by donor agencies and international partners.

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<sup>277</sup> Ibid.

<sup>278</sup> IMHA Website: <https://pis-imha.or.id/index.php>

<sup>279</sup> Interview: Yeni and Team, IMHA, October, 04, 2024

## Abolition of Punishment and Confinement Logics (A.L.C.E) | Colombia<sup>280</sup>

A.L.C.E is an organization of persons with psychosocial disabilities and seeks to dismantle policy and institutional structures that result in confinement and positivism. It has a focus on ways that psychiatric violence gets perpetrated in society to exercise social control over marginalized groups, namely Trans and Lesbian, Gay, Bisexual, Queer, Intersex (LGBQI) people, women labelled with a psychiatric diagnosis, non-verbal persons, indigenous youth, and people who live in the streets. Under the leadership of survivors of psychiatric violence and allies, A.L.C.E challenges hegemonic ways of understanding “mental health” and seeks to strengthen the political power of people with direct experience so they can transform oppressive structures, legal policies and practices and advance the rights to autonomy, self-determination, legal capacity and to live in the community. A.L.C.E advances its mission through a transdisciplinary lens with a team that includes mad activists, legal and public health workers, artists and social scientists.

ALCE conducts peer support and political empowerment of directly impacted persons, community pedagogy, participatory research and advocacy. Through its Mad Popular School, peer-led workshops, and emotional justice work, it builds collective tools for survival and transformation.

The GAM (peer support network by ALCE) focuses on developing and strengthening a peer-to-peer methodology. GAM has held weekly meetings for over two years with people who experience emotional distress or have been psychiatrically mistreated. A WhatsApp group with over 100 members with a team of facilitators who are GAM members has been formed and is used for several collective sharing sessions. Members exchange tools to address emotional distress and create alternatives to the mental health system that discriminates and oppresses persons with psychosocial disabilities. The online group also provides a space where support can be requested and provided in real time. The network has also established in-person spaces for leisure and connection such as the GAM Karaoke, which again counters the narrative set by mental health systems that wellness can only be found through words. Karaoke works as an exercise for discharge where through singing and through coming together, “*we find relief.*” The members of these groups have been able to foster more connections and build networks, which is essential for survivors of institutionalization as there tends to be immense isolation in the practices of psychiatric violence. The network also explores different ways of economic solidarity venues to address economic crisis. Other examples of peers providing support are through working with and recognizing the emotions. An indigenous tradition is followed for this activity, where members make small cloth dolls and place them below their pillows with a belief that the dolls will take away the sorrows. Additionally, some members have also

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<sup>280</sup> [https://whatweneed.tci-global.org/wp-content/uploads/2022/12/Transcript\\_Spotlight-Interview-of-Silvestre-Barragan-ALCE.pdf](https://whatweneed.tci-global.org/wp-content/uploads/2022/12/Transcript_Spotlight-Interview-of-Silvestre-Barragan-ALCE.pdf)

conducted group spaces for yoga as practice or theatre sessions, which is where they work through the body to recognize emotions. These workshops have not only raised awareness but has also provided platforms for individuals to express their experiences and challenges. It is also important to note that these groups are peer led, autonomous, and operate independently from government and institutional controls. The GAM network exemplifies how sustained, peer-led support can strengthen autonomy, restore social connections, and serve as a meaningful alternative to coercive mental health practices.

While this example from A.L.C.E primarily illustrates peer-led support strategies and is therefore included in this section, it also contributes significantly to the development of crisis support tools discussed under Section 4.1. As part of its peer-led crisis support approach, A.L.C.E has developed community-based tools that challenge dominant narratives around crisis and emotional expression. One example is of members coming together to create “mad maps” or crazy maps which basically maps all the steps that are needed to address or mobilize support for the person before, during and after crisis situations. This was developed out of a need to address and change the narrative of mental health systems that “we can only talk of our emotions or with our emotions during crisis”.<sup>281</sup> These networks established have empowered individuals to support one another. For crisis support, ALCE also holds dialogue and learning spaces, where they come together and try to develop community tools that can be utilized during times of crisis. Conversations are also held exploring what crisis means to them, how they have lived through crisis and how the responses differ from person to person, making a very keen observation that these tools can only be developed through social exercises and peer exchanges. These practices not only redefine how crisis is understood and supported, but also demonstrate how collective, peer-driven strategies can serve as powerful alternatives to institutional or coercive interventions.

### **Intentional Peer Support<sup>282</sup>**

Intentional Peer Support involves purposeful relationships, where both individuals or a group use the connection to gain new perspectives, develop greater self-awareness, and support each other as they explore new possibilities. This approach has been applied in crisis respite, by peers, mental health professionals, families, friends, and community-based organizations. It differs from traditional service relationships in several ways. Rather than assuming a problem, it encourages listening to how and why each person makes sense of their experiences to create new perspectives. It promotes a “trauma-informed” way of relating, focusing on “what happened” rather than “what’s wrong.” It also considers our lives within the context of our relationships and communities, viewing peer support relationships as partnerships for mutual

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<sup>281</sup> Interview with Silvestre Barragan, A.L.C.E

<sup>282</sup> Intentional Peer Support Website: <https://www.intentionalpeersupport.org/?v=b8a74b2fbcbb>

learning and growth. Instead of focusing on what to avoid, it encourages moving toward what and where we want to be.

### **Nidahas Chinthana Sansadaya – Consumer Action Forum (NCS – CAF), Sri Lanka<sup>283</sup>**

The NCS-CAF is an organization of persons with psychosocial disabilities and a community-led initiative that brings together mental health “consumers”, persons with psychosocial disabilities and cross disabilities to foster partnerships towards ensuring inclusion.

Their work bridges the gap between marginalized individuals and other stakeholders (health and development) while educating communities on well-being, addressing myths, and spotlighting social, cultural, political and economic stressors that can contribute to distress. Their approach includes sharing personal stories and experiences, organizing community consultation sessions, and creating dialogue through innovative formats like Forum Theatre, human libraries, and contributions to media programs.

The group also collaborates with other cross disability organizations, advocating for policy changes, mobilizing self-help groups, and building community understanding of support needs.

A core component of NCS–CAF’s work is the development of Village Volunteer Committees, which include persons with psychosocial disabilities and community members. Through these platforms, the organization mobilizes peer-led support groups that offer:

- home visits for emotional support and family sensitization;
- self-help group formation, meetings and group-led activities focused on recreation, income generation, sharing responsibilities, financial support etc.
- engaged community to renovate/construct housing health for those who are homeless;
- provide shelter during crises and social inclusion;
- organizing spiritual and recreational activities with other stakeholders, etc.

These efforts go beyond mere service delivery. They actively strengthen community inclusion, restore dignity and build mutual accountability within communities. The peer support groups play a vital role in offering non-institutional pathways to care, reducing reliance on coercive or custodial settings by building local ecosystems of care and solidarity. By embedding support within everyday community life, NCS–CAF helps prevent the cycles of isolation, abandonment, and institutionalization that persons with psychosocial disabilities often face.

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<sup>283</sup> <https://laymensden.wordpress.com/> and Interview with Chintha Munasinghe, NCS-CAF

## Bapu Trust for Research on Mind & Discourse, India

The Seher Programme by Bapu Trust, based in Pune, began with a conventional expert-led model, but evolved in response to community realities. It became evident that individuals in the low-income communities they worked with preferred group-based, relational support over individual counselling. This shift led to the development of Therapeutic Groups, an approach that now forms a core component of Seher.

These groups are embedded within existing community spaces such as women's collectives, *bhajan* groups (devotional groups), and youth clubs and are often composed of persons from marginalized backgrounds, including single women, women living with HIV, and adolescents. The groups combine arts-based therapy, peer engagement, and psychosocial support in culturally resonant and emotionally safe settings.

Crucially, Bapu Trust does not define 'peer' solely through the lens of psychiatric experience. Instead, peerhood is understood through shared experiences of social, economic, or cultural marginalization, which deepens the inclusiveness of the support model.<sup>284</sup> These therapeutic groups prioritize emotional sustainability, recognizing that social capital, trust, reciprocity, belonging is a vital protective factor against psychosocial distress and exclusion.<sup>285</sup>

Group sessions are co-created spaces where members share personal journeys, reflect together, and build collective resilience. While structured with therapeutic intent, the tone is informal and community-rooted which allows members to connect through familiarity, mutual learning, and lived experience, rather than through hierarchical or clinical roles. "It was seen that people were much more compliant to groups than to individual therapy. It was easier to connect to familiar faces and open to them than to speak to an expert who is a stranger."<sup>286</sup>

By grounding well-being in mutuality and social connection, these therapeutic groups offer a sustainable, non-institutional model of care. They enable individuals to access and mobilize support within their own preferred communities, preventing escalation into clinical or custodial systems and promoting long-term inclusion.

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<sup>284</sup> Davar, B. V. (2014, September). Social Inclusion of persons with psychosocial disabilities: Bapu Trust experiences. Paper presented at the Social Exclusion and Mental Health, University of Allahabad.

<sup>285</sup> [https://bapustrust.com/wp-content/uploads/2020/06/TG-Evaluation-report\\_-2-1.pdf](https://bapustrust.com/wp-content/uploads/2020/06/TG-Evaluation-report_-2-1.pdf)

<sup>286</sup> Bapu Trust for Research on Mind & Discourse. (2). Internal Document.

## **KOSHISH, Nepal**

KOSHISH is an organization of persons with psychosocial disabilities in Nepal that promotes the inclusion of mental health within broader health and disability frameworks. It operates through a rights-based, person-centric approach to build community based support systems in a context where formal deinstitutionalization has not yet been enacted. KOSHISH advocates to bring mental health and psychosocial disabilities into the mainstream by breaking the silence surrounding these issues and creating replicable models for psychosocial well-being within communities.<sup>287</sup>

When entering a new community, KOSHISH begins by setting up peer support groups composed of individuals with lived experience of psychosocial disability. These groups provide a space for sharing, mutual learning, and the beginning of personal recovery. Community facilitators and mobilizers are identified to help coordinate the groups, raise awareness, and strengthen local participation. Over time, the peer support groups evolve into self-help groups that not only sustain emotional support but also engage in collective action and leadership development.

With ongoing capacity building, members begin advocating for their rights and engaging local governments to promote policies that support inclusion and protection. The groups organize community dialogues and outreach to build awareness around psychosocial disabilities and to influence local systems to recognize and back peer-led initiatives. In the absence of formal deinstitutionalization policies, KOSHISH's peer support model provides a community-anchored, rights-based alternative that builds solidarity, restores confidence, and prevents institutionalization through local support networks.<sup>288</sup>

### **Risks and Political Tensions in Peer Support Practices**

To define this concept in rigid terms, using narrow frameworks does not do justice to this kind of mutually healing / helping relationships. However, it makes it easier for systems and agencies to appropriate it. Unfortunately, this happened as mental health systems became more open to integration of recovery and inclusionary practices and peer support gained momentum and recognition. To utilize and integrate this concept into the mental health systems, it started being narrowly defined (people with lived experience of mental health issues / users of psychiatric services etc.), peers started being trained and “qualified” to perform “services” and evaluated using traditional methods (like RCTs, systematic reviews, evidence based) diluting the principles of peer support, reducing peers to the role of a “native

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<sup>287</sup> <https://koshish.org.np/>

<sup>288</sup> Interview with Koshish staff and <https://koshish.org.np/ourProgram/strengthenCommunitySupportSystem>

informant”<sup>289</sup> and introducing the conflicting dynamic of helper-helper.<sup>290</sup> Once the government structures, funding agencies and mental health systems started professionalizing the role of a peer, there was a growing focus on “principles, practices, value additions, cost efficiencies, treatment outcomes and less on peer workers as a social phenomenon”.<sup>291</sup> Numerous researchers have expressed concerns regarding the co-optation of peer worker by the system.<sup>292,293</sup> When they are brought into the cultural, legal, ethical and clinical framework, there is always a risk of experience acculturation<sup>294</sup> and a formal, paid position binds them to deliver what is expected of them. And that is usually the role of a para clinical worker, enforcing and ensuring existing clinical recovery.<sup>295</sup> Schmith, Gill, Pratt and Solomon (2008) expressed their concerns that when peer workers are unable to or not supported to bring their values and lived experiences to inform their work, the very concept is diluted or eroded.<sup>296</sup>

These concerns are amplified in the Global South where the concepts of community and self-differ and hence the understanding of peer support. In a country mission meeting of Asia Pacific nations, this was highlighted by the attendees that peer worker trainings were given by the West, a formalized peer system was equivalent to getting recruited in mental health system, peer workers were trained to give injections and also supported coercive treatments and their work was not recognized and undervalued in the system (evidenced by longer working hours, multiple roles and low wages).<sup>297</sup> Similar sentiment was reported where they mentioned that Eastern, collectivist and family centered cultures may not be very comfortable with adopting foreign ways of thinking about peer support<sup>298</sup>. This also highlights the glaring issue as there is no clarity in the literature and in practice on culturally specific versus universal aspects of peer support. The peer support

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<sup>289</sup> Voronka, J. (2019). The mental health peer worker as informant: Performing authenticity and the paradoxes of passing. *Disability & Society*, 34(4), 564–582. <https://doi.org/10.1080/09687599.2018.1545113>

<sup>290</sup> Shery, M., & Macneil, C. (2006). Peer Support: What makes it unique? *International Journal of Psychosocial Rehabilitation*, 10, 29–37.

<sup>291</sup> Voronka, J. (2019). The mental health peer worker as informant: Performing authenticity and the paradoxes of passing. *Disability & Society*, 34(4), 564–582. <https://doi.org/10.1080/09687599.2018.1545113>

<sup>292</sup> Alberta, A. J., & Ploski, R. R. (2014). Co-optation of Peer Support Staff: Quantitative Evidence. *Rehabilitation Process and Outcome*, 3, RPO.S12343. <https://doi.org/10.4137/RPO.S12343>

<sup>293</sup> Gillard, S. (2019). Peer support in mental health services: Where is the research taking us, and do we want to go there? *Journal of Mental Health*, 28(4), 341–344. <https://doi.org/10.1080/09638237.2019.1608935>

<sup>294</sup> Alberta, A. J., & Ploski, R. R. (2014). Cooptation of Peer Support Staff: Quantitative Evidence. *Rehabilitation Process and Outcome*, 3, RPO.S12343. <https://doi.org/10.4137/RPO.S12343>

<sup>295</sup> Gillard, S. (2019). Peer support in mental health services: Where is the research taking us, and do we want to go there? *Journal of Mental Health*, 28(4), 341–344. <https://doi.org/10.1080/09638237.2019.1608935>

<sup>296</sup> Schmidt, L. T., Gill, K. J., Pratt, C. W., & Solomon, P. (2008). Comparison of service outcomes of case management teams with and without a consumer provider. *American Journal of Psychiatric Rehabilitation*, 11(4), 310–329. <https://doi.org/10.1080/15487760802186253>

<sup>297</sup> JNGMDP, & TCI Asia. (2017). “TCI Asia Action in Japan: Peer Support”. Report of a Country Mission Visit to Japan, Ibaraki, Osaka, November 22-23, 2017. Japan National Group of Mentally Disabled People (JNGMDP) in collaboration with TCI Asia, Research Center of Ars Vivendi of Ritsumeikan University, and NPO Corporation Aru. TCI Asia-Pacific.

<sup>298</sup> Stratford, A. C., Halpin, M., Phillips, K., Skerritt, F., Beales, A., Cheng, V., Hammond, M., O’Hagan, M., Loreto, C., Tiengtom, K., Kobe, B., Harrington, S., Fisher, D., & Davidson, L. (2019). The growth of peer support: An international charter. *Journal of Mental Health*, 28(6), 627–632. <https://doi.org/10.1080/09638237.2017.1340593>

experience in the Lower and Middle Income Countries context has been more from the location of disability inclusive development, reaching beyond medical care and building access to support systems by working within communities.<sup>299</sup> The peer should not be trained to deliver “medical care” or “coercive treatments” or “giving injections” as these very practices go against the nature of what or who a peer should be. They should not be merely filling a treatment gap or care gap as suggested by a few studies to address shortage of human resource.<sup>300,301</sup> We should be focusing on and asking ourselves whether the outcomes of these programmes are to support recovery within mental health systems or to mobilize and strengthen communities? If the outcome should be recovery or inclusion within the community? Who should be defining who is a peer and who should be holding up the very support of this concept? The mental health system, the governments, the experts or the community and people themselves?

#### 4.4 Best Practices of Models Enabling Access to Mainstream Services

Often, when it comes to persons with mental, intellectual and psychosocial disabilities, addressing the medical and rehabilitation aspects of impairment takes center stage. Or, mainstream services link providing a service with taking medication or treatment. Access to trainings, skill development, improving employability, housing options, supports needed to live independently and resources for living a life with adequate standard of living, remain forgotten. For community living to have the outcome of inclusion, there must be improved access not only to specific services, but to generic mainstream services. This includes a vibrant educational environment for lifelong learning, respect for diversity in social and economic life, employability and skills development, housing, social protection, opportunities for participation in community life, leisure, recreation, grooming, sports, spiritual pursuits, friendships and relationships and play. Legal barriers to enjoying personhood, political and civic participation must be removed, and the process eased for obtaining personal documentation for citizenship, disability cards, pensions and other entitlements. A compensation package to support people in the immediate time after leaving institutions will help a lot to help them to recover their lives and live with adequate standard of living in open settings without fear and insecurity. Access, use and communication of mainstream services should be accessible to persons with disabilities and reasonable accommodation should be ensured in a way that it respects the person and preserves their identity and personal information.

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<sup>299</sup> JNGMDP, & TCI Asia. (2017). “TCI Asia Action in Japan: Peer Support”. Report of a Country Mission Visit to Japan, Ibaraki, Osaka, November 22-23, 2017. Japan National Group of Mentally Disabled People (JNGMDP) in collaboration with TCI Asia, Research Center of Ars Vivendi of Ritsumeikan University, and NPO Corporation Aru. TCI Asia-Pacific.

<sup>300</sup> Pathare, S., Kalha, J., & Krishnamoorthy, S. (2018). Peer support for mental illness in India: An underutilised resource. *Epidemiology and Psychiatric Sciences*, 27(5), 415–419. <https://doi.org/10.1017/S2045796018000161>

<sup>301</sup> Kakuma, R., Minas, H., Ginneken, N. van, Poz, M. R. D., Desiraju, K., Morris, J. E., Saxena, S., & Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. *The Lancet*, 378(9803), 1654–1663. [https://doi.org/10.1016/S0140-6736\(11\)61093-3](https://doi.org/10.1016/S0140-6736(11)61093-3)

To enable persons with psychosocial disabilities to live independently and be included in their communities, access to mainstream services is essential. However, in many settings, responses to psychosocial disability continue to focus primarily on medical or rehabilitative interventions, often linking access to basic services such as housing, training, or social protection with compliance to medication or treatment.

This narrow framing has led to the neglect of essential supports required for inclusion. Opportunities for training, skill development, employability, housing, and independent living as well as access to personal assistance are often missing. Mainstream services that promote and enable inclusion must encompass a wide range of areas such as lifelong education, cultural and recreational participation, housing, legal documentation, financial entitlements, relationships, leisure, and spiritual and civic engagement.

Many people face legal and administrative barriers to services, particularly in obtaining documentation such as citizenship ID, disability cards, pensions, or civic registration. Removing such barriers and offering transitional compensation or support for those exiting institutions is essential to enable people to live safely, securely, and with dignity in community settings.

It is critical that access, use, and communication around these services be inclusive of persons with psychosocial disabilities, ensuring reasonable accommodations and respect for personal autonomy, privacy, and identity.

The following best practice examples illustrate how organizations have proactively enabled access to housing, personal support. These approaches highlight how structural inclusion measures help prevent institutionalization and reduce reliance on coercive models, aligning with CRPD principles and the right to live in the community.

### **Housing First, Canada**

Housing First is an innovative approach aimed at addressing homelessness, including among persons with psychosocial disabilities, by moving individuals from the streets or emergency shelters into stable, long-term housing accompanied by necessary support services.<sup>302</sup> The primary objectives of Housing First are to enhance housing stability and improve the quality of life for those it serves, while also promoting while promoting autonomy and social inclusion.<sup>303</sup> By prioritizing stable housing without requiring treatment compliance, Housing First offers a rights-based alternative to psychiatric hospitalization and institutional living.

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<sup>302</sup> Housing First: <https://housing-infrastructure.canada.ca/homelessness-sans-abri/resources-ressources/housing-first-logement-abord-eng.html>

<sup>303</sup> Ibid.

As part of the Reaching Home initiative, the Housing First model is endorsed as an effective method for eradicating homelessness, particularly among individuals with psychosocial disabilities.<sup>304</sup> Since April 1, 2019, the federal homelessness program's mandatory Housing First investment targets have been removed, allowing communities greater flexibility to implement the Housing First approach for a wider range of populations and to explore innovative solutions tailored to local needs.

### Key Principles of Housing First

1. **Rapid Housing with Supports:** The approach emphasizes quickly assisting clients in finding and securing permanent housing, along with support for moving in or rehousing if necessary. Notably, housing readiness is not a prerequisite for this assistance.
2. **Client Choice in Housing:** Clients are encouraged to exercise choice in their housing options and the support services they wish to engage with.
3. **Separation of Housing Provision from Services:** Clients are not required to accept any specific services, including treatment or sobriety, to access or maintain housing. However, they must agree to regular check-ins, typically on a weekly basis, and support is provided to assist with rehousing if needed.
4. **Tenancy Rights and Responsibilities:** Clients are expected to contribute a portion of their income to rent, ideally around 30%, while the remainder is covered by rent subsidies. It is important to establish a landlord-tenant relationship, giving clients rights and responsibilities in accordance with relevant landlord-tenant regulations. Building strong relationships with landlords in both public and private sectors is crucial to the Housing First strategy.
5. **Community Integration:** To ensure client choice, reduce stigma, and foster social integration, more emphasis is placed on scattered-site housing within the public or private rental markets. Additionally, other types of housing, such as social housing or supportive congregate housing, may be available for client consideration depending on local resources.
6. **Strength-Based Approach and Promoting Self-Sufficiency:** The goal is to equip individuals with the resources and skills needed to access regular support and successfully transition out of the Housing First program. This approach focuses on building on the individual's strengths and abilities in alignment with their personal objectives, which may include goals related to employment, education, social inclusion, or health improvements—all essential for stabilizing their lives and achieving self-sufficiency.

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<sup>304</sup> Nelson, G., & Aubry, T. (2023, August). What is Housing First?. <https://kmb.camh.ca/eenet/resources/what-is-housing-first>

To better understand what makes Housing First distinct, it is helpful to contrast it with commonly used housing interventions that rely on conditional or segregated models

### What Housing First Is Not

1. **Shelters:** Shelters represent a crisis management approach that does not facilitate permanent housing solutions.<sup>305</sup> Although some shelters provide on-site treatment services such as day programs, vocational training, and transitional housing, they fall under the category of Treatment First rather than Housing First.
2. **Transitional Housing:** This model operates on the belief that individuals require residential treatment before they are ready to live independently.<sup>306</sup> It implies that transitional housing must be a precursor to obtaining permanent housing in the community.
3. **Congregate Supportive Housing:** In many communities, there are buildings dedicated solely to individuals experiencing homelessness, particularly those dealing with psychosocial disabilities and substance use.<sup>307</sup> These facilities employ staff to provide services on-site, which can create a segregated living environment rather than fostering community integration.
4. **Tiny Home Villages:** The effectiveness of tiny home villages in resolving homelessness lacks substantial research. Often, these homes are clustered together, which can lead to segregation from the wider community.<sup>308</sup> Furthermore, tiny home villages may limit the choices individuals have regarding their housing options.

### Personal assistance in Germany<sup>309</sup> and Sweden<sup>310</sup>

The model of personal assistance in Germany cover all areas of life such as personal care, mobility support, household tasks etc. The assistance is user led, enabling autonomy and agency of persons with disabilities to decide who, where, when and how service is provided. This system is financed through a combination of social insurance (e.g., care insurance) and social benefits, including the "personal budget" system. This enables persons with disabilities to receive direct payment, reinforcing the principle of upholding rights and agency. Although the model aligns with CRPD in principles, it often struggles in real life implementation due to disparities in service accessibility and quality, inconsistent funding, administrative hurdles etc.

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<sup>305</sup> Nelson, G., & Aubry, T. (2023, August). What is Housing First?.

<https://kmb.camh.ca/eenet/resources/what-is-housing-first>

<sup>306</sup> Ibid.

<sup>307</sup> Ibid.

<sup>308</sup> Ibid.

<sup>309</sup> Personal Assistance for Disabled People in Germany and Sweden in the Context of the Independent Living Philosophy and the UN Convention on the Rights of People with Disabilities Interviews with Personal Assistance Users and Independent Living Activists

<sup>310</sup> ENIL and EDF. (2019). *TOWARDS INDEPENDENT LIVING: COLLECTION OF EXAMPLES FROM EUROPE*. [https://enil.eu/wp-content/uploads/2022/03/GoodPractice\\_web.pdf](https://enil.eu/wp-content/uploads/2022/03/GoodPractice_web.pdf)

Sweden implemented the Personal Assistance Law in 1994, granting persons with disabilities a legal right to access personal assistance. This system is supported through designated cash allocations provided directly to persons with disabilities, enabling them to cover the cost of their required assistance. Applicants can request assistance and, once approved, receive an allocation of hours for personal assistance per week. Individuals have the freedom to decide how their assistance is organized. They can opt for services provided by the municipality, a user cooperative, or an assistance agency. Alternatively, they may choose to hire personal assistants directly, taking on the role of an employer. The JAG model empowers individuals with intellectual disabilities to maintain autonomy and control over their assistance. Users determine the type of assistance they require, as well as who provides it, where, when, and how it is delivered. This approach fosters greater independence and enables individuals to exercise control over their lives, including decisions about their living arrangements and companions.

### **Inclusive Social Protection in the Pacific<sup>311</sup>**

Several Pacific Island countries are demonstrating inclusive approaches to social protection that support persons with psychosocial disabilities to live with dignity in the community.<sup>312</sup> In Timor-Leste, a universal disability pension provides direct, unconditional cash support to adults with disabilities, enabling individuals to meet their basic needs without being institutionalized or subjected to medical control.<sup>313</sup> Fiji has implemented a range of disability-inclusive schemes including the Disability Allowance, Care and Protection Allowance, and Poverty Benefit Scheme, which rely on home-based assessments and promote autonomy while reducing stigma. In Papua New Guinea, emerging national policies emphasize community-based support and rights-based frameworks, even in the absence of large-scale programs. These initiatives exemplify how access to mainstream social protection systems such as housing, income support, transport, and documentation can significantly reduce the reliance on coercive or institutional responses to psychosocial disability. By enabling individuals and families to meet their needs within the community, these inclusive systems directly contribute to the realization of CRPD Articles 19 and 28 and offer practical, replicable models for preventing forced hospitalization and institutionalization.

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<sup>311</sup> Knox-Vydmanov, C., Soni, N., Satriana, S., & Attenborough, J. (2023). *From historical trends to investment pathways Social protection expenditure in Pacific Island Countries and Timor-Leste*.

[https://p4sp.org/documents/6/P4SP\\_From\\_historical\\_trends\\_to\\_investment\\_pathways.pdf?download=True](https://p4sp.org/documents/6/P4SP_From_historical_trends_to_investment_pathways.pdf?download=True)

<sup>312</sup> Cote, C. K.-V., Alexandre. (2023, October 16). The path towards inclusive social protection for people with disabilities in the Pacific. *Devpolicy Blog from the Development Policy Centre*. <https://devpolicy.org/the-path-towards-inclusive-social-protection-in-the-pacific-20231017/>

<sup>313</sup> *Insights on disability and social protection in the Pacific and Timor-Leste*. (n.d.).

[https://p4sp.org/resources/insights-on-disability-and-social-protection-in-the-pacific-and-timor-leste/?utm\\_source=chatgpt.com](https://p4sp.org/resources/insights-on-disability-and-social-protection-in-the-pacific-and-timor-leste/?utm_source=chatgpt.com)

### 4.3 Best Practices on Supported Decision Making and Enabling Legal Environment

More than 18 years from the adoption of the CRPD, persons with psychosocial disabilities are still denied legal capacity through laws, regulations, policies and practices. Archaic and discriminatory legal frameworks, using redundant and exclusionary language and provisions take away the legal capacity of persons with psychosocial disabilities effectively making them a non-person in the eyes of the law. When incapacity provisions applied in law get entrenched into the daily lives of persons with psychosocial disabilities, there is a cascading and compounding loss of rights and entitlements.

These legislative pieces are in direct contradiction to the Convention. These laws, in complete violation of Article 12 of the CRPD, take away the “right to have rights”<sup>314</sup> and ignore persons with psychosocial disabilities as right holders. An enabling legal environment is needed, which includes legal recognition to live independently in the community and have legal capacity, on an equal basis with others. The recognition of legal capacity also includes the obligation of ensuring that there is support available to exercise this right. Unfortunately, till now, there are no established Supported Decision Making (SDM) frameworks or laws, in line with Article 12 of the CRPD<sup>315</sup>. However, there are a few informal and formal supports for SDM that have been implemented in certain areas. There have also been studies that show that even though it is the State’s obligation to provide legal and policy supports for SDM, the actual application of it takes place closer to people’s home and lives.<sup>316</sup> OPDs and civil society across the global have been advocating for legal reforms to abolish coercive systems and structures and open up the way for freedom from torture, violence and cruel, inhuman or degrading treatment or punishment.

This section presents some best practice examples of collaborative decision making, about how organizations and States have enabled supported decision making in practice and some successful advocacy outcomes on legal reforms carried out by organizations of persons with psychosocial disabilities.

#### Collaborative/Community-based SDM Models

##### Family Group Conferencing (FGC), Netherlands and 30+ Countries

Family Group Consulting (FGC) is a collaborative decision-making model that originated in New Zealand and has been adapted for various contexts, including

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<sup>314</sup> A/HRC/37/56

<sup>315</sup> Implementing supported decision making in Serbia | Mental Disability Rights Initiative MDRI-S

<sup>316</sup> Ibid.

mental health care in the Netherlands.<sup>317</sup> In the Netherlands, it is called an Eigen Kracht conference. It emphasizes using one's strength and resources in the decision-making process, particularly during mental health crises, to direct one's own life.<sup>318,319</sup> The potential of FGC lies in establishing and strengthening communities for effective problem-solving that facilitates persons to regain autonomy and control over their situation.<sup>320</sup>

It aims to give individuals a voice in their care by involving them in discussions about their treatment and support options.<sup>321</sup> This fosters a sense of ownership over their mental health journey. It allows them to actively participate in decision-making processes, leading to more personalized and effective support.

By involving and reconnecting with family and social networks in the decision-making process and providing emotional support with practical assistance, FGC seeks to reduce isolation and reliance on coercive measures in mental health treatment. The model promotes voluntary participation and consensus-building, which can lead to more sustainable and less intrusive forms of support.

The process of FGC consists of four different stages and both professionals and coordinators have specific roles. Professionals like social workers play important roles in referring clients to the option of FGC and providing information for development of action plan.<sup>322</sup> It emphasizes collaboration, empowerment, and holistic support. By involving individuals' families and social networks in decision-making, FGC fosters a more inclusive and supportive approach to mental health treatment. The positive outcomes associated with this model highlight its potential to reduce coercion, strengthen family relationships, enhance satisfaction with care, empower individuals to take an active role in their care, encourage community involvement by recognizing the importance of social networks in mental health care, and improve overall mental health outcomes.<sup>323</sup> FGC can be organized worldwide in different settings such as youth, elderly care, the social sector within the justice system and mental health care. The potential lies in establishment and strengthening of communities for effective problem solving, to facilitate persons to regain autonomy and control over their

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<sup>317</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

<sup>318</sup> Bredewold, F., & Tonkens, E. (2021). Understanding successes and failures of family group conferencing: An in-depth multiple case study. *British Journal of Social Work*, 51(6), 2173-2190.

<sup>319</sup> Eigen Kracht Centrale. (n.d.). What we do - Eigen Kracht Centrale. [Website]. Retrieved from <https://www.eigen-kracht.nl/what-we-do-family-group-conferencing-participation-selfreliance-citizens/>

<sup>320</sup> Meijer, E., Schout, G., & Abma, T. (2021). Family Group Conferences in coercive psychiatry: understanding relational dynamics by plugging in Bourdieu. *European Journal of Social Work*, 24(1), 137-150.

<sup>321</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

<sup>322</sup> Meijer, E., Schout, G., & Abma, T. (2021). Family Group Conferences in coercive psychiatry: understanding relational dynamics by plugging in Bourdieu. *European Journal of Social Work*, 24(1), 137-150.

<sup>323</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

situation.<sup>324</sup>, <sup>325</sup> The focus is on collaborative problem-solving and developing a shared understanding of the individual's needs. The conference is designed to be a safe and supportive space for open dialogue and idea exchange.<sup>326,327,328</sup>

One of the challenges is that studies have shown that professionals do not always inform clients about the possibility of FGC and do not always refer to them, and there is an absence of studies conducting the effectiveness of FGC among the adult population and their social network in the field of rehabilitation medicine.<sup>329,330,331</sup> The other challenges are it can be resource intensive, in complex family dynamics it might not work, require skilled coordinators who can facilitate discussions and manage group dynamic, and may vary across different cultures. FGC will not be helpful when the client is in acute danger and has difficulties in communicating and making decisions. It is also not beneficial when the network is not open to its application.

### **Personal Ombudsman (PO) System | Sweden<sup>332</sup>**

Following the Swedish psychiatric reform of 1995 and abolishment of plenary guardianship of persons with psychosocial disabilities, Sweden government piloted and then implemented a Personal Ombudsmen System in 2000. The appointed Ombudsmen provide support for decision making concerning issues such as daily provisions, homelessness, medical care and improper treatment from medical and social services personnel. This system enabled the decision making process for persons with psychosocial disabilities by putting them in the driver's seat, where they set their goals, direct the process and choose the subjects they wish to address. This also led to a strengthened sense of empowerment and self-esteem of the clients<sup>333</sup>. However, the challenges associated with this system focused on it being a problem based view, wherein the client comes in with a problem that needs to be sorted with the help of PO; sometimes the POs redefine the client's needs to fit in the framework of the organization and lack of intersectoral coordination.

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<sup>324</sup> [Understanding Success and Failures of Family Group Conferencing: An in-Depth Multiple Case Study](#)

<sup>325</sup> Hillebregt, C. F., Scholten, E. W., Ketelaar, M., Post, M. W., & Visser-Meily, J. M. (2018). Effects of family group conferences among high-risk patients of chronic disability and their significant others: study protocol for a multicentre controlled trial. *BMJ open*, 8(3), e018883.

<sup>326</sup> Ibid.

<sup>327</sup> Ramon, S. (2021). Family group conferences as a shared decision-making strategy in adults mental health work. *Frontiers in Psychiatry*, 12, 663288.

<sup>328</sup> Hillebregt, C. F., Scholten, E. W., Ketelaar, M., Post, M. W., & Visser-Meily, J. M. (2018). Effects of family group conferences among high-risk patients of chronic disability and their significant others: study protocol for a multicentre controlled trial. *BMJ open*, 8(3), e018883.

<sup>329</sup> Meijer, E., Schout, G., & Abma, T. (2021). Family Group Conferences in coercive psychiatry: understanding relational dynamics by plugging in Bourdieu. *European Journal of Social Work*, 24(1), 137-150.

<sup>330</sup> Ramon, S. (2021). Family group conferences as a shared decision-making strategy in adults mental health work. *Frontiers in Psychiatry*, 12, 663288.

<sup>331</sup> Hillebregt, C. F., Scholten, E. W., Ketelaar, M., Post, M. W., & Visser-Meily, J. M. (2018). Effects of family group conferences among high-risk patients of chronic disability and their significant others: study protocol for a multicentre controlled trial. *BMJ open*, 8(3), e018883.

<sup>332</sup> <https://www.coe.int/en/web/bioethics/-/personal-ombud-programme-sweden>

<sup>333</sup> Klockmo, C. (2013). *THE ROLE OF PERSONLIGT OMBUD IN SUPPORTING THE RECOVERY PROCESS FOR PEOPLE WITH PSYCHIATRIC DISABILITIES* [PhD, Mid Sweden University]. <https://www.diva-portal.org/smash/get/diva2:663432/FULLTEXT01.pdf>

## Peer Support in Facilitating Supported Decision Making

Peer support has emerged as a pivotal component in promoting the legal capacity of persons with psychosocial disabilities, particularly in preventing forced treatment and hospitalization. In Kenya, the Users and Survivors of Psychiatry Kenya (USP-K) have established community-based peer support groups that operate independently of the formal mental health system.<sup>334</sup> These groups provide a platform for individuals to share experiences, access information about treatment options and rights, and develop mutual strategies for managing crises. By promoting trust and mutual understanding, peer support enables individuals to articulate their preferences and make informed decisions about their care. This approach not only challenges the traditional reliance on coercive measures but also aligns with the principles of the CRPD and the right to make one's own decisions. The Kenyan experience demonstrates that peer-led initiatives can effectively reduce the incidence of involuntary interventions by empowering individuals to exercise their legal capacity through supportive, non-coercive means. Similarly, Bapu Trust (BT) is using the Circle of Care as a community-based strategy to advance supported decision-making in India.<sup>335</sup> This model involves building a trusted, informal network around the person including friends, family, neighbours, and peers who offer non-coercive, rights-based support. These circles operate outside of clinical systems and emphasize every day, culturally rooted strategies to uphold a person's will and preferences, especially during distress or decision-making moments. By doing so, BT helps prevent institutional responses like forced treatment, while reinforcing autonomy, dignity, and inclusion.

## Advance Planning and Legal Tools

### Advance Planning Initiative Towards Reduction of Coercion<sup>336</sup>

The advance planning initiative in mental health care aims to empower individuals with psychosocial disabilities by enabling them to express their preferences and treatment wishes in advance, before they may be unable to do so due to a crisis. This proactive approach seeks to reduce the need for coercive measures by ensuring that patients' voices are heard and respected in their care.

Advance Directives are legal documents that outline a person's treatment preferences in case they cannot express them. These directives can cover instructions about medication, hospitalization, and other treatment options. Joint Crisis Plans can be

<sup>334</sup> USP-K. (n.d.). *THE ROLE OF PEER SUPPORT IN EXERCISING LEGAL CAPACITY*.

<https://rodra.co.za/images/countries/kenya/research/Role-of-Peer-Support-in-Exercising-Legal-Capacity.pdf>

<sup>335</sup> Davar, B. V., Pillai, K., & LaCroix, K. (2021). Seher's "Circle of Care" Model in Advancing Supported Decision Making in India. In C. Sunkel, F. Mahomed, M. A. Stein, & V. Patel (Eds.), *Mental Health, Legal Capacity, and Human Rights* (pp. 213–229). Cambridge University Press. <https://doi.org/10.1017/9781108979016.017>

<sup>336</sup> Council of Europe. (2021). COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

created by the individual and their care team that detail specific steps to take during a crisis, including preferred interventions and support mechanisms. These plans describe the signs of a crisis, coping strategies, and the individual's support network, helping guide care providers in respecting the individual's wishes during emergencies.

The initiative stresses the importance of autonomy by allowing individuals to play an active role in their treatment planning. This empowerment can lead to increased satisfaction with care and better adherence to treatment, as patients feel their preferences are valued and considered. Different jurisdictions have implemented advance planning measures with varying legal frameworks. For example, some regions have enforceable advance directives, while others may require decision-makers to consider the directives without legal enforcement. This variability emphasizes the need for clear guidelines and support for individuals navigating these processes. Research shows that planning can significantly reduce the use of coercive practices in mental health care. Studies have demonstrated positive outcomes associated with advance directives, including decreased hospitalization rates and improved patient satisfaction. Meta-analyses have highlighted the effectiveness of these measures in promoting human rights and reducing the need for involuntary treatment.

The challenges include that many individuals may be unaware of their rights to create advance plans or may have inadequate information regarding the process. Differences in how advanced plans are accepted and utilized across various mental health services can lead to inconsistent experiences for patients. Some mental health professionals may be hesitant to adopt advance planning practices, preferring traditional models of care that prioritize clinical authority.

For example, in Spain, the ACP-Mental Health program promotes advanced care planning to enhance the autonomy of individuals with psychosocial disabilities. This program guides the creation of advance plans that outline personal preferences during crises. Other countries, such as Belgium, Ireland, and Canada, have also implemented similar initiatives, showing a growing recognition of the importance of advance planning in mental health care, in line with the will and preferences of affected individuals.

### **Spain – Andalusian strategy on reducing restraint<sup>337</sup>**

Andalusia, a Spanish region adopted a strategy to reduce cases of use of restraint with an aim to completely eliminate the practice. This was done with the view of respecting the rights of persons with psychosocial disabilities and promoting their

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<sup>337</sup> *Promising practices in prevention, reduction and elimination of coercion across Europe.* (n.d.). <https://mhe-sme.org/wp-content/uploads/2019/01/Coercion-Report.pdf>

autonomy. “The strategy includes the implementation of anticipated treatment plans (advance directives), the need to register data on the use of mechanical restraint, and the provision of training in de-escalation techniques to prevent the use of restraint.” Moreover, a protocol was also developed addressing the use of physical or mechanical restraint aiming to reduce the use of these coercive measures by highlighting its legal aspects and using protective measures.

### **Patient-Led Action Plan to Appeal Compulsory Treatment Orders - The Netherlands**

In the Netherlands, the Patient-Led Action Plan to Appeal Compulsory Treatment Orders is a significant step towards empowering individuals with psychosocial disabilities who are under involuntary psychiatric interventions.<sup>338</sup> This initiative acknowledges patients' rights and emphasizes their active participation in deciding their treatment. By allowing patients to suggest alternative care, the program aims to balance the need for treatment with respect for individual autonomy and dignity. This approach is part of a broader movement in mental health care that aims to reduce coercive practices and promote recovery-oriented care.

The *primary objectives* of the Patient-Led Action Plan include empowering patients by giving them a voice in their treatment plans, reducing coercive practices by providing a structured process for appealing compulsory treatment orders, improving treatment outcomes by tailoring care plans to individual preferences, and promoting collaborative care by encouraging cooperation between patients and mental health professionals.

The Patient-Led Action Plan operates through several key components, including an appeal process, the discretion of medical directors, support and guidance for patients, and monitoring and evaluation of the action plans.<sup>339</sup> Despite its potential benefits, the Patient-Led Action Plan faces several challenges, such as variability in acceptance of action plans, lack of awareness among patients regarding their rights and the appeal process, resource limitations, and cultural resistance from some mental health professionals.<sup>340</sup>

Overall, the Patient-Led Action Plan to Appeal Compulsory Treatment Orders in the Netherlands represents a progressive approach to mental health care that prioritizes patient empowerment and autonomy. While it faces challenges in implementation, the initiative has the potential to significantly improve the experiences and outcomes of individuals subjected to involuntary treatment.

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<sup>338</sup> Council of Europe. (2021). COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

<sup>339</sup> Council of Europe. (2021). COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

<sup>340</sup> Ibid.

## Assisted Decision Making (Capacity) Bill | Ireland<sup>341</sup>

Ireland introduced the Assisted Decision-Making bill in 2013, to replace their guardianship system. Through this, a person who may be facing difficulty in managing their affairs can enter a co-decision-making arrangement with someone of their choice to take decisions, jointly with them. The key role of the chosen individual is to support in gathering information relevant to the decision making, explaining the obtained information to the person, make them understand the pros and cons, ascertain their will and preferences, support them to take the decision and get it implemented. The main challenge with this arrangement, however, is that without proper safeguards and monitoring mechanisms, this can get converted to substituted decision making.

## British Columbia's (Canada) Representation Agreement Act<sup>342</sup>

This Act is an example of setting up supported decision making in practice. It was created from the view that a person with intellectual or psychosocial disability has full capability of taking their own decisions, whether they are for daily life, financial or related to their treatment. This Act allows an individual to establish a mechanism where they can arrange in advance how they can make their decisions, in cases where the legal framework does not recognize their legal capacity or allows them to take legal decisions without support. Through this Act, the individual can draw up representation agreement with any individual of their choice and trust to support them in making decisions about their life in select areas such as health care, financial and obtaining legal services. This Act was also proposed to avoid a guardian being appointed by the Court to help adults make decisions. This ensures the self-determination, autonomy and will of the person is respected.

## Legislative Reforms and Policy Shifts

### Reforms in Italy

The reform law, commonly referred as Law 180 was introduced to shift the focus from custody and coercive treatments by closure of psychiatric hospitals, establish small psychiatric wards within general hospitals and to regulate and ensure the parallel development of community-based services. Except for flagship region Trieste, the reform was not considered to be satisfactory, as a result there were heterogenous development of services across regions.<sup>343</sup> In 2014, the government ordered for the

<sup>341</sup> Assisted Decision-Making (Capacity) Act 2015 (2015).  
<https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>

<sup>342</sup> Representation Agreement Act [RSBC 1996] CHAPTER 405 (2001). Available at:  
[https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96405\\_01#section2](https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96405_01#section2)

<sup>343</sup> Pycha, R., Giupponi, G., Schwitzer, J., Duffy, D., & Conca, A. (2011). *Italian psychiatric reform 1978: milestones for Italy and Europe in 2010?* *European Archives of Psychiatry and Clinical Neuroscience*, 261(S2), 135–139. doi:10.1007/s00406-011-0245-z

final closure of all the Judicial Psychiatric Hospitals (OPGs) and establish Residence for Execution of Security Measures (REMS). This was considered as second wave of deinstitutionalization and fully established community treatment as the primary method of psychiatric care in Italy.<sup>344,345</sup>

Most recently, a national campaign in Italy has focused on abolition of restraint supported by the Mental Health Forum.<sup>346</sup> It calls upon service providers such as psychiatrists, hospitals, hospital staff, organizations to sign up for the appeal and practice no-restraint as a policy. In units practicing no restraint, the focus is on complete “elimination of the use of restraints, having an open door wards, staff debriefing of aggression and violence episodes, early psychosocial interventions, implementation of crisis-resolution protocols and staff training on de-escalation techniques”.<sup>347</sup> Analysing the results of a recent survey among the General Hospital Psychiatric Units practicing this policy, the authors stated that “Despite these services being considered a minority of the 323 Italian units, our analysis demonstrates the feasibility and ethical alignment of operating without restraints.”<sup>348</sup> Specifically, our research documented the existence of 14 unites in Italy that reported zero restraint episodes during 2022. Furthermore, 10 units are committed to reaching the same objective and, in most cases, have obtained encouraging results.”<sup>349</sup>

## Spanish Reforms<sup>350</sup>

Spain’s 2021 civil code reform represents a major legal shift in line with the CRPD by fully abolishing guardianship and replacing it with supported decision-making mechanisms. The law recognizes that all persons with disabilities have legal capacity on an equal basis with others, and explicitly rules out any form of substituted decision-making. It mandates that support be tailored to the individual’s will and preferences, and emphasizes informal, trusted relationships where possible. Coercive measures are not permitted, and judicial intervention is only allowed as a last resort and must still respect the person’s autonomy. This reform provides a strong example of how

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<sup>344</sup> Ibid.

<sup>345</sup> De Luca, V., Pompili, P. M., Paoletti, G., Bianchini, V., Franchi, F., Lombardi, M., ... & Nicolò, G. (2018). The reform of Italian forensic psychiatric hospitals and its impact on risk assessment and management. *International Journal of Risk and Recovery*, 1(3), 22-29.

<sup>346</sup> Sears, R. (2024, June 25). Can Psychiatric Units Function Without Restraints? Italy Says Yes. *Mad In America*. <https://www.madinamerica.com/2024/06/can-psychiatric-units-function-without-restraints-italy-says-yes/>

<sup>347</sup> Colizzi, M., Comacchio, C., Garzitto, M., Napoli, G., Battiston, C., Tam, T., Bertoli, M., Anzallo, C., Palese, A., & Balestrieri, M. (2024). Is a No-Restraint Policy Associated with Increased Aggression Towards Healthcare Professionals Among Inpatient Psychiatric Units? A 16-Year Retrospective Observational Study Conducted in Italy. *Nursing Reports*, 14(4), Article 4. <https://doi.org/10.3390/nursrep14040276>

<sup>348</sup> Ibid.

<sup>349</sup> Pocobello, R., Camilli, F., Rossi, G., Davi, M., Corbascio, C., Tancredi, D., Oretti, A., Bonavigo, T., Galeazzi, G. M., Wegenberger, O., & El Sehity, T. (2024). No-Restraint Committed General Hospital Psychiatric Units (SPDCs) in Italy-A Descriptive Organizational Study. *Healthcare (Basel, Switzerland)*, 12(11), 1104. <https://doi.org/10.3390/healthcare12111104>

<sup>350</sup> Pycha, R., Giupponi, G., Schwitzer, J., Duffy, D., & Conca, A. (2011). *Italian psychiatric reform 1978: milestones for Italy and Europe in 2010? European Archives of Psychiatry and Clinical Neuroscience*, 261(S2), 135–139. doi:10.1007/s00406-011-0245-z

legal systems can uphold rights and dismantle structures that enable forced treatment or institutionalization.<sup>351</sup>

## Mexico's Legal Reforms

Mexico's 2022 General Health Act reform is a landmark legal development that upholds the right to legal capacity and explicitly bans coercive practices in mental health care. The law abolishes forced treatment, involuntary hospitalization, and any form of substitute decision-making, affirming that all mental health services must be provided with the free and informed consent of the individual. It mandates the transition from institutional care to community-based services and emphasizes the role of peer support and autonomy in treatment planning. This reform positions Mexico as a global leader in aligning national legislation with the CRPD, marking a decisive move away from psychiatric control toward rights-based, inclusive mental health systems.<sup>352,353</sup>

## Colombia Legal Reforms<sup>354</sup>

Colombia's landmark legal reform in 2019 ended the guardianship regime and recognized full legal capacity for persons with disabilities. This historic step aligns Colombia's legal framework with the CRPD, especially Article 12, which affirms the right to equal recognition before the law. The reform abolishes substitute decision-making systems such as guardianship and instead promotes supported decision-making, enabling persons with disabilities to exercise their rights and make their own choices. The Special Rapporteur also commended Colombia for demonstrating that legal capacity reform is possible and necessary, and called on other countries to follow suit by repealing discriminatory laws and advancing inclusive legal reforms.

## Ongoing legal reforms in Serbia

While Serbia has not yet enacted full legal capacity reforms, the submission by MDRI-S and the Ombudsman's proposed Roadmap for Deinstitutionalization represent a critical acknowledgment of systemic failures and a step toward aligning with CRPD principles. If implemented, this could lay the foundation for a rights-based shift away

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<sup>351</sup> Rodríguez, S. D. (2022, November 25). *People with disabilities. Spanish legal reform 8/2021: Decision-making rights and assistance* | Susana Rodriguez Puente Abogados.

<https://srpuenteabogados.com/en/2022/11/25/support-people-with-disabilities/>

<sup>352</sup> LEGISLATIVE ORDER Amending, Adding and Abrogating Various Provisions of the General Health Act on Mental Health and Addictions. (2022).

[https://www.ohchr.org/sites/default/files/documents/issues/health/draftguidance/submissions/2022-09-02/Mexico\\_general\\_health\\_act\\_16may2022EN.pdf](https://www.ohchr.org/sites/default/files/documents/issues/health/draftguidance/submissions/2022-09-02/Mexico_general_health_act_16may2022EN.pdf)

<sup>353</sup> *Mexico: States' Inaction on Legal Capacity* | Human Rights Watch. (2023, May 18).

<https://www.hrw.org/news/2023/05/18/mexico-states-inaction-legal-capacity>

<sup>354</sup> *UN expert welcomes legal capacity reform in Colombia to end guardianship regime.* (2019).

<https://www.ohchr.org/en/press-releases/2019/08/un-expert-welcomes-legal-capacity-reform-colombia-end-guardianship-reqime?LangID=E&NewsID=24926>

from guardianship and institutionalization.<sup>355</sup> Despite reforms in social, health, and education sectors, Serbia continues to face serious gaps in protecting the rights of persons with psychosocial disabilities, particularly those in residential and psychiatric institutions. Individuals under guardianship experience a complete loss of legal capacity, which leads to the denial of basic freedoms and autonomy. Additionally, the lack of accessible, integrated community support services further reinforces reliance on institutionalization. Recognizing these systemic barriers, the Protector of Citizens (Ombudsman) has proposed a "Roadmap for De-institutionalization in Serbia," outlining a comprehensive nine-stage process to transition toward community-based care. This includes building consensus among stakeholders, assessing national and local needs, developing legal frameworks, creating sustainable community support systems, and ensuring user and family participation. The roadmap also emphasizes the importance of public awareness and ongoing monitoring. While still in early stages, this plan signals a significant policy direction toward rights-based reform and the gradual replacement of coercive practices with inclusive, community-led support.

### **Landmark Judgement from Guatemala**

In a landmark June 2025 decision, the Inter-American Commission on Human Rights found Guatemala responsible for egregious violations of the rights of a woman with a psychosocial disability who had been forcibly institutionalized for over 17 years without legal recourse. The Commission concluded that Guatemala violated her rights to liberty, legal capacity, personal integrity, and access to justice, and called for the abolition of guardianship systems and involuntary psychiatric interventions. This ruling affirms that forced hospitalization and substitute decision-making are incompatible with human rights law and underscores the obligation of states to adopt supported decision-making and community-based alternatives in line with the CRPD. It marks a major regional precedent in the Americas for ending coercive mental health practices.<sup>356</sup>

### **Recognizing Autonomy Over Guardianship Case, Hungary<sup>357</sup>**

In March 2024, a Hungarian appeals court set a precedent in guardianship law by ruling in favor of individualized support over restrictive guardianship for Bence, a 31-year-old man with disabilities. Following the passing of his primary support person, his grandmother, Bence experienced restrictive control under a court-appointed guardian, who managed his income, residence, daily activities, and property. Seeking to restore his autonomy, Bence partnered with Validity, a legal rights organization focused on

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<sup>355</sup> Beker, K., Milošević, T., European Union, & Disability Rights International. (2016). Serbia Country report on legal capacity. <https://mdri-s.org/public/documents/upload/publications-in-english/2016-Country-report-Legal-Capacity-1.pdf>

<sup>356</sup> <https://www.driadvocacy.org/news/sweeping-legal-victory-inter-american-commission-human-rights>

<sup>357</sup> Bajnay, Z. (2024, June 7). *Guardianship overturned: Hungarian Court recognises young man's autonomy*. Validity Foundation - Mental Disability Advocacy Centre. <https://validity.ngo/2024/06/07/guardianship-overturned-hungarian-court-recognises-young-mans-autonomy/>

disability justice, to challenge his guardianship. This landmark judgment recognized his right to autonomy, dismissing the previous guardian in favor of a supporter in decision-making, thereby aligning with the principles of the UNCRPD. This decision sets a progressive precedent for courts in Hungary and beyond, encouraging the move toward individualized, rights-based approaches that respect the dignity and autonomy of persons with disabilities.

### **Advocating CRPD-Compliant Legal Reform on Guardianship and Reproductive Rights, Indonesia**<sup>358,359</sup>

In addition to the work mentioned of IMHA in section 4.2, the organisation also works on community development through advocacy for legal reforms in Indonesia. On the advocacy initiative front, the organization is actively involved in advocating for changes in laws that affect individuals with psychosocial disabilities. Indonesia has an omnibus law which includes persons with psychosocial disabilities as opposed to being under a separate mental health law. The Omnibus health law is positive, for instance, there is no mention that every province must have a mental health institution, and it also criminalizes shackling, which is a common experience among persons with psychosocial disabilities. However, the organization also acknowledges that there are some negative aspects within it as well. IMHA leads relentless evidence-based advocacy against discriminatory provisions under various laws that affect persons with psychosocial disabilities. Under the Civil Code, there are laws that make it very easy to place a person under guardianship. If it is proven that in case an individual has psychosocial disability, through a psychiatrist's certificate or even through a drug prescription, the person can be placed under guardianship. IMHA successfully *led the judicial review of Guardianship Law in Indonesia* and led the Constitutional Court to convert nature of Guardianship from being mandatory to optional.<sup>360</sup> This also led IMHA to work further on advocating for stringent conditions for any person with psychosocial disability to be placed under guardianship and also for ensuring that the period is the minimum possible in case of an inevitable guardianship arrangement. Also, IMHA advocated against *the discriminatory clause of Anti-Sexual violence Act* to eliminate the statute that gave permission for the State Parties to forcefully sterilize and conduct abortion procedures on women with psychosocial disabilities. Approaching the right to inclusion and following the CRPD, IMHA's strategy is to work on repealing, modifying or adapting any laws that allow for disability-based discrimination. The organisation continuously focuses on raising awareness about the rights of individuals with disabilities. This includes conducting advocacy campaigns and outreach programs to educate the public and policymakers about the challenges and rights of persons with psychosocial disability face. These past engagements have

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<sup>358</sup> <https://pjs-imha.or.id/index.php>

<sup>359</sup> Interview: Yeni and Team, IMHA, 4<sup>th</sup> October 2024

<sup>360</sup> Statement of Expert Testimony on the topic of Legal Capacity and Guardianship of persons with disabilities, before the Hon. Constitutional Court of Indonesia., Hon. Constitutional Court of Indonesia (2023). Available at: <https://tci-global.org/wp-content/uploads/2024/02/Submission-Indonesia-Constitutional-Court-Expert-Testimony-TCI.pdf>

also included training sessions for local leaders and stakeholders to ensure that they are informed about the rights of psychosocial disabilities. This grassroots approach is essential for creating a supportive and enabling legal environment.

#### 4.4 Best Practices of Community Mental Health Services

General Hospital-based mental health services provide treatment and care through mental health in-patients units, outpatient services and community outreach services. It has been documented extensively and has been the experience of persons with psychosocial disabilities that hospital based- psychiatric services are found to be isolated, often use coercive practices and is associated with human rights violations including violence, abuse and neglect as well as involuntary admission and treatment, seclusion and physical, mechanical and chemical restraints as well as inhuman and degrading living conditions. People often reside in these settings for weeks, months and even years. Additionally, community mental health centres have often been cited as extension of the “clinical gaze” and have tended to “colonize the home settings in a “panoptical” way, since the person’s everyday social life, including the family and community become objects to be examined more closely for finer details.”<sup>361</sup> Homes, which are safe havens, or safe spaces (not always), owing to such models, have become synonymous to mobile community care.

The models discussed here enlist services that are built with the intention that people can access mental health care and remain connected to their support networks throughout. These services are the examples of processes in place to end the use of coercive practices. **However, it should be taken into consideration as per the CRPD, services of all kinds, generic health, support and mainstream should be provided in the community.**

#### The No Force First Initiative, United Kingdom<sup>362</sup>

This initiative aims to change ward cultures from containment to recovery and create coercion free environments. The underlying idea is that ‘*there is no such thing as a forced recovery*’ and is implemented through promoting collaboration between users and staff to make wards recovery focused and have a cooperative culture to reduce incidents of aggression and physical intervention. It also includes developing staff training programmes in collaboration with users to promote de-escalation techniques and also conduct awareness raising among families. It also entails recording of data on the use of coercion and immediate analysis after an incident. While the initiative emphasizes systemic change within institutions and communities, it also recognizes

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<sup>361</sup> Alevanti, E. (2020). *Mental Healthcare Reform in Belgium: A qualitative study with mobile teams* [Doctoral, Birmingham City University]. <https://www.open-access.bcu.ac.uk/12383/>

<sup>362</sup> Mental Health Europe. (2021). A short guide to ending coercion and restraint in mental health services. <https://www.mhe-sme.org/wp-content/uploads/2021/06/Short-Guide-on-Alternatives-to-Coercion.pdf>

the need to support individuals in asserting their preferences particularly in unsupportive settings through tools like peer advocacy and advance directives.

**RISKS:** While efforts to improve staff behaviour and reduce coercion may represent progress, they fall short of full CRPD compliance, which calls for the complete abolition of coercive measures. Any model that permits the use of force, even in emergencies, remains misaligned with CRPD principles. Reforms focused solely on minimizing coercion, without addressing deeper systemic issues such as deinstitutionalization and the repeal of discriminatory legal frameworks, offer limited value to persons with psychosocial disabilities. OPDs have raised concerns about the lack of independent human rights-based evaluation mechanisms and emphasize the need to embed service users and OPDs in all monitoring and accountability processes to ensure that reforms are meaningful, participatory, and rights-based.

### **BET Unit, Blakstad Hospital, Vestre Viken Hospital Trust | Norway<sup>363,364</sup>**

BET Unit at Blakstad Hospital provides services to people with psychosocial disabilities who have not benefited from other forms of mental health support. These services concentrate on the psychosocial treatment model called Basal Exposure Therapy (BET), which focuses on the acceptance of frightening thoughts, feelings, and inner experience as a way to self-regulate and cope with these existential challenges. The BET Unit is an independent model of mental health unit, physically separated from Blakstad Hospital in Norway. It serves the wider community of Vestre Viken Hospital Trust, covering a population of 500,000 in the region southwest of Oslo.

The unit was previously a locked psychosis unit at Blakstad Hospital. In 2018, the unit became an independent open-door service available 24X7. At present, the unit is equipped with six beds and provides treatment and support to an average of 6–10 people per month. The service has a total of 19.5 employees, including a psychiatrist and two psychologists.

People are referred to the BET Unit by General Practitioners (GPs), outpatient clinics, and inpatient wards from other hospitals who have previously experienced lengthy, intensive inpatient admissions without improvement. One of the features of the BET unit is that it follows the approach to reducing medication among hospitalized patients who are often heavy, long-term users of multiple benzodiazepines, opioids, antipsychotics, antidepressants, and mood stabilizers. The BET Unit considers

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<sup>363</sup> Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available:

<https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y>

<sup>364</sup> Website: <https://vestreviken.no/avdelinger/klinikk-for-psykisk-helse-og-rus/psykiatrisk-avdelingblakstad/bet-seksjon-blakstad>

Videos: Didrik Heggdal: What is Basal Exposure Therapy? Presentation in Norwegian, with English subtitles and chapter descriptions <https://www.youtube.com/watch?v=PXrdwOMzns&t=10s>

Didrik Heggdal: Basal Exposure Therapy (BET): Alternative to coercion and control in suicide prevention. Presentation in English, National conference on the prevention of suicide <https://youtu.be/fsfdrFoEhfQ>

medications to be secondary to the psychotherapeutic approach. Staff help individuals reduce or taper off, if they wish, in order to improve health outcomes and allow people to better access their feelings and fears as a part of therapy. The unit work is guided by respect for legal capacity, non-coercive practices, participation, community inclusion and recovery approach.

The evidence suggests that use of coercive treatment can be reduced by as much as 97% and that service users' quality of life and psychological and psychosocial functioning have been significantly improved. A study conducted in 2017 found that individuals who used the service had fewer admissions to psychiatric and general hospitals in the 12-month period after discharge from BET.<sup>365</sup> In a qualitative study of service users, it was found that participants displayed fewer support needs, a significantly improved level of functioning, and re-established connections with their families.<sup>366</sup>

The BET service has been publicly funded for 20 years as part of the public healthcare system. The cost per person per day of the BET Unit is about US\$1040, which is about 30–40% less than the costs of other mental health units at the Vestre Viken Hospital Trust.<sup>367</sup> The BET Unit also has lower medication costs compared with other inpatient units.

**RISKS:** While the BET model introduces non-coercive and psychotherapeutic approaches, it remains embedded within a highly structured therapeutic framework developed by service providers. This raises critical questions about who ultimately makes decisions, whether it truly promotes supported decision-making or reinforces substituted models under a different guise. The emphasis on exposure, regulation, and coping strategies may inadvertently reinforce a medicalised understanding of psychosocial disability, focusing on individual adaptation rather than addressing structural injustices or social determinants. Furthermore, as the model operates within institutional healthcare settings, it falls short of advancing community inclusion and may continue to frame persons with psychosocial disabilities as subjects of therapy rather than agents of their own healing and rights.

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<sup>365</sup> Hammer J, Ludvigsen K, Heggdal D, Fosse R. Reduksjon av unngåelsesatferd og innleggelses grunnet villet egenskade etter Basal eksponeringsterapi (BET). *Suicidologi*. 2017;22:20-6. doi: 10.5617/suicidologi.4682 as cited in *Guidance on community mental health services: promoting person-centred and rights-based approaches*. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available:

<https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y>

<sup>366</sup> Heggdal D, Hammer J, Alsos T, Malin I, Fosse R. Erfaringer med å få og ta ansvar for bedringsprosessen og sitt eget liv gjennom basal eksponeringsterapi (BET). *Tidsskrift for psykisk helsearbeid*. 2015;12:119-28. As cited in *Guidance on community mental health services: promoting person-centred and rights-based approaches*.

Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available:

<https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y>

<sup>367</sup> Conversion as of February 2021

## Kliniken Landkreis Heidenheim gGmbH | Germany<sup>368</sup>

Kliniken Landkreis Heidenheim is located in a small rural town in southwest Germany. The hospital introduced a flexible, user-oriented, and community-based mental health service and described it as a lighthouse model, particularly in its focus on preventing coercion. The service operates 24 hours a day, 365 days a year, supporting people with higher support needs and is an essential part of the network of community mental health services coordinated by the district council.

People can flexibly opt for a change from inpatient to home-based services, or to day-based hospital service at any time based on their own preference. The services provided at the facility are closely aligned and run by the same teams with a focus on consistent recovery. There are three in-patient units for adults, managed by four teams with three dedicated to inpatient units and one to the day clinic. For outpatient services, a wide range of therapy and support, in a group or individually, is provided.

One of the features of this model is that the same multi-professional team supports the person across all settings, in inpatient, outpatient, and home-based care which ensures continuity, trust, and therapeutic safety throughout the recovery process. Each person receives an individual crisis and recovery plan developed together with the treatment team, which provides clarity and shared goals. Clients are free to contact their treatment team and can receive visits either in person or via digital platforms, ensuring flexibility and accessibility. Family members and support networks are actively involved in the planning and care process, reinforcing a circle of support.

There is no requirement to accept or adhere to medication. The person's decision not to take medication is fully respected and does not affect their access to services. The use of peer experts is a further strength of the model, particularly within home-based outreach services, enhancing trust and shared understanding.

The service has gradually transformed from a traditional hospital department of psychiatry to a community mental health service. An evaluation project conducted by Dresden University found that with the introduction of home treatment and flexible day-clinic treatment, average bed occupancy decreased from 95% in 2016 to 60% in 2019 and to 52% in 2020. Fewer people were admitted to the inpatient service, and more were seen to opt for outpatient clinic services or home-based outreach services. The service is contracted with all public and private health insurance companies, with a budget amounting to approximately US\$10.9 million, or US\$82.50 per district resident per year. The budget structure is designed to provide incentives for care and treatment in community settings rather than hospital-based models.

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<sup>368</sup>Website: <https://kliniken-heidenheim.de/klinikum/patienten/kliniken/psychiatrie-psychotherapie-undpsychosomatik/> Videos: Mildere Mittel. A film about the experience in Heidenheim, made by a service users' collective from Berlin. (German language) <https://vimeo.com/521292563>

**RISKS:** This model focuses primarily on transitioning individuals to community mental health services but falls short of fostering true community inclusion for persons with psychosocial disabilities. Rooted in a medical model and often operating from hospital settings or extensions into the community, its primary aim is to increase access to various forms of treatment. Well-being activities such as art therapy, dance, peer support, and group work are bundled under the category of “services”, still framed as therapeutic interventions rather than opportunities for agency or connection. Despite the shift in setting, the approach remains shaped by institutional norms. A glance at the centre’s pamphlet reveals rigid rules dictating daily life, from meal schedules to medication routines, all determined by service providers.<sup>369</sup> Even decisions around discharge remain in the hands of medical professionals, reinforcing a system of control rather than empowerment.

### **TANDEM plus: Mobile Crisis Support and Social Network Development (Belgium)<sup>370</sup>**

TANDEMplus is a mobile crisis service operating in Belgium (active in low-income settings of Brussels), providing support to individuals during and shortly after a crisis in their preferred environment, rather than at a hospital. The service is characterized by its non-coercive approach and its emphasis on empowering individuals to define their own support needs. The service provided is free and people in need are not required to present their ID card and can remain anonymous. TANDEMplus serves adults over 18 years of age and operates with interdisciplinary teams that include clinical psychologists, social workers, nurses, educators along with a psychiatrist as a consulting member. It is to be noted that the majority of the staff has had some professional experience of working in mental health settings. The team also includes individuals with psychosocial disabilities, which enhances the relatability and effectiveness of the support provided.

People can flexibly opt for support in the location of their choice, and outreach workers meet individuals either in their homes or other locations. This flexibility helps to create a comfortable environment for the person seeking help. The service does not provide traditional "treatment" but focuses on emotional support, coping strategies, and practical problem-solving. This can include assistance with debt management, household bills, or family relationships. While staff members do not require formal mental health training to participate in TANDEMplus, many have relevant professional backgrounds. Emphasis is placed on their ability to communicate effectively, collaborate, and be personable and creative in their approach to support.

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<sup>369</sup> Kliniken Landkreis Heidenheim gGmbH. (n.d.). Kliniken Landkreis Heidenheim gGmbH [Website]. Retrieved from [https://kliniken-heidenheim.de/klinikum/patienten/ihr-aufenthalt/20221202\\_Englische-Uebersetzung-Hausordnung-Kliniken-Landkreis-Heidenheim-gGmbH.pdf](https://kliniken-heidenheim.de/klinikum/patienten/ihr-aufenthalt/20221202_Englische-Uebersetzung-Hausordnung-Kliniken-Landkreis-Heidenheim-gGmbH.pdf)

<sup>370</sup> TandemPlus Website: <https://www.coe.int/en/web/bioethics/-/tandemplus-mobile-crisis-support-and-social-network-development-belgium>

The intervention approach is strictly non-coercive and puts persons with psychosocial disabilities in the driver's seat and lets them have full control of what support they would like to receive. To be directed to the care network, HERMESplus telephone helplines have been established which operate from 9:00 a.m. to 3:00 p.m. on weekdays. At least one staff member on the hotline has lived experience of using mental health services, which can help build trust and rapport with callers. Approximately half of the calls to the hotline result in a home visit, while others may involve information sharing or guidance.

The intervention is short-term (averaging 29.5 days) and focused on helping individuals (re)activate their local support networks, whether through formal services or informal resources like family and friends. The core philosophy of TANDEMplus revolves around the belief that individuals in crisis should have control over their own lives. This is reflected in how support is offered, ensuring that it aligns with the expressed needs and preferences of the person receiving help.

**RISKS:** There are notable risks attached to this model. Although the model talks about working within community spaces, it broadly functions under the umbrella of hospitals. This 'paradoxical position' undermines their goal to provide non-coercive, user led alternatives. There is also an issue with a restrictive scope of identifying and working with persons with psychosocial disabilities who are eligible for first line or ambulatory care hence avoiding cases with high support needs. The framework is bureaucratic, and the team is often made up of professionals with experience of working in the mental health settings. The model does not recommend hospitalization, however, there are referrals made to external psychiatrists. Professionals were working outside institutions but were still bound by "psychiatric dominance". Although there is a focus on providing alternatives to psychiatric care, diagnosis and medications, there is still a tendency to fall towards coercive practices due to systemic pressures. The model is still embedded in a mental health system, relying on medical model, which perpetuates the reductionist approach failing to address broader socio-political contexts and structural inequalities. Additionally, the emergence of this new form of "surveillant psychiatry" utilizes practices of social control and "mental health becomes the total absence or abnormality which is now considered a personal/individual responsibility and choice, promoted by societal value judgements reflected in professional practice."<sup>371</sup>

### **The Mental Health Mobile Units (MHMUs), Greece<sup>372</sup>**

The Mental Health Mobile Units (MMHUs) in Greece deliver mental health support, especially in rural and remote areas. These units aim to address the challenges of

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<sup>371</sup> Alevanti, E. (2020). *Mental Healthcare Reform in Belgium: A qualitative study with mobile teams* [Doctoral, Birmingham City University]. <https://www.open-access.bcu.ac.uk/12383/>

<sup>372</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

accessibility and stigma associated with mental health services by keeping individuals connected to their communities while providing comprehensive mental health care. The MMHUs operate under the principle that mental health services should be delivered as close to the individual's home as possible, ensuring continuity of care and support. MMHUs aim to reduce involuntary hospital admissions, promote community integration, provide comprehensive care, and enhance accessibility. By providing timely and effective support in the community, MMHUs aim to decrease the need for involuntary hospitalizations, which can be traumatic and stigmatizing for individuals experiencing crises. Additionally, the units work to ensure that individuals remain active members of their communities, reduce isolation, and foster social connections. They also address the bio-psycho-social needs of individuals, offering a holistic approach that considers mental health, social issues, and work-related challenges. By bringing services directly to individuals in remote areas, MMHUs aim to overcome barriers to access, such as transportation difficulties and stigma associated with visiting traditional mental health facilities.

MMHUs provide a wide range of services tailored to meet the needs of individuals in their communities. These include crisis intervention, therapeutic support through individual and group therapy, psychoeducation to empower individuals and families, and social support services that enable access to rehabilitation and vocational training. The units also prioritize family support by offering counseling and involving family members in the recovery journey. Active community engagement through awareness-building workshops and events helps reduce stigma and promote well-being. Each mobile unit is staffed by a diverse team of professionals, including psychiatrists, psychologists, social workers, occupational therapists, and peer support workers. This interdisciplinary approach ensures that individuals receive comprehensive care tailored to their needs. MMHUs collaborate with local authorities, healthcare providers, and community organizations to create an individual support network. The units operate flexibly, adapting to the specific needs of communities by scheduling regular visits or responding to urgent support requests. They use data collection and analysis to monitor impact, guide service improvements, and inform advocacy for mental health policy reforms.

Implementing MMHUs in Greece has led to positive outcomes, including reduced hospitalizations and increased access to care. Studies have shown that areas served by MMHUs experience lower rates of involuntary hospitalizations compared to regions without such services, indicating the effectiveness of this approach in providing mental health support to individuals in need. The presence of MMHUs has fostered a greater sense of community support for individuals experiencing mental health challenges. Residents are more informed about mental health issues and are better equipped to provide support to their peers. By focusing on recovery-oriented practices and community integration, MMHUs empower individuals to take an active role in their mental health journeys. This empowerment is crucial for building resilience and promoting long-term recovery.

However, the model still faces challenges. Sustaining funding for mobile units can be difficult, especially during periods of economic constraint, and continued advocacy for financial support is needed. Stigma around mental health remains a barrier despite ongoing awareness efforts. Ensuring better integration with traditional services is necessary for seamless care delivery. As demand for mental health services grows, MMHUs must expand their geographic reach and service capacity to meet the needs of underserved populations.

**RISKS:** While mobile mental health units aim to increase access to services and reduce reliance on institutional care, they also carry inherent risks that require careful examination. By bringing mental health services directly into communities and even into the intimate spaces of a person's home, these units have the potential to improve accessibility but they may also risk extending the clinical gaze into the community, replicating the same medicalized approach in non-institutional settings. In many instances, such units focus predominantly on providing psychiatric or therapeutic interventions, often under the biomedical model of disability. This may result in medicalizing distress and reinforcing the idea that support should primarily come through diagnosis and treatment, rather than through structural changes, community inclusion, or rights-based supports.

From a CRPD-compliant perspective, community living is not merely about decentralizing services; it must also involve enabling autonomy, legal capacity, and holistic social inclusion. When mobile units center their work around symptom management or treatment compliance, they may risk narrowing the agency of persons with psychosocial disabilities to their engagement with the mental health system. Instead of being active agents of their own support networks and life choices, individuals may become passive recipients of care, just in a more geographically convenient form. Furthermore, when mobile services dominate without adequate investment in peer-led supports, inclusive housing, or community participation mechanisms, they may inadvertently perpetuate coercive dynamics, even if not overtly forceful.

It is important, therefore, to critically assess whether mobile mental health services are truly advancing rights-based, person-centered, and community-owned approaches or merely relocating institutional paradigms into community spaces. Without a strong emphasis on supported decision-making, cross-sectoral linkages (housing, employment, education), and community ownership, these units risk offering proximity without empowerment, care without rights, and access without inclusion.

## Trieste Model: Open Door—No Restraint System Italy<sup>373,374</sup>

The Trieste Model, developed in Trieste, Italy, represents a pioneering approach to mental health care that prioritizes community integration, recovery, and the reduction of coercive practices. Established in the mid-20th century, this model signifies the end of traditional psychiatric care, which frequently relied on hospitalization and restraint. Instead, the Trieste Model advocates for an "open door" policy, where individuals with psychosocial disabilities are supported within their communities rather than being confined to institutions.<sup>375</sup> This innovative approach has garnered international attention as a leading example of progressive mental health care.

The primary objectives of the Trieste Model encompass promoting recovery through the provision of comprehensive, person-centered care that addresses social, psychological, and emotional needs; reducing the utilization of coercive measures, such as involuntary hospitalization and restraint; enhancing social inclusion by integrating individuals with psychosocial disabilities into the community; and ensuring continuous care to prevent crises and relapses.

### Interventions

The Trieste Model implements several key interventions, including establishing

- Community Mental Health Centres (CMHCs) that operate 24/7.
- Delivering crisis intervention, outpatient care, and rehabilitation.
- It also advocates for a holistic approach by integrating various services, such as housing, employment support, and social services, to address the diverse needs of individuals with psychosocial disabilities.
- Individuals receiving care are actively engaged in their treatment planning and decision-making processes, fostering a sense of agency and empowerment, while proactive crisis management strategies are emphasized.

Despite its achievements, the Trieste Model encounters several challenges, including cultural resistance from some mental health professionals and families, resource constraints, variability in implementation across different regions, and the necessity for comprehensive training of mental health professionals in the principles and practices of the model.<sup>376</sup> The Trieste Model aims to expand community services, promote ongoing research and evaluation of its effectiveness, foster international collaboration, and further promote user involvement in the decision making process.

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<sup>373</sup> Trieste Website: <https://www.livingwellsystems.uk/trieste>

<sup>374</sup> Mezzina R, Vidoni D. Beyond the Mental Hospital: Crisis Intervention and Continuity of Care in Trieste. A Four Year Follow-Up Study in a Community Mental Health Centre. *International Journal of Social Psychiatry*. 1995;41(1):1-20. doi:[10.1177/002076409504100101](https://doi.org/10.1177/002076409504100101)

<sup>375</sup> Council of Europe. (2021). *COMPENDIUM REPORT: GOOD PRACTICES TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH*. Strasbourg. Available: <https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60>

<sup>376</sup> Frances, A. (2021). Save Trieste's mental health system. *The Lancet Psychiatry*, 8(9), 744–746. [https://doi.org/10.1016/S2215-0366\(21\)00252-2](https://doi.org/10.1016/S2215-0366(21)00252-2)

This approach was first adopted in 1978, where psychiatric units were established in general hospitals - Servizi Psichiatrici di Diagnosi e Cura (SPDCs) in Italy.<sup>377</sup> The SPDCs aimed at hosting people in a critical condition, both voluntary and involuntary, when the support of the community services has been unsuccessful.

SPDCs established are of generally two types, one which are complete open and have no restraint at all. It is based on the policy of open doors and respect for the rights, freedom and dignity of people. The focus was on dialogue and stimulating people to take responsibility for their recovery.

The second is locked wards aimed to reduce or eliminate restraint. Becoming no restraint wards is a long process which requires education and new skills for mental health professionals, and changing attitude towards persons with psychosocial disability in the wider community. The whole process requires openness, trust and cooperation with people both inside and outside the hospital. It also involves a large network of organizations and services both at the hospital and community level, such as a user and family organizations, local authorities, and the police and justice systems. To reduce hospitalization, these services need to be well organized.

### Impacts and achievements

The number of people subjected to involuntary treatment dropped from 150 in 1971 to 18 in 2019. This means approx. rate of 8.11 per 100,000 population of involuntary hospitalization. This was recorded as the lowest of the western European countries in 2015. In a study conducted in 2014, 27 people with complex needs who used the services were found to have high rate of social recovery at 5 year follow-up, 9 participants secured jobs, 12 achieved independent living. In 2018, it was estimated that the cost of the network of mental health services amounted to 37% of cost of the old psychiatric hospital.

**RISKS:** However, despite these achievements, the Trieste Model is not without risks or limitations, especially when evaluated against CRPD standards. While the emphasis on reducing coercion and enhancing community care aligns with CRPD principles, there remains the concern that certain elements such as the ongoing existence of SPDCs for involuntary admissions could still reproduce substituted decision-making. The presence of locked wards, even with good intentions to reform them, still violate the right to liberty and security and the freedom from torture or ill-treatment. Furthermore, the reliance on psychiatric professionals and institutional actors to implement cultural change may fall short in ensuring that persons with psychosocial disabilities lead and shape the system reform. While community inclusion is a stated goal, the model still operates within the boundaries of clinical and state-defined support systems, raising the question of how much real control individuals hold over their care and lives. CRPD compliance requires not only non-

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<sup>377</sup> Mental Health Europe. (2021). A short guide to ending coercion and restraint in mental health services. <https://www.mhe-sme.org/wp-content/uploads/2021/06/Short-Guide-on-Alternatives-to-Coercion.pdf>

coercion and open doors, but a decisive shift in power, decision-making, and support structures toward persons with disabilities and their chosen networks.

### **Brazil Community Mental Health Service Network | A Focus on Campinas<sup>378</sup>**

It is a network which is implementing services at large scale, anchored in human rights principles. The network operates under unified public health system and provides comprehensive services including the community based mental health centre. The network is a reflection on how a network can be configured between individual, family and community. Community-based mental health centres (CBHCs) and community – based primary healthcare centres are the primary (CBHCs) coordinating mechanisms in the network. The services are complemented by the other network including specialist services, providing mental health support to CBHCs, street outreach teams, deinstitutionalization strategies, mental health beds in general hospitals and emergency and urgent services. The key services include:

1. **Community-based mental health centres (CAPS):** The primary goal is to provide psychosocial care, promote autonomy, address power imbalances and increase social participation. CAPS provide mental health support to other mental health and general health services. The strategies developed by CAPS are also linked with other community resources and services in health, education, justice and social assistance. Generally, three levels exist based on the catchment area, population covered and operating hours. The CAPS III (third level) are open 24X7 a week and provide overnight accommodation if needed.<sup>379</sup> All CAPS have three guiding principles of having open door policies, promote community engagement, and deinstitutionalization.
2. **Community Based Health Centres (CBHC):** These are considered first contact point for people to enter the Brazilian public health system, providing basic community care across general practice, paediatrics, gynaecology, nursing and dentistry. Family health teams are linked with CBHCs. Approximately, there is one CBHC for every 20,000 residents.
3. **Multi-professional teams with training in mental health (NASF):** NASFs are multidisciplinary teams which include specialists with wide range of expertise in general support and in mental health. NASFs discuss clinical cases, undertake

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<sup>378</sup> Website: <https://www.gov.br/saude/pt-br> and <http://www.saude.campinas.sp.gov.br/> Videos: Morar em liberdade: retratos da reforma psiquiátrica Brasileira - Fiocruz (portuguese)/ living in Freedom: portraits of the Brazilian psychiatric reform - Fiocruz (english) [https://www.youtube.com/channel/ucd2xln\\_gieJrwqos8ywldpQ/videos](https://www.youtube.com/channel/ucd2xln_gieJrwqos8ywldpQ/videos) Memórias da reforma psiquiátrica no Brasil - Fiocruz (portuguese)/memories of psychiatric reform in Brazil - Fiocruz (english) <http://laps.ensp.fiocruz.br/> Rádio 'maluco Beleza' - campinas (portuguese)/radio 'maluco Beleza' - campinas (english) [https://www.youtube.com/watch?v=ujrdwel\\_cnm](https://www.youtube.com/watch?v=ujrdwel_cnm)

<sup>379</sup> The various types of CAPS services are classified according to the size of the population area covered. CAPS I services serve the adult population in catchment areas of over 15,000 people, CAPS II in areas of over 70,000 and CAPS III in areas of over 150,000 people. Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available: <https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y>

shared consultations, collaborate in the development of person-centred recovery plans and promote overall health and well-being of the individuals.

4. **Street Outreach Teams:** These are part of CBHCs, which provides support and health care to the homeless community. They provide support in general health and as well as, psychosocial disabilities and other related problems. The teams are consistently in touch with CBCs, Family Health Teams and CAPS. In 2020, the two street outreach teams in Campinas provided support to approx. 486 individuals per month.
5. **Mental Health Beds at General Hospitals:** Some general hospitals are provided with limited dedicated mental health beds which can be accessed on request of a mental health network service based on the severity of the situation. These services continue to remain linked to the main community-based network.
6. **Emergency and urgent services:** Urgent and emergency mental health care is part of the emergency services network of the general health system. These services work together with the CAPS.
7. **Independent living facilities:** These include deinstitutionalization strategies specifically designed for individuals who are discharged from psychiatric hospitals or custody of hospitals after long periods of hospitalization. Independent living are the houses located in the community that provide an independent accommodation option to individuals. Psychosocial rehabilitation is provided through a close partnership with individual, the independent living facility and CAPS with the objective of promoting autonomy, social inclusion and guaranteeing rights. At present there are 20 independent living facilities which accommodate 139 people.
8. **Cross-network initiatives:** Initiatives that are transformative in terms of individual, the community and wider perception on engaging with mental health and psychosocial disability. Examples:
  - a. community centres that reflects co-existence and partnership with public institutions and civil society.
  - b. Work and income generation initiatives: The initiatives that promote the right to work and provide training and qualification for work. These initiatives follow a solidarity economy approach.
  - c. Cultural Initiatives: There are collectives and cross network projects that include participation of individuals who use mental health services, as well as professionals and family members from different CAPS, independent living facilities, community centres and beyond.

A 2019 study demonstrated a co-relation between increasing CAPS and primary health centre coverage with decreased psychiatric hospitalization. A 2015 systematic review of studies on mental health services reported satisfaction with the services that were developed as a substitute to institutionalization. In another study, 24% of users agreed that after attending CAPS practices, they were crisis free, 60% experienced

crises less frequently and 70% with less intensity.<sup>380</sup> The implementation of CAPS has also found to reduce the risk of suicide by 14%.

The cost of community-based mental health network in 2019 was approx. R\$67 per capita (US\$ 12)<sup>381</sup> based on an approximate population of 1.2 million and excluding cost of mental health beds in general hospitals and the wider (non-mental health) costs of CBHCs.<sup>382</sup> CAPS services in Brazil are completely free for users and are delivered under the public health system (SUS). The operational costs are shared with the federal government covering around 50–70% of the total cost, and the remaining amount taken on by the municipality. In 2020, the monthly operational cost of CAPS III in Brasília was around R\$500,000 (approximately US\$88,200). This translates to about R\$1,100 (roughly US\$200)<sup>383</sup> per user, per month. In contrast, the cost of psychiatric hospitalization in Brazil ranges between R\$1,200–2,400 (about US\$210–420) per day.<sup>384</sup>

**RISKS:** Despite the shift toward community-based services, Brazil's mental health network particularly in Campinas continues to rely heavily on psychiatric expertise and medical frameworks. The formal structure of multidisciplinary teams and service entry points such as CBHCs, CAPS, and NASFs may inadvertently reproduce clinical hierarchies under the banner of community care. Even deinstitutionalization efforts like independent living facilities often remain anchored in medical supervision, blurring the line between autonomy and managed care. While the network emphasizes autonomy and inclusion, its sheer scale and service complexity risks reinforcing a top-down, service-driven approach rather than promoting user-led, peer-supported pathways. There is limited evidence of structural involvement of persons with psychosocial disabilities in governance or decision-making, raising concerns of tokenism and lack of user control. Access to mental health beds or crisis support still hinges on approvals from within the service network, reinforcing professional gatekeeping and undermining self-determination during moments of distress. Moreover, independent living settings, if not grounded in supported decision-making and full user choice, can resemble smaller-scale institutions governed by clinical logics. The network also faces challenges related to equitable access and cultural relevance, what works in Campinas may not reflect conditions in other regions of Brazil, given the country's vastness, funding disparities, and political fluctuations. Perhaps most critically, despite CAPS' commitment to open-door principles, the absence of clear legal safeguards against coercion such as forced medication or involuntary admissions, especially in

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<sup>380</sup> Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available:

<https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y>

<sup>381</sup> conversion as of march 2021

<sup>382</sup> Ibid. p.159

<sup>383</sup> Conversion as of February 2021.

<sup>384</sup> Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Available:

<https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y>

hospital settings leaves a gap in CRPD compliance. Ultimately, while the network represents meaningful progress, the persistence of institutional mindsets, absence of user-led governance, and weak structural protections against coercion demand close attention to ensure the system truly reflects a rights-based, community-driven approach to mental health.

## 5 | Situational Analysis on Rights of Persons with Psychosocial Disability in Armenia

### Background and Health System Overview

“Armenia is a landlocked mountainous country in Eurasia. It shares borders with Turkey to the West, Georgia to the North, Azerbaijan to the East, and Iran and the Nakhchivan exclave of Azerbaijan to the South”.<sup>385</sup> The current estimated population in Armenia is 2,943,393.<sup>386,387,388</sup>

In 2019, “the per capita income was US \$4,680, classifying Armenia as an upper middle-income country”.<sup>389</sup> Approximately, “2% of the population lives below US\$1.90 per day and 13% lives below \$3.10 per day”.<sup>390</sup> Quality of care remains a challenge as “1,600 deaths occur annually due to poor quality care as per capita spending on health is approximately US\$408 per capita or 10.4% of GDP (7.6%)”.<sup>391,392</sup>

Armenia is exploring reforms to expand increasing access to healthcare services. At present, primary care is universally covered and coverage to outpatient medications, inpatient care, and other specialized services is only limited to vulnerable groups and civil leading to significant out-of-pocket payments (OOPs) for healthcare services.<sup>393</sup> The country is also in the process to redesign its primary health care (PHC) model and structure.<sup>394</sup> The country has committed to “develop PHC reforms based on the European Program of Work, 2020–2025, the 2018 Astana Declaration on Primary Health Care, and the 2020 WHO and UNICEF Operational Framework for Primary Health Care”.<sup>395</sup> Following the decentralization of public services, for efficient use of resources, health services have been devolved to local and provincial governments, but the majority of financing is still derived from out-of-pocket payments, both formal and informal.<sup>396</sup> The population still has limited access to health services, or services

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<sup>385</sup> WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009.

<sup>386</sup> Ibid.

<sup>387</sup> World Health Organization (WHO): [data.who.int/countries/051](https://data.who.int/countries/051)

<sup>388</sup> JLN DRM Collaborative. 2020. Narrative Summary on Public Expenditure for Health in Armenia. Domestic Resource Mobilization Collaborative. Joint Learning Network for Universal Health Coverage. Available: <https://www.jointlearningnetwork.org/wp-content/uploads/2021/02/Armenia-JLN-Health-Expenditure-18Feb2021.pdf>

<sup>389</sup> Ibid.

<sup>390</sup> Ibid.

<sup>391</sup> Ibid.

<sup>392</sup> [https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/arm.pdf?sfvrsn=c5b92e08\\_7&download=true](https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/arm.pdf?sfvrsn=c5b92e08_7&download=true)

<sup>393</sup> Ibid.

<sup>394</sup> World Health Organization. (2023, March 16). Armenia takes steps to improve its primary health care system [Press release]. <https://www.who.int/armenia/news/item/16-03-2023-armenia-takes-steps-to-improve-its-primary-health-care-system>

<sup>395</sup> Ibid.

<sup>396</sup> WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009.

delivered are sometimes of questionable quality and lack technology, especially in rural areas.<sup>397</sup>

## Historical and Social Drivers of Trauma and Psychiatry

Armenia witnessed and bore the brunt of multiple disasters, natural and man-made over the years of its existence. Starting with the Armenian genocide of 1915-1917 which is cited as one of the largest examples of ethnic cleansing in history. The Armenians witnessed a violent and torturous erasure of its people and its culture and history. The 1988 Spitak earthquake was another traumatic event in the nation's history killing thousands of people, displacing communities and leaving a dreadful impact on the survivors. This was also the tragedy that formally introduced psychotherapy to Soviet Armenia which came in along with the rush of humanitarian aid including psychologists.<sup>398</sup> However, decades later, the development of such services remains low and the mental health landscape is still dominated by psychiatric care.

In 2020, the global COVID pandemic fractured the health system, disrupted economy and interrupted the lives of Armenians, something the whole world was collectively going through. Tragedy struck Armenia in the wake of the pandemic by the 44 days war (Nagorno-Karabakh conflict) that deeply scarred the nation as a whole. The people are still dealing with the passing away of loved ones, massive displacement, traumas of the battlefield and visuals of graphic videos of torture.<sup>399</sup>

WHO has been highlighting the immediate need of mental health and psychosocial support (MHPSS) in Armenia, as displaced people attempt to deal with a range of emergency-induced social problems that include family separation, lack of safety, loss of livelihoods and disrupted social networks.<sup>400</sup> Because Armenia's cognitive system is centralized, it primarily delivers MHPSS services to refugees through urban facilities.<sup>401</sup> Recognizing the need for broader geographic reach, efforts to decentralize healthcare services were initiated.<sup>402</sup> "Most of the mental health support services are still exclusively provided in specialized mental health institutions, including hospitals

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<sup>397</sup> Ibid.

<sup>398</sup> Shakhnazaryan, N. (2021). Of Two Minds: Armenia's ambivalence towards mental health. AGBU Magazine. National Wellness. <https://aqbu.org/national-wellness/two-minds>

<sup>399</sup> Ibid.

<sup>400</sup> World Health Organization (WHO). (2024). Scaling up mental health and psychosocial services for Armenian refugees [Feature story]. World Health Organization. <https://www.who.int/about/accountability/results/who-results-report-2020-mtr/country-story/2023/integrating-mental-health-services-into-primary-health-care-systems-for-internally-displaced-persons-and-host-communities-in-armenia>

<sup>401</sup> WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009.

<sup>402</sup> World Health Organization. (2023). Integrating mental health services into primary health care systems for internally displaced persons and host communities in Armenia. <https://www.who.int/about/accountability/results/who-results-report-2020-mtr/country-story/2023/integrating-mental-health-services-into-primary-health-care-systems-for-internally-displaced-persons-and-host-communities-in-armenia>

and social psychoneurological centres.”<sup>403</sup> and there is a high incidence of admission of persons with psychosocial disability.<sup>404</sup> However, it should be ensured that “MHPSS services are not overly reliant on providing psychiatric services or medications, are CRPD compliant and are adapted to the local and cultural contexts of Armenian population”.<sup>405,406</sup> MHPSS services should be inclusive of peer led support, trauma informed approaches, psychosocial support, psychological treatments, various interpersonal therapies and group support, and trauma counselling to name a few.<sup>407</sup>

## Legal Instruments and CRPD Compliance Gaps

The legal and policy frameworks currently governing mental health and psychosocial disability in Armenia continue to reflect outdated, medicalized models of care that are fundamentally misaligned with the CRPD. Provisions across multiple laws, ranging from the Civil Code to the Criminal Procedure Code, continue to permit the deprivation of legal capacity, forced treatment, and substituted decision-making, often justified through discriminatory legal language.

Mental health care in Armenia is currently governed by the Law on Psychiatric Care (2004, updated in 2020) and the Law on Medical Aid and Service to the Population (2020). These laws address involuntary treatment and cover civil and human rights protection of persons with psychosocial disabilities. The Law on Psychiatric Aid and Service uphold provisions that deny legal capacity of this group.<sup>408</sup> Article 24 permits involuntary hospitalization and treatment of individuals with psychosocial disabilities when it is deemed necessary to prevent danger to themselves or others. In cases where a person has a legal representative such as those recognized as legally incapacitated, even voluntary services require the representative’s consent.<sup>409</sup> Article 17 provides limited exceptions but that ultimately reinforce psychiatric authority and uphold substituted decision-making, as they rely on the psychiatrist’s discretion to determine whether the individual’s consent can be accepted. Article 15 and 16 define the right to receive or refuse any treatment at their own will and consent. The law also places importance on maintaining confidentiality and right to receive full and true information. Although this law was seen as a significant step towards protecting rights

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<sup>403</sup> WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009.

<sup>404</sup> Ibid.

<sup>405</sup> TCI-Global (2023). Transforming Communities for Inclusion contribution to the call for submission from the Committee on the Rights of Persons with Disabilities on the Day of General Discussion (DGD) Article 11 of CRPD. Available: [TCI-Global Submission-for-General-Comment-on-Article-11-CRPD.pdf](#)

<sup>406</sup> Watters, E. (2011). The wave that brought PTSD to Sri Lanka. In *Crazy Like Us: The Globalization of the Western Mind*. Robinson.

<sup>407</sup> Transforming Communities for Inclusion (TCI). (n.d.). *A discussion paper on global mental health and human rights: history and the need for change*. [Discussion paper]. Available: [Discussion-Paper-Dialogue.pdf](#)

<sup>408</sup> HCAV. (2022). *Alternative Report on Implementation of the UN Convention on the Rights of Persons with Disabilities (the second and third periodic reports of the Republic of Armenia)*.

<sup>409</sup> Ibid

of persons with psychosocial disabilities, it still retains a medicalized approach.<sup>410</sup> The provision of determination of temporary incapacity and guardianship also undermines the legal capacity of persons with psychosocial disabilities. These provisions facilitate forced medical treatment, particularly for persons under guardianship, and reinforce discriminatory medical models.

The Armenian Civil Code also permits the complete deprivation of legal capacity for adults with psychosocial and intellectual disabilities, “who, due to a mental disorder, cannot understand the meaning of his actions or manage them” (Article 31). Articles 249–255 establish the procedure for declaring a person legally incapable or with limited capacity. The application to deprive someone of legal capacity can be initiated by relatives, psychiatric institutions, or guardianship bodies. Article 252 permits the use of forced psychiatric examinations if the person resists evaluation. Once incapacity is declared by the court, Article 254 mandates that a guardian be assigned to take legal responsibility for the individual. These provisions allow for substituted decision-making and legal incapacitation based primarily on psychiatric evaluations, raising serious concerns about compliance with Article 12 of the CRPD.

Armenia’s Criminal Code also contains provisions on mental health mainly focusing on involuntary treatment.<sup>411</sup> These provisions permit coercive practices when a person is deemed to have committed an offence while of “unsound mind” or considered a danger to themselves or others. These provisions are often framed as protective or therapeutic, but in practice they enable indefinite deprivation of liberty without trial or consent reinforcing a medico-legal model that treats persons with psychosocial disabilities as objects of control rather than as rights-holders. The Criminal Procedure Code contains numerous provisions that authorize coercive psychiatric measures within legal proceedings. Article 69 mandates the appointment of a defence attorney for persons with psychosocial disabilities. Article 86(2.1) limits the testimonial capacity of persons with mental disabilities. Articles 452–473 allow for court-ordered compulsory forensic psychiatric evaluations and involuntary hospitalization in psychiatric institutions, which may continue indefinitely under Article 472 until the individual is declared ‘recovered’. These provisions allow for indefinite forced treatment in lieu of criminal responsibility, violating Articles 14 and 15 of the CRPD, which guarantee liberty and protection from torture or cruel, inhuman, or degrading treatment or punishment.

The Armenian Constitution guarantees equality before the law (Article 14.1) and prohibits torture and inhuman or degrading treatment (Article 17). But even the revised version of the Constitution still uses the term “incapacitated” (Articles 48; 98; 164;

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<sup>410</sup> The Armenian government approved a 2014–2019 Strategy for the Protection and Improvement of Mental Health (Republic of Armenia Government Session No. 15, April 17, 2014). Available: <https://www.arlis.am/DocumentView.aspx?DocID=90364>

<sup>411</sup> WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009.

193).<sup>412</sup> This framing is in direct contradiction to the rights based perspectives as it perpetuates harmful stereotypes thereby justifying deprivation of liberty and coercive practices.

## **Mental Health Infrastructure and Services**

In Armenia, there is a strong focus on psychiatry and inpatient care. Psychiatric care and services provide outpatient, inpatient and support services within the psychiatric institutions. There have been multiple suggestions on developing community-based support services, the plans for the same are yet to take off. Some of Armenia's national policies have mentions of setting up community based services but implementation remains incomplete. This arrangement has resulted in persons languishing in psychiatric institutions for years, long after their recovery, because of an abysmal state of support services and systems within communities<sup>413</sup>. The identity of being a person with psychosocial disability as part of disability movement is not yet accepted by the wider community and policy makers framing 'mental health conditions' as illnesses in sole need of medicalized treatment.<sup>414</sup>

Regarding the mental health infrastructure, there are seven state managed psychiatric hospitals in Armenia. Additionally, there are 4 state managed institutions for elderly and those with intellectual and psychosocial disabilities. Three of them are in Yerevan and one in Gegharkunik. 993 individuals live in these institutions, including 504 women. Vardenis has the largest institution in the country housing 450 individuals with intellectual and psychosocial disabilities.<sup>415</sup>

Several private institutions are also present throughout the country. A consultation with the stakeholders also suggested that people prefer private care over public institutions as they have more professionals, give more time for consultations, experience better services and more confidentiality. Most of the mental health support services are still exclusively provided in specialized mental health institutions, including hospitals and social psychoneurological centres.<sup>416</sup> There is a high incidence of admission of persons with psychosocial disability.<sup>417</sup> There are gaps in the training of mental health specialists, in particular, the educational programs are not modernized, and the training system of mental health specialists remains incomplete.<sup>418</sup> In recent years, a few short-term measures have been implemented in the field of mental health care,

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<sup>412</sup> HCAV. (2022). *Alternative Report on Implementation of the UN Convention on the Rights of Persons with Disabilities (the second and third periodic reports of the Republic of Armenia)*.

<sup>413</sup> Martirosyan, S. (2022, August 11). Why Are Reforms in Armenia's Mental Health Sector Being Delayed? [Blog post]. [Why Are Reforms in Armenia's Mental Health Sector Being Delayed? - EVN Report](#)

<sup>414</sup> Ibid.

<sup>415</sup> Disability Rights Agenda (DRA) & European Disability Forum (EDF). (2023, October 8). Written Submission on the Status of Institutionalization of Individuals with Disabilities in Armenia. [Report]. Available: <https://www.edf-feph.org/content/uploads/2023/12/Written-Submission-on-Armenia-DRA-and-EDF.pdf>

<sup>416</sup> WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009.

<sup>417</sup> Ibid.

<sup>418</sup> Ibid.

but the lack of a common policy hinders the process of achieving sustainable results in the field.

The psychiatric hospitals and institutions are a hotbed for gross human rights violations including intimidation, starvation and seclusion by staff members.<sup>419,420</sup> Reporting by a human rights organization in 2018 said that workers beat patients in front of other patients, illegal drugs are used to sedate patients and expired drugs are administered to them.<sup>421</sup> In 2017, the UN reported that the pattern for mental health practice in Armenia was to institutionalize an excessive number of patients, give them medications in excess and keep them for longer durations, ultimately labelling them as chronic patients.<sup>422</sup>

Currently, only 2.3% of healthcare expenditure is allocated to mental health.<sup>423,424</sup> Due to the centralized mental health services system, approximately 88% of all expenses are dedicated to mental health hospitals.<sup>425</sup> The current system diverts funding from community-based support services and for programs that can support community living for persons with psychosocial disabilities.

“Persons with psychosocial disabilities are covered by social insurance schemes, and they not only get free treatment but also receive a disability pension.”<sup>426</sup> Inclusion in social insurance schemes is a welcome step as a disability pension provides essential financial support for persons with psychosocial disabilities to support with living expenses and establishing their independence, keeping their autonomy and rights in order.

## Decision Making Power and Lack of Participation

In the current scenario, the main decision makers are police and health care professionals in different situations. The use of police (law enforcement) as first

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<sup>419</sup> Rushforth, M., & Jensen, S. (2021, Winter). Mental Health Concerns in Armenia. Ballard Brief. Available: <https://ballardbrief.byu.edu/issue-briefs/mental-health-concerns-in-armenia?rq=Mental%20Health%20Concerns%20in%20Armenia>

<sup>420</sup> Grigoryan, M. (2015, October 12). They locked me up and left me’: Armenia’s outdated mental health laws. *The Guardian*. Available: [They locked me up and left me’: Armenia’s outdated mental health laws | Armenia | The Guardian](https://www.theguardian.com/world/2015/oct/12/armenia-mental-health-laws)

<sup>421</sup> Human Rights Defender of the Republic of Armenia. (2018). *Ad hoc public report on ensuring rights of persons with mental health problems in psychiatric organizations*. [Report]. Available: <https://ombuds.am/images/files/10ea24ebac14fc8ae30a2da9283a1bec.pdf>

<sup>422</sup> Puras, D. (2018, June 18 - July 6). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Armenia. *Human Rights Council, 38th Session*. Available: <https://documents.un.org/doc/undoc/gen/q18/116/45/pdf/q1811645.pdf>

<sup>423</sup> WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2020. [https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/arm.pdf?sfvrsn=c5b92e08\\_7&download=true](https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/arm.pdf?sfvrsn=c5b92e08_7&download=true)

<sup>424</sup> Chilingaryan, A. (2020). *Right to Non-discrimination and Liberty of Persons with Psychosocial Disabilities who are under the “insane” Status or who are at Risk of such in Criminal Proceedings in Armenia*. Yerevan

<sup>425</sup> Chilingaryan, A. (2020). *Right to Non-discrimination and Liberty of Persons with Psychosocial Disabilities who are under the “insane” Status or who are at Risk of such in Criminal Proceedings in Armenia*. Yerevan

<sup>426</sup> WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009.

responders to such situations often further exacerbates the risk of distress, injury or death.<sup>427</sup> Engagement of health personnel in such situations is also a pathway towards forced admission into hospitals and being subjected to forced procedures or treatments. This manifests itself in the loss of autonomy, right to self-determination and expressing will and preferences of persons with psychosocial disabilities. Professionals and service providers, since centuries, have been engaged in taking decisions, passing judgements and declaring this constituency as medically or socially unfit to justify their deprivation of liberty based on disability.

Within the policy environment, Armenia had a stand-alone strategy on mental health that finished in 2019 but there were no human or financial resources allocated for its implementation.<sup>428</sup> Armenia continues to lack an independent mental health authority. The General Psychiatrist remains the primary government advisor on mental health legislation and as well as service planning, service management and coordination, reinforcing a medicalized and centralized model of care. Despite recent initiatives, such as EU-WHO training programs aimed at promoting rights-based, person-centered approaches, there is still an absence of comprehensive, rights-based training for both medical and non-medical professionals. The monitoring and quality assessment of mental health services is the responsibility of the Department of Health Care of the Ministry of Health.<sup>429</sup> Until now, the Ministry of Health has reviewed functions to investigate complaints but does not have the authority to impose sanctions based on the facts of human rights violations.<sup>430</sup>

The process of registering Organization of Persons with psychosocial disabilities (OPDs) “is not disability sensitive and places restrictions on registering groups of persons with intellectual and psychosocial disabilities”.<sup>431</sup> There has been an increase in the number of OPDs in recent years, however, groups of persons of psychosocial disabilities are less engaged in OPDs.<sup>432</sup> This highlights the low engagement of persons with psychosocial disabilities in the various consultative processes of the government’s reforms. There is a need to “develop clear mechanisms to facilitate effective participation of OPDs in policy development and decision making processes of the State to inform the needs and recommendations of the affected groups”.<sup>433</sup> For

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<sup>427</sup> Human Rights Watch. (2023, November 15). *Mental Health Crisis Support Rooted in Community: Governments Should Invest in Rights-Respecting Alternatives to Punitive, Involuntary Treatment*. Human Rights Watch. <https://www.hrw.org/news/2023/11/15/mental-health-crisis-support-rooted-community>

<sup>428</sup> WHO. (2020). *Mental Health Atlas 2020- Armenia*. [https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/arm.pdf?sfvrsn=c5b92e08\\_7&download=true](https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/arm.pdf?sfvrsn=c5b92e08_7&download=true)

<sup>429</sup> Ibid.

<sup>430</sup> Ibid.

<sup>431</sup> Helsinki Citizens' Assembly-Vanadzor. (2014.). *Shadow report on the Convention on the Rights of Persons with Disabilities*. [Report]. Available: <https://archive.hcav.am/wp-content/uploads/2015/02/Shadow-Report.pdf>

<sup>432</sup> SITUATIONAL ANALYSIS OF THE RIGHTS OF PERSONS WITH DISABILITIES IN ARMENIA. Country Status Report. 2022. <https://unprpd.org/document/situational-analysis-of-the-rights-of-persons-with-disabilities-in-armenia-country-report/>

<sup>433</sup> Ibid.

example, there could be introduction or expansion of OPD monitoring functions in state funded programmes.<sup>434</sup>

This ongoing reliance on medical authority and the limited implementation of inclusive mental health practices highlights the need for systemic reforms to align Armenia's mental health system with international human rights standards. While there have been initiatives aimed at integrating mental health services into primary health care and promoting community-based approaches, the overarching system remains heavily reliant on institutional care. This reliance underscores the need for systemic reforms to establish independent oversight and diversify the perspectives influencing mental health policy and practice in Armenia.

Since 2013, legal assistance is now provided based on the application of a person with psychosocial disability being treated in a psychiatric institution or his legal representative, by a lawyer of the Public Defender's and the procedure for providing assistance should be defined by the Government of the Republic of Armenia.<sup>435</sup>

### **International Commitment**

As elaborated in chapter 3, Armenia has ratified a comprehensive body of international human rights instruments that establish strong protections for the rights of persons with psychosocial disabilities such as CRPD, CRC, CAT, ICCPR and CEDAW. The obligations are further reinforced by Armenia's accession to the European Convention on Human Rights (ECHR) and its commitment to comply with rulings of the European Court of Human Rights. Collectively, these instruments place a binding responsibility on Armenia to abolish coercive and institutional practices in the mental health system and to build rights-based, inclusive support structures aligned with international law.

### **Promising Legal Reforms**

There have been some promising reforms in Armenia aimed at ensuring rights of persons with psychosocial disabilities are upheld and protected. The RA Constitutional Court made a decision to recognize anti-constitutional provisions of a number of the Republic of Armenia laws not guaranteeing informed consent of minors and persons recognized incapacitated regarding their medical interventions (2020). Additionally, RA law "On rights of persons with disabilities" was passed (2021)<sup>436</sup>. This is a step towards the implementation of CRPD "as the law guarantees accessibility,

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<sup>434</sup> Ibid.

<sup>435</sup> The Armenian government approved a 2014-2019 Strategy for the Protection and Improvement of Mental Health (Republic of Armenia Government Session No. 15, April 17, 2014). Available: <https://www.arlis.am/DocumentView.aspx?DocID=90364>

<sup>436</sup> Helsinki Citizens' Assembly-Vanadzor. (2014.). *Shadow report on the Convention on the Rights of Persons with Disabilities*. [Report]. Available: <https://archive.hcav.am/wp-content/uploads/2015/02/Shadow-Report.pdf>

independent living, access to justice and reasonable accommodation”.<sup>437</sup> The law also bans disability-based discrimination and treats refusal to provide reasonable accommodation as discrimination.<sup>438</sup> In 2022, Action Plan for the Maintenance and Promotion of Mental Health (2022-2026) was approved by Minister of Health and Armenia also ratified the Optional Protocol to the Convention on the Rights of Persons with Disabilities. A public monitoring group was also formed to conduct regular monitoring in psychiatric institutions, in accordance with the procedure established by the RA Law "On Psychiatric Aid and Service". However, the work of the group in care houses was terminated and RA has introduced the concept of limited legal capacity.<sup>439</sup> The draft Law “on ensuring legal equality” was developed by Ministry of Justice in 2019 and put for public discussion, but it has not yet been adopted.<sup>440,441</sup>

Armenia has taken encouraging steps in recent years, signalling a growing recognition of the rights of persons with psychosocial disabilities. The adoption of new disability legislation, the ratification of the CRPD Optional Protocol, and the formulation of action plans reflect a broader commitment to reform. However, for these reforms to translate into meaningful change, they must be fully implemented, adequately resourced, and aligned with the principles of autonomy, legal capacity, and community inclusion. Continued political will, inclusive policy-making, and strong civil society engagement will be essential to close the gap between legal progress and lived realities.

## **Understanding the Need to Reform the Response to Mental Health and Psychosocial Disability in Armenia**

In the absence of community support services, no infrastructure or policies around peer support and limited access to generic services such as education, livelihood, housing etc. and retaining a strong focus on psychiatric services and institutions, persons with psychosocial disabilities often end up within these structures and systems. The presence of discriminatory legal frameworks that allow for disability based discrimination further enables forced hospitalization and treatment of persons with psychosocial disabilities. Institutions have also been used by families and care providers and communities because of a lack of alternatives and also as means to

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<sup>437</sup> Chilingaryan, A. (2021, May 11). Important Progress for People with Disabilities in Armenia: New Law Bans Discrimination, Promotes Inclusion. Human Rights Watch. <https://www.hrw.org/news/2021/05/11/important-progress-people-disabilities-armenia>

<sup>438</sup> The Armenian government approved a 2014-2019 Strategy for the Protection and Improvement of Mental Health (Republic of Armenia Government Session No. 15, April 17, 2014). Available: <https://www.arlis.am/DocumentView.aspx?DocID=90364>

<sup>439</sup> *Joint Announcement on the Termination of the Monitoring Group in Care Institutions*. (2024). Available at: <https://dra.am/articles/latest-news/joint-announcement-on-the-termination-of-the-monitoring-group-in-the-care-institutions>

<sup>440</sup> CEDAW/C/ARM/7

<sup>441</sup> HCAV. (2022). *Alternative Report on Implementation of the UN Convention on the Rights of Persons with Disabilities (the second and third periodic reports of the Republic of Armenia)*.

settle property, financial, assets disputes.<sup>442</sup> The social protection system in Armenia primarily focuses on addressing the basic needs of marginalized groups of society.

Mental health and psychosocial disability are rife with stigma, stereotypes and misconceptions. These conditions are often perceived as a punishment from God encouraging maltreatment and violence against persons with psychosocial disabilities.<sup>443</sup> “While educational programs have helped to curb the violence, their implementation has been experimental and limited”.<sup>444</sup> “The idea of paying for “advice” runs counter to the self-reliant individualism and maybe considered as shameful or dishonourable”.<sup>445</sup> According to a study conducted by Doctors Without Borders (2005), “63% of Armenians believe that those with psychosocial disabilities are dangerous and 56% believe that they should be kept in hospitals”.<sup>446</sup> “If society views as incapable of recovering or improving to any degree, then it will not create opportunities to support the outcomes.”<sup>447</sup> These individuals may be perceived as less capable as those without disabilities. More efforts must be made to ensure that the public recognizes capabilities and full potential of persons with psychosocial disabilities or mental health.<sup>448</sup> This is widely assumed and encourages the idea that being a person with psychosocial disability is a social barrier for both employment and living an everyday life in Armenia.<sup>449</sup> Article 8 of the CRPD (Awareness raising) should be taken into consideration while planning awareness activities in the communities and larger public. The awareness raising should be around dismantling harmful stereotypes associated with persons with psychosocial disabilities, rights and dignity of the individuals, their right to being included in community life and taking their own decisions etc.<sup>450</sup> Media (print, digital, social) should also be cautious while portraying negative stereotypes of persons with psychosocial disabilities.<sup>451</sup>

There is a need to adapt more human rights approach in the mental health domain. The psychiatric staff and teams need to be updated on the CRPD, understand clearly

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<sup>442</sup> Grigoryan, M. (2015, October 12). They locked me up and left me’: Armenia’s outdated mental health laws. The Guardian. Available: [‘They locked me up and left me’: Armenia's outdated mental health laws | Armenia | The Guardian](https://www.theguardian.com/world/2015/oct/12/armenia-mental-health-laws)

<sup>443</sup> Puras, D. (2018, June 18 - July 6). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Armenia. *Human Rights Council, 38th Session*. Available: <https://documents.un.org/doc/undoc/gen/q18/116/45/pdf/q1811645.pdf>

<sup>444</sup> Ibid.

<sup>445</sup> Dagirmanjian, S. (2005). Armenian families. *Ethnicity and family therapy*, 437-450. Available: [https://students.aiu.edu/submissions/profiles/resources/onlineBook/x4a5q5\\_Ethnicity\\_and\\_Family\\_Therapy-3.pdf#page=457](https://students.aiu.edu/submissions/profiles/resources/onlineBook/x4a5q5_Ethnicity_and_Family_Therapy-3.pdf#page=457)

<sup>446</sup> Van Baelen, L., Theocharopoulos, Y., & Hargreaves, S. (2005). Mental health problems in Armenia: low demand, high needs. *British Journal of General Practice*, 55(510), 64-65. Available: <https://bjgp.org/content/bjgp/55/510/64.full.pdf>

<sup>447</sup> Puras, D. (2018, June 18 - July 6). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Armenia. *Human Rights Council, 38th Session*. Available: <https://documents.un.org/doc/undoc/gen/q18/116/45/pdf/q1811645.pdf>

<sup>448</sup> Van Baelen, L., Theocharopoulos, Y., & Hargreaves, S. (2005). Mental health problems in Armenia: low demand, high needs. *British Journal of General Practice*, 55(510), 64-65. Available: <https://bjgp.org/content/bjgp/55/510/64.full.pdf>

<sup>449</sup> Ibid.

<sup>450</sup> Davar, B., Sharma-Dhamorikar, R., & Nair, K. (2023). Transforming Communities for Inclusion: Examples of Practice. Available: [Photo-Story.pdf](#)

<sup>451</sup> Ibid.

about the rights of persons with psychosocial disabilities and the importance of offering choices, advising services in line with will and preferences of the individual and sharing full information on drugs, side effects and withdrawals of the same.

Even though the “foundation of deinstitutionalization policy was laid in Armenia in 2013, no institution has so far been dissolved, additionally due to shortage of community services, there are queues to be accepted to institutions. “There is a limited number of community services (12) that serve 363 persons and are located in the RA capital city Yerevan and 3 out of 10 provinces (there are about 54.000 persons with psychosocial and intellectual disabilities)”.<sup>452</sup> Furthermore, these services often face the danger of being closed down due to insufficient funds or irregular provision.”<sup>453</sup> These other types of group homes, segregated settings are classified as mini-institutions, as per the UN Guidelines on Deinstitutionalization, including in emergencies.<sup>454</sup>

Amidst the devastation caused by the pandemic and the aftermath of Artsakh conflict, there will be a tendency of over reliance on psychiatric services. However, there remains a debilitating absence of “rights-based supports such as psychosocial support, psychological treatments, various interpersonal therapies and group support, and trauma counselling that have been documented in trials and acknowledged by UN high agencies”.<sup>455</sup> There are also several other non-governmental organizations that carry out the psychological rehabilitation of children with psychosocial disabilities.

There is the view that, “accelerating community support services will make institutions go away. However, as long as legal barriers are provided as a solution and a “service”, exclusion will persist, and lives in the communities will always run the risk of having their lives interrupted and fragmented, exposing them to the risks and violations of inhuman, degrading, torturous treatments”.<sup>456</sup>

Global best practices, led by OPDs and civil society groups have demonstrated that alternatives to forced treatments and hospitalization begins at the community level. Inclusion begins from home, proceeding to the community and affecting policy changes. There needs to be a focus on strengthening community support systems and developing community support services in order to make deinstitutionalization a

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<sup>452</sup> Alternative Report on Implementation of the UN Convention on the Rights of Persons with Disabilities (the second and third periodic reports of the Republic of Armenia) 2022

<sup>453</sup> Ibid.

<sup>454</sup> “Definitions of community-based support services, including in-home and other support services, and personal assistance should prevent the emergence of new segregated services, such as group housing – including small group homes – sheltered workshops, institutions for the provision of respite care, transit homes, day-care centres, or coercive measures such as community treatment orders, which are not community-based services.”<sup>454</sup>

<sup>455</sup> Transforming Communities for Inclusion (TCI). (n.d.). *A discussion paper on global mental health and human rights: history and the need for change*. [Discussion paper]. Available: [Discussion-Paper-Dialogue.pdf](#)

<sup>456</sup> Transforming Communities for Inclusion (TCI). (2022, October 14). Report on “Re-Imagining Services in the 21st Century to give effect to the right to live independently and be included in the community for persons with disabilities”. Available: <https://tci-global.org/wp-content/uploads/2023/07/TCI-CFI-SRDisabilities-Re-Imagining-Services.pdf>

possibility. Additionally, intersectoral collaboration between various government sectors is needed so that interagency efforts can be streamlined and put together toward enabling an inclusive environment.

As per the CRPD, it is necessary to implement community level housing regardless of the state of health and social conditions. The services provided should offer rights-based living environment and the opportunity to utilize public services and participate in community life with dignity, which may include the provision of non-state and specialized services at the community level.<sup>457</sup> The Convention should be base of any the legal reform and a guiding document to develop and implement pilot programs at the community level.

When implementing pilot projects, the available resources in the community should be taken into account, including:

- active neighbourhood,
- local universities or other schools for volunteers,
- local non-governmental organizations (not necessarily health or social workers), volunteers,
- cultural or community programs implemented in the area,
- initiatives by the church/cultural centres,
- activities carried out as a favourite pastime,
- public community places,
- friendly entrepreneurs,
- leaders at the local level (not necessarily politicians or official leaders).

The strategy envisages the establishment of clear standards for the provision of services at the state level. Common standards for the delivery of all services should be developed.

### **Structural challenges and key barriers**

The analysis of the situation shows that currently the following problems in the social sphere of Armenia:

1. The presence of large boarding houses, where many people live, many of whom are able to live independently, but having no alternative option for living, they are forced to stay in boarding houses as alternative stay arrangements. A person's right to choose a place of residence is violated, and the community inclusion of these persons is also not possible<sup>458</sup>. It should be taken into consideration that group homes, care homes, half way homes etc. are included in the ambit of institutions. Hence, there should be clear guidance on providing

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<sup>457</sup> Ibid.

<sup>458</sup> The Armenian government approved a 2014-2019 Strategy for the Protection and Improvement of Mental Health (Republic of Armenia Government Session No. 15, April 17, 2014). Available: <https://www.arlis.am/DocumentView.aspx?DocID=90364>

inclusive, safe, accessible, affordable housing in the community. Examples of residential services are social housing, self-managed co-housing, free matching services, and assistance in challenging housing discrimination etc.

2. Insufficient opportunities for employment and skill development. State Parties must ensure that persons with psychosocial disabilities have access to employment opportunities and are not discriminated against based on disability.
3. Persons with mental health conditions are not accepted as persons with psychosocial disabilities or disability specifically, hence are excluded from social protection. There should be efforts towards understanding the identity of being persons with psychosocial disabilities and being included in the disability movement and sector.\*

**\*Diagnostic label as cause of deprivation of rights:** Psychosocial disabilities are those disabilities that arise from barriers to social participation experienced by people who have or who are perceived to have mental health conditions. This identity is inclusive of persons who identify as “users and survivors of psychiatry”, “mad” persons”, persons of “unsound mind” and persons with intersectional and neurodiverse identities. Psychosocial disability also refers to a person’s experience of discrimination, which may include segregation, confinement, violations of autonomy and physical and mental integrity, and/or denial of desired supports and accommodations, based on their subjective distress or disturbance or others' attribution to them of distress or disturbance.<sup>459</sup> This identity was put forward by the CRPD. It aligns with the human rights model of disability and shifts the locus of issues from within the individual to a focus on societal, attitudinal and legal barriers that restrict full participation. In contrast, persons with mental illness, mental health disorders or mental health conditions fall within the ambit of the medical model of disability where the issue is located within an individual and hence the focus is on improving and “treating” the person, rather than the barriers.

The current situation in Armenia reveals deep-rooted legal, social, and systemic barriers that continue to marginalize persons with psychosocial disabilities. Despite some progress and global attention, outdated laws, harmful stereotypes, lack of rights-based services, and institutional overreliance persist. Without immediate and coordinated reforms grounded in the CRPD, Armenia risks reinforcing cycles of exclusion, coercion, and human rights violations. Urgent action is needed to dismantle discriminatory frameworks, invest in inclusive community-based support systems, and recognize psychosocial disability as a legitimate and rights-bearing identity. Reform is not only necessary—it is long overdue

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<sup>459</sup> CHRUSP. (n.d.). Submission by Center for the Human Rights of Users and Survivor of Psychiatry (CHRUSP) and the Campaign to Support CRPD Absolute Prohibition of Commitment and Forced Treatment (Absolute Prohibition Campaign): Response to draft General Comment 7 on Article 4.3, paragraph 14(a) and (d) and transversal.

## 6 | A Roadmap for Mental Health Reform in Armenia

Article 19 of the Convention on the Rights of Persons with Disabilities demonstrates “the paradigm shifts from a medical and charity approach to a social and human rights-based approach to disability”.<sup>460</sup> Persons with disabilities, “have the right to live independently and be included in the community”<sup>461</sup>. In practice, however, some groups particularly persons with psychosocial disabilities and intellectual disabilities are more likely to be excluded than others.

The Convention on the Rights of Persons with Disabilities, a legally binding human rights treaty, contains norms relating to the right to live independently and be included in the community, which should be considered as the minimum standards when developing future legislation at national and regional levels. The denial of liberty based on disability is a human rights violation and is a consequence of the inability of the country to fulfil human rights obligations towards persons with disabilities, in line with multiple human rights Conventions.

The report illustrates upon the discrimination and exclusion faced by persons with disabilities in everyday life. Psychosocial needs are often neglected and are dominated by a medical model, discriminatory attitudes and power imbalances resulting in coercive practices. People with psychosocial disabilities often lack adequate support and receive services that are ineffective and harmful. As a result, persons with psychosocial disabilities are sent to institutions and mental health facilities for “cure” or “care”, where structural discrimination is embedded into the system based on the existence or presumption of having an impairment.

Ensuring access and support for persons with disabilities is a human rights obligation for countries and this ensures that no one is left behind as identified in 2030 Agenda for Sustainable Development. Progress in the areas of accessibility and non-discrimination is important, however it is also important that persons with disabilities have reliable access to support services.<sup>462</sup> Without the necessary assistance for daily activities and social participation, many persons with disabilities will be unable to fully exercise their human rights and fundamental freedoms, leaving them at risk of abuse and institutionalization. Rights-based support measures are important in allowing persons with disabilities to benefit from policies and programmes and to live inclusively within the communities on an equal basis with others. We recommend the following with an aim of assisting the State to reform, develop and implement legislations and policies which are rights-based and uphold the liberty and security of persons with psychosocial disabilities.

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<sup>460</sup>United Nations High Commissioner for Human Rights. (2014, December 12). *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights (A/HRC/28/37)*. Geneva: United Nations.

<sup>461</sup> Ibid.

<sup>462</sup> Puras, D. (2018, June 18 - July 6). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Armenia. *Human Rights Council, 38th Session*. Available: <https://documents.un.org/doc/undoc/gen/q18/116/45/pdf/q1811645.pdf>

To uphold the rights of persons with disabilities, Armenia must adopt sustainable strategies and action plans. The larger aim is to achieve de-institutionalization so that people living in the institutions can lead independent lives in their communities, with rights-based support. The transition is complex and a long-term process that requires careful planning and collaboration with a wide range of organizations and individuals to develop a holistic approach. The UN Guidelines on Deinstitutionalization, including in emergencies lays down the pathway for a successful State led deinstitutionalization process.

The Common European Guidelines on the Transition from Institutional to Community-Based Care suggest to consider following key areas for action:<sup>463</sup>

1. Make the case for developing community-based alternatives to institutions.
2. Assess the situation.
3. Adopt rights-based approach to all legislative frameworks
4. Develop strategy and an action plan for implementation
5. Develop a range of services in the community.
6. Allocate financial, material, and human resources.
7. Develop individual plans.
8. Support individuals and communities during the transition.
9. Define, monitor, and evaluate the quality of services.
10. Develop the workforce.

These ten elements describe a range of actions the government can take to successfully transition from institutional care to a system of community-based services for persons with psychosocial disabilities. These can be further categorized into 5 pillars:<sup>464</sup>

- Pillar 1: Legal and Policy Framework
- Pillar 2: Structure and Types of Programs and Services
- Pillar 3: Developing Human Capacity
- Pillar 4: Performance Outcomes and Measures
- Pillar 5: Increasing Awareness and Participation

Based on these key pillars and their associated actions this chapter provides recommendations and short-term and long-term key actions.

Regarding the alternatives to forced treatment and forced hospitalization, as a short-term strategy, it is vital to establish crisis support interventions, at community levels

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<sup>463</sup> European Network for Independent Living (ENIL). (2013). Study on Deinstitutionalization of Children and Adults with Disabilities in Europe and Eurasia. Retrieved from <https://enil.eu/wp-content/uploads/2022/03/Study-on-Deinstitutionalization-of-Children-and-Adults-with-Disabilities-in-Europe-and-Eurasia.pdf>

<sup>464</sup> Ibid.

and within centre/institutions, mainly composed of peer networks with lived experiences, families and service providers. However, it is **imperative to engage and be led by persons with psychosocial disabilities** as part of these interventions so that the will and preferences of the individuals are put at the centre. Additionally, crisis support should be rights based, non-coercive, upholding dignity with a comprehensive approach that attends to needs before, during after the crisis. These interventions should focus on immediate mobilizing of community-based support for individuals in distress giving priority to de-escalation and voluntary engagement. In the short term, arrangements can be made to develop peer respite centres/respite houses/respite spaces that offer a gentle, non-coercive environment for individuals in distress to access, heal and receive needed support. Training and sensitization of healthcare professionals, hospital staff, families, peers and communities should be done focusing on rights-based, non-coercive approaches to provide support to persons with psychosocial disabilities. Additionally, developing policies that reinforce the use of no coercion, no restraints within any health services should be done.

As a long-term strategy, focus should be on development of comprehensive and robust community support services which includes peer led services, inclusive social protection programs, access to disability specific benefits etc., that address broader needs related to independent living in the community. Legislative reforms, as described in this section, are essential to abolish substituted decision and discriminatory laws along with safeguarding individuals from forced interventions so that decision making and dignity of persons with psychosocial disabilities are respected and upheld. Long term strategy should also include thorough awareness campaigns (led through various mediums) with a variety of stakeholders to dispel myths and misconceptions and educate about the rights of persons with psychosocial disabilities.

### **Recommendation 1**

#### **End Coercive Practices by Recognizing Rights Through Restoring Legal Capacity and Harmonizing Laws, Regulations and Policies with CRPD**

Armenia must take immediate steps to end all forms of coercive practices, particularly in mental health settings, and guarantee the dignity, liberty, and informed consent of persons with psychosocial disabilities. Forced institutionalization violates Article 19 of the UNCRPD and must be abolished. A complete ban should be imposed on non-consensual practices such as psychosurgery, electric shock, administration of mind-altering drugs, and the use of restraint or solitary confinement, whether short- or long-term.

It is essential to legally recognize the equal right of persons with psychosocial disabilities to liberty and security, ensuring they can exercise control over their lives on an equal basis with others. Supported decision-making must be made accessible where required.

Community inclusion must be positioned as a core policy goal. Armenia should develop a clear and time-bound deinstitutionalization strategy supported by strong legislation and financial commitments. This shift must also address population-level innovations that move away from a medical model focused on "curing" mental health conditions, and instead respond to social and environmental determinants.

All national policies and programmes must allocate dedicated budgets for support services and arrangements, including access to essential assistive technologies within the health and social protection systems. These must be provided free of cost. Persons with psychosocial disabilities and their representative organizations must be meaningfully involved in all stages of decision-making and policy design.

Deinstitutionalization must be implemented with urgency through concrete benchmarks, and new admissions to institutions must be halted immediately. The focus must shift toward building strong, rights-based community support systems.

### **Short-Term (0–12 months): Immediate Legal and Procedural Reforms**

- Conduct a comprehensive legal and policy mapping to identify clauses permitting coercion, legal incapacity, or disability-based detention.
- Place a moratorium and initiate bans on all forced institutionalization and coercive practices including electroshock, psychosurgery, and restraints.
- Establish informed consent protocols as legally binding; train staff, families, and peers on how to share information clearly and accessibly.
- Create a national working group with OPDs, survivors, and rights groups to co-lead these processes alongside government bodies.
- Review and urgently amend core laws (constitution, civil code, health, family, guardianship) that infringe on liberty, autonomy, and legal capacity.
- Begin community education on CRPD-compliant crisis support models and develop guidelines for healthcare providers, police, and institutional staff.

### **Mid-Term (1–3 years): Systems Transformation and Supported Decision-Making Infrastructure**

- Establish a national supported decision-making (SDM) policy with clear protocols, safeguards, and resource allocation.
- Train all relevant stakeholders (families, community workers, professionals) on how to implement SDM, informed consent, and community-based supports.
- Provide immediate access to legal aid and advocacy. If the person rejects treatment or hospitalization, provide the right to legal aid and the compulsory condition of providing a state-ensured advocate through the Office of Public

Defender.<sup>465</sup> OPDs, self-advocates and disability rights organizations can be identified and engaged to provide information on their rights, legal aids, enable access to justice etc.

- Develop robust guidelines and penalties for institutions violating consent or using coercion, especially during crises or high-support needs situations.
- Pilot and scale up alternatives to institutional care, including peer-run services and non-medicalized community support hubs.
- Introduce social protection reforms (assistive technology, community-based entitlements, income support) to enable persons with psychosocial disabilities to live independently.
- Allocate budgets across ministries to fund support services as alternatives to institutionalization.

### **Long-Term (3–5 years and beyond): Full Legal Capacity and Rights-Based Ecosystem**

- Fully abolish guardianship and replace it with supported decision-making mechanisms across all settings.
- Harmonize all legislation with CRPD including education, employment, housing, civil, and criminal laws.
- Implement a comprehensive national deinstitutionalization strategy with timelines, budget lines, and clear benchmarks.
- Prohibit new admissions to psychiatric or custodial institutions and shift focus to building community-based alternatives.
- Establish independent, OPD-led accountability mechanisms with legal authority to oversee compliance, redress violations, and monitor progress.
- Institutionalize ongoing capacity building and rights training for police, judges, service providers, and disability actors.
- Develop national indicators to measure CRPD compliance, lived experiences, and rights fulfillment in mental health settings.

### **Recommendation 2: Establishing and Strengthening Monitoring Mechanisms**

Armenia must establish clear, CRPD-aligned guidelines and robust monitoring mechanisms across all systems and institutions such as health agencies, social care centres, prisons, orphanages, and community-based services. These mechanisms must ensure that new laws and policies are effectively implemented and rights violations are promptly identified. Independent, accessible, and anonymous complaint

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<sup>465</sup> HCAV. (2023). Report on the practice of involuntary hospitalization and treatment in Armenia. Available at: Report on the practice of involuntary hospitalization and treatment in Armenia Read more <https://hcav.am/en/hospitalization-17-11-2023/>

systems must also be created to enable persons with psychosocial disabilities to report abuse or coercion without fear, and to ensure timely redress.

### **Short-Term (Immediate – 1 year)**

1. Constitute an interim monitoring body comprised of persons with psychosocial disabilities, survivors, and self-advocates. Ensure no conflict of interest (exclude institutional or healthcare staff).
2. Develop initial CRPD-aligned quality standards and indicators to check for rights violations and institutional practices creeping into community services.
3. Conduct routine inspections in all places of detention and care. Publish findings and hold accountability sessions.
4. Design and operationalize an independent complaint and grievance mechanism (e.g., hotline, online form, community access points), allowing for anonymous submissions.
5. Disseminate information on how to use complaint channels through OPDs, media, and service providers.
6. Organize capacity-building workshops for interim monitors on CRPD standards, documentation, and ethical investigation.

### **Mid-Term (1–3 years)**

1. Establish a formal, independent monitoring and accountability body through national legislation. Define clear mandate, resourcing, and reporting structure.
2. Expand the mandate to cover public and private institutions, orphanages, group homes, community-based services, and new models.
3. Ensure legal access rights for monitors to visit any care or support setting, examine records, and meet service users without restriction.
4. Pilot digital and remote monitoring approaches where physical access is limited, such as in rural or emergency contexts.
5. Develop and launch a public-facing dashboard tracking monitoring visits, violations found, and follow-up actions taken by the State.

### **Long-Term (3–5+ years)**

1. Institutionalize shadow reporting by OPDs and self-advocate groups as part of official human rights monitoring frameworks.
2. Ensure routine reporting to UN Committees on the implementation status of CRPD, including national and parallel reports.
3. Embed timely redress and remedy mechanisms in national law to address violations found by monitoring bodies.
4. Make transparency a norm: institutionalize open publication of monitoring findings and progress reviews in public platforms.

### **Recommendation 3:**

#### **Re-Allocation of Resources and Establishing Adequate Community Support Services and Strengthening Community Support Systems**

To uphold the rights of persons with psychosocial disabilities and eliminate forced institutionalization, Armenia must immediately cease public funding to large psychiatric hospitals and segregated institutions. These settings perpetuate coercion, violate liberty and dignity, and are incompatible with CRPD standards. Instead, investments must shift toward building inclusive, community-based services that are grounded in the values of autonomy, self-determination, and social inclusion. This requires systemic transformation—not just closing institutions, but developing individualized support, inclusive mainstream services, and robust community-led systems. Such reforms must prioritize the transfer of power from providers to users and ensure meaningful participation of persons with psychosocial disabilities in design, delivery, and monitoring. While initial investments may be required, inclusive systems are more effective and sustainable in the long term, and create healthier, more equitable societies.

#### **Short-Term Actions (0–2 years): Planning and Immediate Resource Redirection**

- Conduct a comprehensive needs assessment of persons with psychosocial disabilities, including those in institutions and hospitals.
- Initiate reallocation of budgets away from institutional care and begin securing guaranteed funding for community-based services.
- Establish pilot projects on support services based on needs expressed by persons with psychosocial disabilities.
- Launch public awareness campaigns to build community acceptance of deinstitutionalization and inclusion of persons with psychosocial disabilities.
- Create hotlines and peer-led crisis support models, ensuring training on non-coercive, community-based alternatives.
- Engage persons with psychosocial disabilities in planning and design of support services and monitor early rollouts.
- Begin workforce assessments and establish training committees involving persons with disabilities to co-develop materials.
- Mobilize community-based OPDs, NGOs, CBOs and create referral networks and inclusive event spaces.
- Create crisis support frameworks, staffed by trained peer responders.

#### **Mid-Term Actions (2–5 years): Scaling Infrastructure and Services**

- Expand a range of support services: personal assistance, peer counselling, emergency services, assistive technologies, supported housing, and inclusive childcare.
- Develop accessible housing and family-based alternatives for children.

- Formalize community partnerships (e.g., with civil society, local governments, cultural organizations).
- Establish peer respite centres which are open, free-access spaces embedded in communities.
- Scale up inclusive recreational and cultural activities to promote social participation and visibility.
- Formalize linkages with community-led support systems and peer groups; begin public funding to sustain these groups.
- Develop decentralized budget systems to increase local responsiveness and autonomy.
- Roll out user-led evaluations and participatory quality monitoring mechanisms across pilot areas.
- Build systems for direct payments and personalized budgets to support user choice.

### **Long-Term Actions (5+ years): Sustainable Systemic Reform**

- Create and implement a national framework for community-based support services, grounded in human rights.
- Fully replace institutional care with a network of inclusive and non-medicalized community supports.
- Institutionalize peer support and mutual aid systems with formal recognition, funding, and legal protections.
- Ensure all services are co-managed or led by persons with psychosocial disabilities.
- Scale workforce development and licensing to sustain inclusive and CRPD-compliant community services.
- Transform the social work profession to reflect inclusion, autonomy, and rights-based practice.
- Ensure universal access to community-based mental health care under national health coverage.
- Strengthen accountability mechanisms and participatory oversight, with regular CRPD-aligned reviews.
- Embed culturally appropriate psychosocial supports in rural and underserved areas.

### **Recommendation 4:**

#### **Implement Deinstitutionalization in line with the UN Guidelines**

Armenia must prioritize the urgent implementation of deinstitutionalization to end the systemic exclusion and harm experienced by persons with psychosocial disabilities in institutions. This requires shifting away from institutional models and building rights-based, person-centred alternatives within communities. Deinstitutionalization must be recognized not as a gradual or technical process but as a matter of restoring rights,

dignity, and freedom to those forcibly segregated. Using the UN Guidelines on Deinstitutionalization, including in Emergencies, as a guiding framework, Armenia must immediately begin building inclusive community-based systems and services, with the direct leadership and involvement of persons with psychosocial disabilities and their representative organizations.

### **Short-Term Actions (0–2 years):**

1. Conduct a needs assessment to understand the current state of institutions and the support needs of institutionalized persons.
2. Assess existing institutional practices and gather evidence of exclusion, discrimination, and coercive practices faced by persons with psychosocial disabilities.
3. Conduct a resource assessment of human, financial, and material assets available within psychiatric institutions, residential facilities, and social care provisions to inform alternative community-based service planning.
4. Undertake a system analysis to identify barriers to inclusion in mainstream services such as education, health, social care and communities. This should include interviews with residents and institutional staff, demographic mapping, and a feasibility study on community alternatives.
5. Review existing community-based services, identify gaps, and examine promising practices from other countries that can be adapted to Armenia's cultural and demographic context.
6. Create a detailed transition plan for deinstitutionalization, identifying responsible agencies and allocating necessary resources. Use the UN Guidelines on Deinstitutionalization, including in Emergencies, as a reference.
7. Start working with institutionalized persons, to prepare them for life outside institutions and equip them with skills to live independently in the communities.

### **Mid-Term Actions (2–5 years):**

1. Establish support programs for families and caregivers to equip them to provide rights-based, non-coercive support aligned with individuals' will and preferences.
2. Expand inclusive housing options and mainstream access to lifelong learning, employment, social protection schemes, and civic documentation for persons transitioning into community life.
3. Ensure new placements do not result in smaller or rebranded institutions. Avoid any form of institutional transfer disguised as reform.
4. Secure and sustain community services before closing institutions to ensure smooth, uninterrupted support.
5. Establish a national platform (or join an international one) for sharing good practices and lessons on deinstitutionalization, in close consultation with survivors and OPDs

## **Long-Term Actions (5+ years)**

1. Develop a comprehensive national deinstitutionalization strategy and action plan, both at regional and national levels. Include timelines, clear benchmarks, and allocated budgets.
2. Include specific provisions to:
  - Prevent re-institutionalization,
  - Guide development of community-based, rights-aligned services,
  - Assign roles to all stakeholders (policymakers, social workers, health professionals, etc.),
  - Identify financial frameworks to support the transition.
3. Strengthen monitoring and accountability systems led by OPDs and survivors to oversee implementation.
4. Make deinstitutionalization a national development and human rights priority.
5. Mainstream the rights of persons with psychosocial disabilities in all international cooperation and development efforts, ensuring alignment with the 2030 Sustainable Development Agenda.

## **Recommendation 5: Raising CRPD-Compliant Public Awareness**

Armenia must actively promote CRPD-compliant public awareness to dismantle stereotypes and shift societal narratives around psychosocial disability. Awareness-raising efforts must move beyond messaging on diagnosis, symptom management, or service locations. Instead, they should promote rights-based understanding of liberty, autonomy, dignity, and full community participation of persons with psychosocial disabilities. Public institutions, professionals, and communities must be equipped to understand and uphold these rights, while persons with psychosocial disabilities and their organizations must be central to the design, delivery, and evaluation of awareness efforts.

## **Short-Term Actions (0-2 years)**

1. Disseminate the text of the CRPD widely in Armenian and accessible formats (e.g., easy-to-read versions, audio formats, sign language, braille).
2. Launch a national awareness campaign targeting public officers, policymakers, legal and healthcare professionals, media, and communities. Focus on the right to liberty and freedom from coercion, and counter harmful stereotypes and discriminatory practices.
3. Ensure all communications emphasize human rights, dignity, and community inclusion, not illness labels, symptoms, or clinical services.
4. Begin CRPD-specific training for judges, police, healthcare workers, educators, and institutional staff on non-coercion and supported decision-making.

5. Begin capacity building of persons with psychosocial disabilities on CRPD and their rights.

### **Mid-Term Actions (2-5 years)**

1. Develop training modules co-created with persons with psychosocial disabilities and OPDs, tailored to specific sectors (health, education, police, justice).
2. Institutionalize human rights and CRPD education into public service, medical, and legal training curricula at national and regional levels.
3. Launch public storytelling or digital campaigns led by persons with psychosocial disabilities to shift social narratives and build solidarity.

### **Long-Term Actions (5+ years)**

1. Promote long-term behavioral change by embedding rights-based messaging in school education, government information systems, and media codes of conduct.
2. Build public understanding around deinstitutionalization by supporting community dialogues that prepare families and communities for the transition to inclusive living.
3. Establish national days or observances highlighting the rights and contributions of persons with psychosocial disabilities.
4. For children and youth transitioning out of institutions, invest in programs that help rebuild family relationships and prepare them for independent community life.

### **Recommendation 6: Multisectoral Partnership**

Armenia must encourage international cooperation actors, including non-profit organizations, public-private partners, and multi-sectoral ministries, to participate and collaborate in adopting a rights-based approach to establishing mental health support systems. The government should create enabling frameworks for inclusive participation and co-leadership of persons with psychosocial disabilities and their organizations in shaping service design, research, and policy implementation.

Armenian leadership must call for immediate, coordinated action to develop inclusive, CRPD-compliant mental health systems. This requires forming alliances that bring together state champions, persons with psychosocial disabilities, policy stakeholders, civil society organizations, disability rights professionals, and social workers. These stakeholders must work collectively to:

- Recalibrate mental health research priorities toward participatory, rights-based, and social science approaches that fill current knowledge gaps;

- Promote non-coercive, community-based alternatives that align with lived experiences and cultural contexts;
- Support cross-sector platforms that integrate housing, education, employment, and legal aid into mental health reform efforts.

Such partnerships should not be symbolic but structured for sustained impact, with co-developed goals, shared accountability, and transparent progress monitoring frameworks. The ultimate goal is to build a collaborative mental health ecosystem that centers dignity, autonomy, and inclusion over institutional or medical control.

### **Short-Term Goals (0-2 years)**

1. Map and identify potential partners (ministries, NGOs, donors, universities, user-led OPDs) already working on disability, social protection, and mental health.
2. Convene a national dialogue platform involving government ministries, OPDs, civil society, and academic institutions to align on shared CRPD-compliant priorities.
3. Begin collaborative knowledge exchange with regional and international actors who have experience in rights-based, non-coercive mental health models.

### **Mid-Term Goals (2-5 years)**

1. Develop a multisectoral coordination mechanism, possibly a task force, co-led by the Ministry of Health and OPDs, to guide community-based mental health policy development and implementation.
2. Launch pilot programs for non-coercive alternatives to hospitalization, supported by international or cross-sector partners.
3. Co-create national research agendas focused on lived experiences, rights violations, and culturally grounded psychosocial support, ensuring they are developed in collaboration with persons with psychosocial disabilities.

### **Long-Term Goals (5+ years)**

1. Institutionalize cross-sector partnerships in national development and public health strategies, with dedicated funding and long-term resource allocation.
2. Establish regional centers of excellence (hosted by universities or OPDs) to lead on participatory mental health research, training, and innovation.
3. Include psychosocial disability perspective into all major policy frameworks (housing, education, labour, gender, climate resilience) using a disability rights lens, through coordinated inter-ministerial collaboration.

In conclusion,

The conclusion is a re-enforcement to adapting alternative practices to involuntary hospitalization. It is important that the alternative practices to involuntary hospitalization and treatment to reform the system are implemented in accordance with the CRPD and the UN Guidelines on De-institutionalization. It is important that rights of persons with psychosocial disabilities are recognised in the policies and procedures and monitoring mechanisms are established to address the grievances. The Government of Armenia must end all forms of coercive practices and begin its transitioning from institution-based services to community-based services. To transition from long-stay residential systems to community-based systems, it is necessary to adapt to a short-term, mid-term and long-term strategy. The short and mid-term strategy will most entail bringing changes in laws, regulations and policies, assessing the current situation. On the other hand, long-term strategy would include various implementation aspects such as training of workforce, multi-sectoral collaboration, development of monitoring and evaluation frameworks. It is essential to engage persons with psychosocial disabilities, their representative organizations, survivors of institutionalization and forced procedures in all these processes.



**Transforming Communities for Inclusion**