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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Mental health and human rights

Report of the United Nations High Commissioner for Human Rights

Summary

The present report, prepared pursuant to Human Rights Council resolution 52/12, contains an analysis of the main obstacles and challenges in applying a human rights-based approach to mental health. The report also contains recommendations for the integration of a human rights-based approach to mental health.

I. Introduction

1. The present report is submitted to the Human Rights Council in accordance with its resolution 52/12. The United Nations High Commissioner for Human Rights builds on previous reports on mental health and human rights issued by the High Commissioner and other relevant publications.[1]

2. As requested by the Human Rights Council, the High Commissioner organized a one-day consultation, on 23 October 2024, on the challenges and best ways to implement at the local, national and regional levels enabling normative and policy measures for the realization of the human rights of persons with psychosocial disabilities and current or potential users of mental health services.[2] The report contains views shared by experts during the consultation and is prepared on the basis of research carried out by the Office of the United Nations High Commissioner for Human Rights (OHCHR). In addition, the High Commissioner draws upon more than 80 submissions from Member States and other stakeholders.[3]

II. Background

3. The right to health is recognized in several international human rights instruments, including the Universal Declaration of Human Rights (art. 25), the International Covenant on Economic, Social and Cultural Rights (art. 12), the Convention on the Rights of the Child (art. 24), the Convention on the Rights of Persons with Disabilities (art. 25) and the Convention on the Elimination of All Forms of Discrimination against Women (arts. 10 (h), 11 (1) (f) and (2), 12 and 14 (2) (b)). States parties to the International Covenant on Economic, Social and Cultural Rights have the obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights, including the right to health.[4] The same obligations apply as much to mental health as to physical health.[5]

4. Pursuant to international human rights norms and standards, States are obliged to protect, respect and fulfil all economic, social and cultural rights. While the International Covenant on Economic, Social and Cultural Rights does not contain a provision expressly establishing the right to an effective remedy, the Committee on Economic, Social and Cultural Rights has noted that, under article 2 (1) of the Covenant, States parties must take measures to ensure the enjoyment of the rights set forth therein and that this obligation includes the adoption of measures to guarantee access to effective judicial remedies for the protection of the rights recognized in the Covenant.[6]

5. While some progress has been achieved, such as increased awareness and recognition of mental health needs, as well as additional research and technology, experts noted that the overall progress remained uneven, fragmented and inconsistent with the norms and standards of international human rights law, including the right to health.[7] Those gaps are further challenged by a fragmented understanding of a human rights-based approach to mental health, which often leads to stigmatization, discrimination and harmful practices affecting persons engaging with mental health systems. Persons with psychosocial disabilities and users of mental health systems are frequently deprived of legal capacity, which is a

[1] A/HRC/34/32, A/HRC/35/21, A/HRC/41/34, A/HRC/44/48 and A/HRC/49/29. See also https://www.ohchr.org/en/publications/policy-and-methodological-publications/mental-health-human-rights-and-legislation.

[2] See https://www.ohchr.org/en/health/mental-health-and-human-rights.

[3] Submissions are available at https://www.ohchr.org/en/calls-for-input/2024/call-inputs-mental-health-and-human-rights.

[4] Committee on Economic, Social and Cultural Rights, general comment No. 3 (1990), para. 10.

[5] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 4 and 11.

[6] *I.D.G. v. Spain* (E/C.12/55/D/2/2014), para. 11.3; and *Ben Djazia and Bellili v. Spain* (E/C.12/61/D/5/2015), para. 13.4. See also Committee on Economic, Social and Cultural Rights, general comment No. 9 (1999), para. 2.

[7] See A/HRC/35/21.

fundamental cornerstone of human dignity, including with regard to accepting or rejecting treatment, healthcare and admission to hospital, leading to institutionalization in mental health facilities.[8] Their lived experiences have not been sufficiently considered in policy development and implementation. The enjoyment and realization of the right to health, including mental health, is shaped by intersecting factors, such as social class, race, ethnicity, historical discrimination, poverty, inadequate housing, limited education and exposure to violence, conflict or disaster.[9] Addressing those factors needs cross-sectoral interventions outside health systems and in coordination with them.[10] For instance, people living in poverty, working mostly in informal or precarious jobs, are disproportionately affected by mental health conditions while having no or limited resources to cope.[11] Changes in working conditions and moves towards temporary, unstable employment have played a major role in the increase in mental health conditions affecting people on low incomes. Poor working environments – including discrimination and inequality, excessive workloads, low job control and job insecurity – also pose a risk to mental health.[12] In addition, many individuals at the intersection of race, class and gender may be at higher risk of overmedicalization.

6. Access to mental healthcare services remains a major challenge globally. The coronavirus disease (COVID-19) pandemic amplified mental health concerns due to uncertainty, isolation, domestic violence and other factors.[13] The most marginalized and disadvantaged groups, including persons with mental health conditions, bear the brunt of that crisis. Today, a significant majority of those who need mental healthcare lack access to quality mental health services.[14] Stigma, human resource shortages, fragmented service delivery models and a lack of research to inform rights-based policy change and implementation strategies contribute to widening the current global gaps in responding to mental health needs. High costs, lack of insurance coverage and long delays exacerbate the difficulty of receiving timely mental healthcare, including in high-income countries.[15]

7. Globally, mental healthcare services remain focused on a biomedical model, overlooking key social determinants of health, such as cultural diversity, lived experience and social and environmental factors.[16] That focus does not prioritize a holistic response, including community-based healthcare services and psychosocial support. As a result, the systems of mental healthcare are often unable to provide comprehensive responses and support that take into account the complex interplay between mental health and broader social, environmental, educational and economic factors.[17]

8. Gaps remain in policies addressing overlapping types of discrimination, such as those based on race, gender, socioeconomic status or disability, which can create unique barriers to accessing mental healthcare. That worsens systemic inequalities and the risks of human rights violations. Moreover, poor governance, including coordination among health, education and social sectors, prevents comprehensive, holistic services.[18]

[8] A/72/55, annex.
[9] See A/78/185 and A/HRC/41/34.
[10] See A/78/185 and A/HRC/35/21.
[11] See A/79/162.
[12] See https://www.who.int/news-room/fact-sheets/detail/mental-health-at-work.
[13] See https://www.who.int/news-room/feature-stories/detail/the-impact-of-covid-19-on-mental-health-cannot-be-made-light-of.
[14] Milton L. Wainberg and others, “Challenges and opportunities in global mental health: a research-to-practice perspective”, *Current Psychiatry Reports*, vol. 19, No. 5 (May 2017). See also the submission of the United Nations Children’s Fund (UNICEF).
[15] See https://www.thenationalcouncil.org/news/lack-of-access-root-cause-mental-health-crisis-in-america; and https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-10593-0.
[16] World Health Organization (WHO) and OHCHR, *Mental Health, Human Rights and Legislation: Guidance and Practice* (Geneva, 2023).
[17] Ibid., p. 19; and Human Rights Council resolution 52/12.
[18] Submissions of the Centre for Mental Health Law and Policy (India) and the National Commission on Violence against Women (Indonesia).

A. Intersecting forms of discrimination and stigma

9. Discrimination and stigmatization of persons with psychosocial disabilities and users of mental health services remain alarmingly pervasive around the globe.[19] Those challenges manifest in multiple forms, through systematic undue restrictions on their human rights due to barriers that hinder their equal access to the basic services and facilities that they require.[20] According to the World Health Organization (WHO), more than 75 per cent of persons with mental, neurological and substance use disorders in low- and middle-income countries receive no treatment at all.[21]

10. There are unique mental health challenges as a result of biological, social and cultural factors associated with sex and gender. Gender norms, roles and relations, and gender inequality and inequity, affect people's health, including mental health, all around the world. For instance, women and girls are disproportionately affected by gender-based violence, and gender inequality in work and providing unpaid care and support. The understanding of mental health and well-being are culturally bound and influenced by cultural factors, such as beliefs, values and traditions.

11. In some countries, mental health conditions are misconstrued as witchcraft or curses, exposing individuals to violence, and human rights abuses and violations.[22] Women and girls face intersecting forms of discrimination, increasing their risk of being subjected to violence and limiting access to protective networks.[23] Older persons, children, persons with disabilities, ethnic and racial minorities, LGBTIQ+ individuals, migrants and refugees face risks of discrimination and abuse in institutional settings.[24] Refugees and asylum-seekers may also receive inappropriate mental healthcare and support and may not be granted the same coverage or quality of services as citizens of the host country.[25] People living in poverty are often unable to access basic healthcare services because they cannot afford them, which in turn increases vulnerability to violence, compounding any existing physical ailments and exacerbating mental health issues.[26] There is also a correlation between education levels and income and better education generally translates into better physical and mental health.[27]

12. Persons with psychosocial disabilities and users of mental health services are disproportionately exposed to violence and excessive use of force by law enforcement authorities.[28] It has been shown that people of African descent with mental health conditions have been subjected to excessive use of force by police during encounters, exacerbating the risks of injury or even death during arrest.[29]

13. Similarly, persons with psychosocial disabilities and users of mental health systems are disproportionately exposed to criminal justice systems, reflecting multiple vectors of

[19] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. xvii.

[20] Submissions of Morocco; Spain; the National Council for Human Rights (Egypt); the Office of the Public Defender (Georgia); the Commission on Human Rights and Administrative Justice of Ghana; the Office of the Human Rights Advocate (Guatemala); the National Commission on Violence against Women (Indonesia); the National Human Rights Commission of Lebanon; and the Uganda Human Rights Commission.

[21] See https://www.who.int/initiatives/who-special-initiative-for-mental-health.

[22] Submissions of the Kenya National Commission on Human Rights and the Uganda Human Rights Commission.

[23] Submissions of Spain; and the National Commission on Violence against Women (Indonesia).

[24] A/HRC/32/44, para. 40; and A/HRC/54/26, para. 17.

[25] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. 96.

[26] World Bank Group, "Poverty and health", 25 August 2014, available at https://www.worldbank.org/en/topic/health/brief/poverty-health.

[27] A/79/162, para. 12.

[28] See https://www.ohchr.org/en/news/2024/03/experts-committee-rights-persons-disabilities-commend-sweden-its-commitment-committees.

[29] See the conference room paper of the International Independent Expert Mechanism to Advance Racial Justice and Equality in Law Enforcement on its visit to the United States of America, paras. 48 and 49, available on the OHCHR website, at https://www.ohchr.org/sites/default/files/documents/hrbodies/hrcouncil/sessions-regular/session54/A_HRC_54_CRP.7.docx.

discrimination.[30] For instance, the International Independent Expert Mechanism to Advance Racial Justice and Equality in Law Enforcement was alarmed about the fact that a disproportionate number of persons with a current mental health condition or psychosocial disability were incarcerated in prisons and jails in the United States of America: 43 per cent in state prisons[31] and 44 per cent in local jails.[32] Many of those persons are Africans and people of African descent,[33] providing evidence of the fact that racial discrimination exacerbates the criminalization of individuals with psychosocial disabilities. WHO estimates that one third of people in prison in Europe have a mental health condition.

14. Another systemic challenge faced by persons with psychosocial disabilities and users of mental health services is the tendency for law enforcement and criminalization to serve as default responses to public health and social problems, including with regard to housing, education, employment, addiction and mental healthcare.[34] Criminal legislation disproportionately affects persons with psychosocial disabilities or mental health service users. They face overincarceration and severe hardships due to discrimination, stigma, perceived dangerousness, and barriers, such as denial of legal capacity and restricted access to courts and quasi-judicial bodies.[35] At the same time, exposure to the criminal justice system can in itself have a profound impact on mental health.[36] The practice of solitary confinement contributes to the acuity of the mental health crisis in criminal justice systems and can amount to torture or ill-treatment.[37]

15. Persons with lived experience of mental health conditions or psychosocial disabilities often face stigma among health professionals. In a report published in 2021, WHO showed that, in countries with limited oversight of psychiatric practices, persons with mental health conditions were two to three times more likely to experience coercion compared with other groups of people.[38] Those issues are further exacerbated by the denial of legal capacity and lack of effective access to legal protection against practices such as arbitrary detention or other human rights violations.

B. Coercive practices

16. Laws and health practices continue to allow involuntary treatment and institutionalization, affecting, in particular, persons with psychosocial disabilities.[39] Persons with psychosocial disabilities and users of mental health services remain in institutions, confined and subjected to involuntary treatment, often in inhumane conditions, including being chained.[40]

17. The Committee on the Rights of Persons with Disabilities considers that involuntary hospitalization is contrary to articles 12, 13, 14 and 19 of the Convention on the Rights of

[30] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, pp. 21 and 111.
[31] Leah Wang, "Chronic punishment: the unmet health needs of people in state prisons", Prison Policy Initiative, June 2022.
[32] Jennifer Bronson and Marcus Berzofsky, "Indicators of mental health problems reported by prisoners and jail inmates, 2011–12" (Washington, D.C., United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, June 2017).
[33] See the conference room paper of the International Independent Expert Mechanism to Advance Racial Justice and Equality in Law Enforcement on its visit to the United States of America, para. 106.
[34] A/HRC/54/69, para. 27.
[35] Julinda Beqiraj, Lawrence McNamara and Victoria Wicks, *Access to Justice for Persons with Disabilities: From International Principles to Practice* (International Bar Association, 2017).
[36] Miguel Clemente and Dolores Padilla-Racero, "The effects of the justice system on mental health", *Psychiatry, Psychology and Law*, vol. 27, No. 5 (May 2020).
[37] Human Rights Committee, general comment No. 20 (1992), para. 6.
[38] WHO, *Mental Health Atlas 2020* (Geneva, 2021).
[39] Submission of the Indonesia Revolution and Education for Social Inclusion.
[40] See https://www.hrw.org/report/2020/10/06/living-chains/shackling-people-psychosocial-disabilities-worldwide.

Persons with Disabilities.[41] There is insufficient independent oversight and accountability to address the reoccurring violations in the context of compulsory admissions and use of outdated facilities.[42]

18. Institutionalization does not affect only persons with psychosocial disabilities and users of mental health systems but also individuals using drugs, those experiencing homelessness and others.[43]

19. A median of only 2.1 per cent of health budgets globally is allocated to mental health, of which most resources go to psychiatric institutions rather than non-biomedical community-based care.[44] Consequently, community-based care systems are underdeveloped and underutilized. The limited efforts to transition from institutionalization to community-based mental healthcare services and support is hampered by infrastructure limitations, chronic underfunding and resistance within biomedical mental health systems.[45] Those practices often leave persons with psychosocial disabilities or persons with mental health needs behind.

20. Survivors of psychiatric institutionalization have called for recognition, redress and reparations for human rights violations suffered, in line with international human rights law.[46] Past harms and human rights abuses need to be acknowledged and meaningful steps should be taken towards recognition and reparations. That includes but is not limited to restitution and rehabilitation. Those steps should extend beyond financial compensation.[47] It is also essential to prioritize access to community-based care.

21. Another area of concern regarding coercive practices are so-called conversion therapies, including in the context of mental health services. United Nations human rights mechanisms and WHO have expressed concern about such interventions, which are intended to forcibly change the sexual orientation or gender identity of lesbian, gay, bisexual or transgender persons.[48] Such practices, which often target young persons, can include involuntary confinement in psychiatric institutions, the administration of electroshocks and "aversion therapy", resulting in physical and psychological harm. They have been found to be unethical, and in some instances could amount to torture or cruel, inhuman or degrading treatment or punishment, and should be prohibited.[49]

C. Systemic challenges in legislation and policy implementation

22. The vast majority of States have ratified relevant human rights treaties recognizing the right to the highest attainable standard of physical and mental health, including the Convention on the Right of Persons with Disabilities. However, efforts are needed to ensure that international obligations are incorporated into national laws and that competent institutions have the necessary capacity to effectively uphold and enforce these rights.

[41] CRPD/C/KOR/CO/1, para. 29; CRPD/C/DOM/CO/1, para. 27; and CRPD/C/AUT/CO/1, para. 30. See also A/72/55, annex.

[42] Submissions of Health Justice; the Office of the Ombudsman (Argentina); the Office of the Public Defender (Ombudsman) (Georgia); the Commission on Human Rights and Administrative Justice of Ghana; and the National Human Rights Committee (Qatar).

[43] See https://www.ohchr.org/sites/default/files/documents/issues/health/consultation/mentalhealthoct2024/writtenstatements/2024-10-31-stm-doc.pdf (in Spanish).

[44] Submission of UNICEF.

[45] Submissions of Integrative Wellbeing; the Office of the Ombudsman (Argentina); the Centre for Mental Health Law and Policy (India); and the National Commission on Violence against Women (Indonesia).

[46] See also CRPD/C/5.

[47] Statement of the Chair of the Committee on the Rights of Persons with Disabilities at the closing of the panel on deinstitutionalization, Geneva, 18 August 2023, available at https://www.ohchr.org/sites/default/files/documents/hrbodies/crpd/statements/20230911-stm-deinstitutionalization.docx.

[48] A/HRC/29/23, paras. 14, 38 and 52; and A/HRC/44/53.

[49] A/56/156, para. 24; A/HRC/29/23, para. 52; A/HRC/44/53; and CAT/C/CHN/CO/5, paras. 55 and 56.

Several studies and reports highlight the challenges in implementing human rights-based mental healthcare frameworks, particularly in rural and low-resource settings.[50]

23. In many contexts, the rights of persons with psychosocial disabilities are violated, restricting their autonomy, participation and ability to provide free and informed consent. Those restrictions are widely recognized as systemic issues that require alignment with international human rights standards, including the Convention on the Rights of Persons with Disabilities.[51] For instance, many countries have laws that allow forced treatment or institutionalization, under specific circumstances, such as when a person is deemed to be a risk to themselves or others, for example through criteria such as "last resort", "medical necessity" or "incapacity".[52] Those legal exceptions are of concern as they result in restrictions on the rights set forth in the Convention on the Rights of Persons with Disabilities, unduly limiting the autonomy of persons with lived experience, their participation in decision-making processes and their ability to provide consent. Denial of legal capacity, as outlined in the Convention, is one of the main gaps in domestic legislation, critically affecting the enjoyment and exercise of a wide range of human rights, including access to justice, effective remedy and reparation.[53]

24. The American Convention on Human Rights, the African Charter on Human and Peoples' Rights, the Arab Charter on Human Rights and the Association of Southeast Asian Nations Human Rights Declaration all include provisions on the highest attainable standard of physical and mental health. Notably, in its Principles and Guidelines on the Implementation of Economic, Social, and Cultural Rights in the African Charter on Human and Peoples' Rights, the African Commission on Human and Peoples' Rights calls upon States to "Integrate mental health care as far as possible into community health care systems and support persons with disabilities to live independently in the community, rather than in institutions. To this end, enhanced efforts are needed to make appropriate services available, especially to persons living in rural areas and slums, and survivors of conflict."[54]

25. Articles 6, 7 and 8 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Oviedo Convention) establish exceptions to the principle of free and informed consent outlined in article 5 of the same treaty, based on multiple grounds.[55] Since 2014, the Council of Europe has been drafting an additional protocol to the Oviedo Convention entitled "the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment". United Nations human rights mechanisms, civil society organizations and other stakeholders have called for the withdrawal of the current draft protocol, which, in their view, maintains an approach to mental health policy and practice that is based on coercion and is incompatible with contemporary human rights

[50] Submissions of Malaysia, Morocco; the National Commission on Violence against Women (Indonesia); the Office of the Ombudsman (Argentina); the Austrian Ombudsman Board; the Office of the Public Defender (Georgia); the Commission on Human Rights and Administrative Justice of Ghana; Kenya National Commission on Human Rights; the People's Advocate Office of the Republic of Moldova; the National Council for Human Rights (Egypt); and the Uganda Human Rights Commission.

[51] Statements during the consultation on mental health and human rights by Víctor Lizama, member of Red Orgullo Loco Mexico (in Spanish); Richa Sharma-Dhamorikar, Research and Advocacy Officer at Transforming Communities for Inclusion; and Carlos Ríos Espinosa, Associate Director of the Disability Rights Division of Human Rights Watch. See https://www.ohchr.org/en/health/mental-health-and-human-rights. See also the submissions of New Script for Health; and the Global Human Rights Centre.

[52] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, pp. 13, 19 and 53; and Sangeeta Dey and others, "Comparing legislation for involuntary admission and treatment of mental illness in four South Asian countries", *International Journal of Mental Health Systems*, vol. 13, No. 1 (December 2019).

[53] Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014), paras. 9, 15 and 42; and A/HRC/37/56, para. 15.

[54] See https://achpr.au.int/en/node/871.

[55] See https://rm.coe.int/168007cf98.

principles and standards and the rights enshrined in the Convention on the Rights of Persons with Disabilities, particularly in relation to institutionalization.[56]

26. Another concern relates to both the criminalization of suicide and suicide attempts, as well as of drug use, reinforcing stigma and discouraging individuals from seeking help.[57]

D. Access to mental healthcare and support

27. As pointed out, chronic underfunding limits the availability, quality and accessibility of rights-based mental health services globally. It also supports the view that mental health remains a low priority for public financing in most healthcare systems.

28. Timely access to psychosocial support systems is critical. Unaddressed mental health conditions cause more psychological distress, exacerbate physical health problems and necessitate greater use of emergency care and social services, resulting in additional direct and indirect costs[58] across healthcare, social welfare systems and other sectors.

29. Mental health support and human rights-based early and targeted interventions improve the quality of life, economic productivity and the overall resilience of individuals and communities, reducing long-term costs and needs.[59] Consequently, investing in rights-based health systems is also economically more sustainable.[60]

30. States have put in place measures in response to mounting debt burdens and economic crises that have resulted in reduced access to timely and quality care and support systems.[61] Those measures have affected both individuals seeking care and support and those providing it. Health professionals and family caregivers are frequently exposed to mental distress because of systemic precarious conditions and a lack of community-based services.[62]

31. Budget cuts and reductions in mental health budgets and resources have led to increasing numbers of persons with mental health conditions and of those who use drugs coming into contact with the police.[63] They are at a risk of being incarcerated[64] and tend to experience longer periods of incarceration, compared with persons without mental health conditions facing similar charges.[65] In some countries, law enforcement services are the primary responders to health and other social services calls, including those relating to healthcare.[66] In order to break from the criminal justice approach to mental health, it is urgent to adopt alternative responses.

32. School staff around the world lack mental health training, leaving children and adolescents often without adequate and timely healthcare. Consequently, too often youth

[56] See https://www.mentalhealtheurope.org/what-we-do/human-rights/withdraw-oviedo; and https://www.ohchr.org/en/press-releases/2021/05/un-rights-experts-call-council-europe-stop-legislation-coercive-mental.

[57] See A/HRC/56/52.

[58] See https://tpchd.org/wp-content/uploads/2023/12/Unattended-Mental-Health-Impact-on-Society.pdf; and Heather L. Taylor and others, "Economic burden associated with untreated mental illness in Indiana", *JAMA Health Forum* (2023).

[59] Long Khanh-Dao Le and others, "Cost-effectiveness evidence of mental health prevention and promotion interventions: a systematic review of economic evaluations, *PLOS Medicine* (2021).

[60] Organisation for Economic Co-operation and Development (OECD), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, OECD Health Policy Studies (Paris, 2021).

[61] Julia Nadine Doetsch and others, "A scoping review on the impact of austerity on healthcare access in the European Union: rethinking austerity for the most vulnerable", *International Journal for Equity in Health*, vol. 22, No. 3 (2023).

[62] Submissions of the International Association for Hospice and Palliative Care; and Maat for Peace, Development and Human Rights Association.

[63] A/HRC/54/69, para. 34; and A/HRC/56/52, para. 5.

[64] A/HRC/54/69, para. 34; and A/HRC/56/52, para. 5.

[65] A/HRC/54/69, para. 34; and https://www.tac.org/reports_publications/serious-mental-illness-prevalence-in-jails-and-prisons.

[66] A/HRC/54/69, paras. 35–52.

have not been able to access timely, quality mental healthcare, leaving conditions to go unidentified or worsen.[67]

E. Lack of adequate and timely data

33. Globally, data gaps on rights-based mental health hinder a full understanding of the national and global situation, reducing transparency and accountability. Lack of adequate and timely data limits the ability of national authorities and other actors to adopt targeted and tailored measures that respond to the rights and needs of individuals with psychosocial disabilities and other mental health service users.[68] To address current gaps, the collection of comprehensive qualitative and quantitative data is essential and a key component of a human rights-based approach. In the context of rights-based mental health, data collection should focus, inter alia, on resource allocation, disparities in access to rights-based mental healthcare and support, including for the most vulnerable and marginalized and patterns of discrimination. Data should be disaggregated by age, sex, socioeconomic status, disability and other factors, as relevant to the national context.[69] Data collection efforts should apply a human rights-based approach, including, among other requirements, close consultation with organizations that represent persons with psychosocial disabilities, users of mental health services and racial and ethnic minority populations.[70]

34. The collection of data on indicators, such as access to employment, housing and education and the general socioeconomic situation of persons using mental health services, can provide important insights into intersecting forms of discrimination. More granular data should also be collected on the indirect mental health impacts of climate change, migration and economic hardship to inform mental healthcare responses.[71]

F. Limited meaningful participation and inclusion of persons with lived experience

35. Communities and persons with lived experience should be actively involved in the process of shaping policies and legislation on mental healthcare.[72] Meaningful participation helps ensure that policies are better informed by the needs of rights holders and more effective.[73] However, entrenched power asymmetries within many mental health settings have hampered meaningful participation.[74] The involvement of persons with lived experience has too often been shaped by systemic biases, hindering their meaningful participation and ability to influence decisions affecting them.[75] Moreover, families and communities are often excluded from participating in the process of elaboration and implementation of mental health policy and legislation. Resource constraints have limited the ability of States to secure genuine participation.

III. Enabling normative and policy measures to promote a human rights-based approach to mental health

36. Realizing the human rights of persons with psychosocial disabilities and users of mental health services requires enabling normative and policy actions. Those include developing legal frameworks with an inclusive approach; aligning policies with international

[67] A/HRC/51/19, para. 47.
[68] Submissions of Concepts of Truth, Inc; and Patriots for Growth and Development Initiative. See also WHO, *World Mental Health Report: Transforming Mental Health for All* (Geneva, 2022), pp. 51–53.
[69] A/HRC/34/32, para. 36.
[70] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. 86.
[71] Submission of the Special Rapporteur on the promotion and protection of human rights in the context of climate change.
[72] Submission of Integrative Wellbeing.
[73] A/79/162, para. 66.
[74] See A/HRC/35/21.
[75] Submission of Spain.

human rights norms and standards; ensuring access to quality healthcare; addressing stigma and discrimination; and promoting active participation of persons with lived experience in decision-making processes and in their own recovery. Such measures aim to foster equity, respect and empowerment while building systems that uphold dignity and support the autonomy of all individuals.

37. At the same time, external determinants including social, economic and environmental factors, affect mental health systems, and multisectoral efforts outside the mental health system are essential to making progress in implementing a human rights-based approach to mental health. Further research and analysis relating to cross-sectoral strategies to address these issues is essential, but beyond the scope of this report.

A. Policy or legislative reforms

38. Rights-based mental healthcare is approached as an integral part of healthcare for all.[76] Adopting, amending or implementing rights-based legislation at the national levels is key to ensure that mental health policies, systems, services and programmes provide quality human rights and community-based mental healthcare for all. Where national policy measures are in place, it is critical to ensure that they are in line with international human rights law.

39. Broader efforts in civil law reforms on legal capacity and ensuring free and informed consent in health system reforms are essential preconditions for establishing human rights-based mental healthcare.[77] To that end, legislation should provide safeguards and prevent coercion and potential abuses in the use of specific interventions. In that context, it is crucial to create an enabling legal framework for the development of mental health services that respect the rights of all service users and bases all treatment decisions on free and informed consent of the individual.

40. Decriminalization of suicide is an area in which legislative reform is needed.[78] That could help to reduce stigma, encourage those contemplating suicide to seek timely psychosocial support and facilitate a more accurate collection of suicide-related statistics for better informed policy responses.[79] Examples of collaboration among and within national, regional and international stakeholders to foster policy exchange and suicide prevention and to seek guidance on policy and legislative development are commendable, but these efforts need to be grounded in human rights.[80]

41. In some locations, legislative reforms are under way to abolish guardianships, focusing on supported decision-making models for mental healthcare[81] or to prohibit the creation of new psychiatric institutions in an effort to shift towards community-based mental healthcare.[82]

42. Broader efforts to expand mental healthcare are needed. Of note in that regard is the European Commission's updating of its comprehensive approach to mental health in May 2024, which put mental health on a par with physical health. Among other elements, the policy focuses on access to quality and affordable mental healthcare and reintegration into society.[83] To that end, the European Union has been introducing 20 flagship initiatives and committed €1.23 billion in funding from different financial instruments.

[76] A/HRC/35/21, para. 54.
[77] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, pp. 22–27.
[78] Submissions of the Centre for Mental Health Law and Policy (India); Integrative Wellbeing; the People's Advocate Office of the Republic of Moldova; and the Office of the Ombudsman (Portugal).
[79] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. 75.
[80] Submissions of Uruguay; the Commission on Human Rights and Administrative Justice of Ghana; the Office of the Human Rights Advocate (Guatemala); and the Ukrainian Parliament Commissioner for Human Rights.
[81] See https://govern.cat/salapremsa/acords-govern/14321/govern-incorpora-al-codi-civil-catala-figura-lassistencia (in Catalan).
[82] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. 93.
[83] See https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/promoting-our-european-way-life/european-health-union/comprehensive-approach-mental-health_en.

B. Community-based services

43. Prioritizing community-based approaches is critical to effectively address mental health in line with international human rights law. Some countries, cities and regions have been making efforts towards a gradual transition from centralized psychiatric institutions towards community-based and person-centred mental health services.[84] The city of Trieste, in Italy, for instance, has four community mental health centres and health professionals engage closely with family members, housing support, further training or education, and work placements. Those efforts are carried out in collaboration with persons with lived experience themselves.[85] In Ukraine, community mental health teams have been strengthened in the context of armed conflict in order to address mental health needs more holistically.[86]

44. In some local contexts, the collaboration among local governments, community health promoters and mental health advocates, with the involvement of persons with lived experience, has fostered inclusive, community-oriented mental healthcare models. In India, a programme has exemplified community-based mental healthcare by training community members to provide mental health support, aligning traditional self-care practices with professional mental health strategies.[87] Such forums in which the community members are able to align their knowledge on mental health with their own self-care practices, outreach methods and support providers have proven effective.

45. Community-based models exemplify rights-based mental healthcare by prioritizing autonomy and social inclusion. For instance, the Gerstein Crisis Centre in Canada has been providing non-coercive crisis intervention services, such as 24/7 telephone support, mobile crisis teams, community support referrals, substance use crisis management, follow-up and access to short-term crisis beds.[88] Other community-based programmes leverage technology and community engagement to enhance access to mental healthcare and reduce stigma, such as the Atmiyata community volunteer service in India.[89] It provides psychosocial support and mental health services across six districts. In Brazil, the psychosocial care centres are the bedrock of the country's community-based mental health network, providing specialized services that are integrated at the primary mental healthcare level.[90]

46. Some community inclusion models apply a holistic focus on self-care, nutrition, fitness, family empowerment, skill-building, livelihood support, peer assistance and facilitating access to mainstream community services. To encourage community-based living and reduce restrictive environments, conflict resolution is prioritized and spaces for dialogue are created, preventing institutionalization, and transforming a community's psychosocial ecosystem.[91] A community-based housing model in India supports women in transitioning

[84] Submissions of Albania; Malaysia; Slovenia; Spain; Türkiye; the Office of the Human Rights Advocate (Guatemala); the Slovak National Centre for Human Rights; and the Uganda Human Rights Commission.

[85] See https://www.who.int/europe/news-room/19-12-2023-central-asian-countries-seek-secrets-to-success-in-community-based-mental-health-reform-from-trieste--italy.

[86] See https://www.who.int/europe/news-room/12-03-2024-reaching-patients-with-severe-mental-health-disorders--who-hands-over-12-vehicles-for-community-health-providers-in-ukraine.

[87] See https://reachalliance.org/case-study/atmiyatas-volunteer-led-approaches-to-addressing-mental-health-in-rural-india.

[88] See https://gersteincentre.org.

[89] Statement made at the consultation on mental health and human rights by Soumitra Pathare, Director of the Centre for Mental Health Law and Policy (India), available at https://www.ohchr.org/sites/default/files/documents/issues/health/consultation/mentalhealthoct2024/session1-segment2/Promising-initiatives_Soumitra-Pathare.docx; and https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y, p. 118.

[90] WHO, *Guidance on Community Mental Health Services: Promoting Person-centred and Rights-based Approaches* (Geneva, 2021), pp. 61–64.

[91] Statement made at the consultation on mental health and human rights by Ms. Sharma-Dhamorikar, Transforming Communities for Inclusion.

from psychiatric institutions[92] and an initiative in France consists of local councils for mental health that have been established in regional governments.[93] They reunite representatives of mental health service users and professionals, and elected representatives in order to implement and improve local mental health policies.

47. Community-based mental health initiatives also include 24/7 adolescent support services and hotlines, providing immediate access to assistance and care. Moreover, community networks play a vital role in fostering inclusive cultural and artistic engagement. Anti-stigma campaigns enhance those efforts by recruiting activists and sharing the stories of individuals with lived experience, reducing prejudice.[94] In some countries, crisis intervention strategies have been integrated into suicide prevention and broader mental health plans, offering timely and multidisciplinary support. Tele-counselling, and post-crisis care have been put in place to provide immediate, interdisciplinary support for individuals in need.[95] Furthermore, mental health services are increasingly made accessible through digitalization, which can be particularly beneficial in low-income settings in which healthcare delivery systems face constraints.[96]

48. In post-conflict contexts, the inclusion of mental health interventions in national strategies and the provision of long-term support related to trauma is essential, although often not prioritized and significantly underresourced.[97] Some national policies have integrated mental healthcare into broader reconciliation efforts and have used a community-based model.[98] Local counsellors have been trained and both individual healing and societal cohesion prioritized. In other contexts, mobile teams were deployed to identify and address the mental health needs of displaced populations, facilitating access to relevant services.[99]

49. For children and youth, it is crucial to have access to a range of mental health services in schools and in the community. Some States have responded to the post-COVID-19 mental health crisis by establishing school counselling programmes with the aim of strengthening early intervention, leading to positive results.[100]

C. Enhancing accountability through independent monitoring and oversight

50. Groups in a marginalized situation – such as those from low socioeconomic origins, minorities or migrants – frequently lack protection under mental health laws.[101] That may result in mistreatment in "therapeutic communities" and "prayer camps", in which shackling

[92] Submission by the Centre for Mental Health Law and Policy (India); and https://www.mhinnovation.net/innovations/home-again-housing-supportive-services-women-mental-illness-experiencing-long-term-care.

[93] Article L3221-2 of the Public Health Code of France, available at https://www.legifrance.gouv.fr/codes/article_lc/LEGIARTI000006687966/2011-08-01 (in French); and submission of Fundación para la Democracia Internacional.

[94] Statement made at the consultation on mental health and human rights by Magda Casamitjana Aguilà, Director of the National Mental Health Pact of Catalonia, Department of the Presidency of the Generalitat de Catalunya, available at https://www.ohchr.org/sites/default/files/documents/issues/health/consultation/mentalhealthoct2024/session1-segment2/M-CASAMITJANA.pdf (in Spanish).

[95] Submissions of Ecuador; El Salvador; Malaysia; and the National Human Rights Commission of Lebanon.

[96] Janos L. Kalman and others, "Digitalising mental health care: practical recommendations from the European Psychiatric Association", *European Psychiatry*, vol. 67, No. 1 (2024).

[97] Chesmal Siriwardhana and others, "Integrating mental health into primary care for post-conflict populations: a pilot study", *International Journal of Mental Health Systems*, vol. 10, No. 1 (December 2016). See also the submission of the American University of Paris Working Group on Human Rights.

[98] See https://www.thinkglobalhealth.org/article/mental-health-care-rwanda-three-decades-resilience.

[99] Submission of Armenia.

[100] Commissioner for Children and Young People in Scotland, "Mental health: counselling in schools" (Edinburgh, 2023).

[101] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. 14.

and incarceration are practised, even if they are illegal. Structural discrimination and insufficient State oversight often leave those groups without access to justice, while fear of law enforcement further reinforces exclusion. Persistent human rights violations, including compulsory admissions and the use of outdated facilities, are compounded by a lack of independent oversight and accountability.[102]

51. Accountability for the enjoyment of the right to mental health 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) effective remedies and full reparation.[103] Countries can establish accountability mechanisms relating to mental health through legislation, which is central to monitoring and improving mental health systems and services.

52. Those mechanisms should ensure access to justice and the right to an effective remedy. In particular, the ability to file complaints and seek redress should be available to those interacting with mental health services. In some countries, courts have played a helpful role in upholding the rights of persons with psychosocial disabilities and users of mental health services through progressive rulings and judicial reforms.[104]

53. The Convention on the Rights of Persons with Disabilities establishes that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities (art. 16 (3)). That obligation also applies to health-related facilities and programmes. Inter-disciplinary supervisory commissions composed of representatives of the Government, academia, mental health workers, organizations of persons with disabilities and organizations of family members are an example of oversight mechanisms[105] and mental health boards, which ensure compliance with human rights standards.[106] Countries may have different frameworks to monitor the rights of persons using mental health services, such as mental health review bodies, national human rights institutions and national preventive mechanisms, among others. The involvement of persons with lived experience in decisions and processes affecting them, including in the design and implementation of accountability and oversight mechanisms, remains weak, demonstrating the need for increased efforts in this area.[107]

D. Addressing stigma and raising awareness

54. In many countries, stakeholders are actively promoting a holistic rights-based approach to health. They are working to prevent social exclusion and promoting equality in employment, healthcare and education for persons with psychosocial disabilities and current or potential users of mental health services.

55. Some States have led public mental health awareness-raising campaigns to reduce stigma and to prevent suicide.[108] Civil society and other organizations have raised awareness about the rights of persons with lived experience.[109] In Sri Lanka, Nidhas Chinthana Sansadaya, a consumer action forum, connects marginalized individuals in communities with mental health practitioners, thereby promoting local solutions.[110]

[102] Submissions of Health Justice; the Office of the Ombudsman (Argentina); the Office of the Public Defender (Georgia); the Commission on Human Rights and Administrative Justice of Ghana; and the National Human Rights Committee (Qatar).

[103] A/HRC/35/21, para. 51.

[104] Submission of the Kenya National Commission on Human Rights.

[105] Submission of Uruguay.

[106] Submission of the Kenya National Commission on Human Rights.

[107] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. 101.

[108] Submissions of El Salvador; Malaysia; Mauritius; Montenegro; Saudia Arabia; Türkiye; the Kenya National Commission on Human Rights; the Oman Human Rights Commission; and the National Human Rights Committee (Qatar).

[109] Submission of the National Commission on Violence against Women (Indonesia).

[110] See https://www.mhinnovation.net/organisations/nidhas-chinthana-sansadaya-consumer-action-forum.

56. With climate change-related mental health risks on the rise, some States have integrated mental health and psychosocial support into practical disaster preparedness. Some countries have put in place coordination mechanisms and emergency preparedness and response plans to address mental health and psychosocial needs in the event of climate-related emergencies.[111] In Australia, Bangladesh, Burkina Faso, Haiti and India, community resilience has been strengthened by promoting mental health education and improving climate literacy. In some contexts, mental health applications have been designed for adolescent survivors of wildfires, which are released in tandem with media campaigns to raise post-disaster mental health awareness, destigmatize help-seeking and promote available resources.

E. Integrating culturally appropriate practices

57. Particularly in countries in which the quality of services is poor or not available, individuals and their families tend to seek alternative practices to mental healthcare, such as the support of religious leaders, shamans or alternative therapists.[112]

58. Incorporating alternative and Indigenous mental health practices into mainstream mental healthcare models can provide culturally appropriate and effective support if these practices are fully compatible with human rights standards.[113] The Indigenous concept of *buen vivir* (living well) as applied in some Latin American countries emphasizes community, dignity and harmony with nature, inspiring mental health reforms that prioritize cultural relevance.[114] That and other approaches promote paradigms that seek social transformation by integrating traditional values and practices into mental health policy, creating more inclusive and effective mental healthcare models.

F. Integration of mental health into primary healthcare

59. Mental health services should be accessible and available to all at the primary and specialized care levels.[115] Integrating mental health into primary healthcare is an effective strategy for improving access for underserved populations and ensuring that anyone can access mental health services at an early stage and near to their homes and communities.[116] A promising development in that regard is the intensified effort to integrate mental healthcare services into primary healthcare, making these services more affordable, acceptable, destigmatizing, holistic and culturally appropriate. In Armenia, mental health services have been integrated into primary healthcare systems for internally displaced persons and host communities.[117] In Zimbabwe, lay counsellors offer support to persons with lived experience as part of the "Friendship Bench". That community outreach service has been implemented nationwide as part of the country's public primary health services.[118]

60. In some States, comprehensive strategies and service networks have improved access to mental healthcare, particularly in response to the increased demand following the COVID-19 pandemic. Legislation has also played a key role, supporting the introduction of mental health interventions, services and support at the primary healthcare level, in alignment with the principle that mental health should be of equal importance to physical health.

[111] Submission of the Special Rapporteur on the promotion and protection of human rights in the context of climate change.

[112] Muhammad Arsyad Subu and others, "Types of stigma experienced by patients with mental illness and mental health nurses in Indonesia: a qualitative content analysis", *International Journal of Mental Health Systems*, vol. 15, No. 1 (December 2021).

[113] Submission of the Kailash Union.

[114] Statement made at the consultation on mental health and human rights by Mr. Lizama.

[115] A/HRC/35/21, para. 78.

[116] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. 88.

[117] See https://www.who.int/about/accountability/results/who-results-report-2020-mtr/country-story/2023.

[118] See https://www.friendshipbenchzimbabwe.org.

61. While those measures are relevant, they are insufficient to guarantee that all individuals in need have access to comprehensive, rights-based mental health services. Concerted efforts are necessary to ensure that interventions offered in primary care are aligned with a rights-based approach. Persistent and substantial challenges to achieving universal access to primary healthcare must also be addressed.

G. Addressing the social determinants of mental health

62. The social determinants of health refer to the broader, non-biological factors that influence health outcomes, including the environmental, social, economic and political conditions in which individuals live, shaped by the distribution of resources, policies and societal structures.[119] Action within the economic, social and justice sectors is needed to address those determinants, for example through anti-discrimination and equal opportunity strategies, community-based support and social protection systems, housing, employment, climate change action, and the promotion of community structures that increase social recognition and the support of diversity.[120]

63. There are promising initiatives that aim at promoting the inclusion of persons with lived experience in the workplace by providing vocational and other capacity-building programmes. Such training initiatives build or strengthen participants' skills in the areas of income generation or job applications. Israel, Switzerland and Thailand have carried out community-based mental health rehabilitation services. Bicycle mechanics, culinary skills and public speaking facilitate access to employment.[121] In some countries, multiple stakeholders have trained mental health professionals on the application of a human rights-based approach and on community-based mental health service provision.

64. Peer support programmes play a critical role in addressing the social determinants of health by fostering connection, reducing stigma and providing access to resources that influence mental health and well-being.[122]

65. Such programmes have proven successful in empowering persons with lived experience. For example, the Uganda National Self-Advocacy Initiative organizes peer support groups in collaboration with local leaders to provide assistance regarding housing, employment and social support.[123] Other States facilitate outpatient services, home visits and digital platforms for remote access to services.

66. In some settings, associations have facilitated the active participation of persons with lived experience in planning and implementing policies and other initiatives.[124] Globally, however, the meaningful participation of mental health service users and their families in policy development and decision-making processes has been insufficient and mostly limited to health promotion and awareness-raising rather than involvement in higher-level decision-making.[125]

67. During financial and economic crises, austerity measures, including the adoption of retrogressive measures, should only be adopted when it is unavoidable. Those measures should be necessary and proportionate, and in line with international human rights obligations,[126] including the right to health. That includes paying more attention to the human

[119] See https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
[120] WHO and OHCHR, *Mental Health, Human Rights and Legislation*, p. 23.
[121] See https://www.enosh.org.il/english; and https://iris.who.int/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1.
[122] Prashant Shekhar Tripathi, "Peer support programs in mental health nursing: harnessing lived experience for recovery", *BRIO International Journal of Nursing Research*, vol. 5, No. 1 (2024).
[123] Statement made at the consultation on mental health and human rights by Ms. Sharma-Dhamorikar, Transforming Communities for Inclusion.
[124] Statement made at the consultation on mental health and human rights by Ms. Casamitjana Aguilà.
[125] Teresa Hall and others, "Service user and family participation in mental health policy making in Timor-Leste: a qualitative study with multiple stakeholders", *BMC Psychiatry*, vol. 20, No. 117 (2020).
[126] See E/C.12/2016/1.

rights of family caregivers,[127] and to the protection of just and favourable conditions of work for care and support workers. Their needs are often overlooked while they are regularly exposed to mental distress.[128]

IV. Conclusions and the way forward

68. **Systemic reform of mental health systems is urgently needed, prioritizing a human rights-based approach. That involves a transition away from a narrow emphasis on biomedical approaches towards a more holistic and inclusive understanding of mental health and, therefore, a transition to community-based mental healthcare and support is essential. It requires changes in legislation and policies, shifting from institutionalization to community-based mental healthcare and properly resourcing community-based mental healthcare alternatives to institutionalization.**

69. **Legislative reform efforts need to be accompanied by efforts to address stigma and discrimination, expand access to human rights-based mental healthcare and support, and build a stronger foundation for work in this area based on disaggregated data. Underlying all of those initiatives should be a fundamental commitment to ensuring the meaningful participation of persons with psychosocial disabilities, those with lived experience and users of mental health services in the process of policymaking relating to these issues.**

70. **Adequate funding and cross-sectoral collaboration are critical for fostering sustainable human rights and community-based mental health services. An intersectional approach is needed to address compounded discrimination based on race, socioeconomic status, sexual orientation, disability, gender identity and others that persons with mental health conditions face. Those factors significantly affect mental health outcomes.**

71. **To achieve those ends, a substantial expansion of financial resources for human rights-based mental health approaches is needed, particularly in lower- and middle-income countries. Donors and international development partners should support the countries in need, and there is a greater need for international cooperation to ensure that rights-based mental health systems are properly funded. Such support is urgently needed to enable countries to transition from institutionalization to community-based and rights-based mental healthcare. Broader efforts to create fiscal space to provide the maximum available resources with the view to achieving progressively the full realization of economic, social and cultural rights are needed, including ensuring an adequate standard of living, just and favourable work conditions, housing and access to education.**

72. **Collecting granular data and conducting in-depth analysis to empower historically marginalized groups to realize their right to health is similarly crucial. The role of data is fundamental in achieving parity between physical and mental health demands, including the integration of mental healthcare into primary and general healthcare systems, with the active participation of all stakeholders in shaping public policies.**

73. **OHCHR stands ready to support efforts to implement a human rights-based approach to mental health. Further research and efforts in this area could include consultations across five regions with States, regional intergovernmental bodies, human rights experts and civil society organizations to gather evidence, understand challenges**

[127] Committee on the Rights of Persons with Disabilities, general comment No. 5 (2017), para. 67; and A/HRC/52/32, para. 97 (f).

[128] Submissions of the International Association for Hospice and Palliative Care, Inc; and Maat for Peace, Development and Human Rights Association. See also Edward Cruz and others, "Caring for the caregiver: an exploration of the experiences of caregivers of adults with mental illness", *SSM – Qualitative Research in Health*, vol. 5 (2024).

and gather lived experiences. Such consultations could help OHCHR provide tailored support for Governments and policymakers to incorporate rights-based approaches into mental health systems. OHCHR is also working with WHO to disseminate guidance on mental health, human rights and legislation. Further support for those areas of work will be needed to address the major gaps and challenges identified in the present report.

V. Recommendations

74. **The High Commissioner underscores the urgent need to adopt a human rights-based approach to mental health as a fundamental element of the right to the highest attainable standard of health under international human rights law. In the report, the High Commissioner also recognizes the importance of ensuring coherence and synergy among initiatives taken by Governments and other national and international levels to strengthen the integration of human rights into mental health frameworks.**

75. **The High Commissioner recommends that States and other stakeholders:**

(a) **Ensure that national legislation on mental health is fully compatible with international human rights norms and standards. When appropriate, legislation reform and harmonization should serve as a vehicle for promoting the exercise of rights and social inclusion**;

(b) **Consider the adoption of legal, policy and institutional reforms on the following structural issues as a matter of priority:**

(i) **Shift the paradigm from punitive approaches to health- and human rights-centred measures, decriminalizing suicide and drug use and possession for personal use, providing alternatives to incarceration; and address stigma and introduce timely access to care and support. That includes implementing a restorative approach that focuses on providing community-based mental healthcare rather than punishment**;

(ii) **Ensure that free and informed consent is the basis of all mental health-related interventions, recognizing that the ability of individuals to make decisions about their own healthcare and treatment choices is an essential element of the right to health. Consequently, end coercive practices in mental health, including involuntary commitment, forced treatment, seclusion and restraints in order to respect the rights of persons using mental health services. Ensure that all mental healthcare systems respect the autonomy and informed consent of persons with psychosocial disabilities and users of mental health services, in accordance with international human rights law;**

(iii) **Take steps, to the maximum of their available resources, with a view to ensuring that mental health services are available, affordable, accessible, equitable and culturally appropriate, including for groups in marginalized or vulnerable situations;**

(iv) **Adopt protocols and training programmes that provide holistic responses in case of non-violent mental health situations, through crisis teams of mental health professionals, social workers and peer specialists. Any law enforcement responses, including the use of force and deprivation of liberty, should be exceptional and in full compliance with international human rights law and standards;**

(c) **Prioritize shifting from institutional mental healthcare to community- and rights-based mental healthcare and support services that emphasize recovery, self-determination and societal integration;**

(d) **Integrate community-based, peer-led interventions that are culturally appropriate in mental healthcare initiatives. Allocate sufficient resources for mental health, in particular for community-based mental healthcare and support. Take into**

account the needs of persons in rural areas, low-income communities and marginalized populations;

(e) **Carry out national campaigns to combat mental health stigma by including the voices of those with lived experience and promote societal awareness and understanding;**

(f) **Ensure that law enforcement, health professionals, policymakers and community leaders receive targeted training to address biases, adopt rights-based approaches, and combat stigma and abuse, as required under international human rights law. Develop comprehensive programmes focusing on the needs of women, children, persons with disabilities, youth, LGBTIQ+ individuals, refugees and minorities to promote equity and inclusivity;**

(g) **Implement non-contributory social benefit programmes for persons with mental health conditions, with a view to addressing systemic inequities and to ensuring an adequate standard of living, in line with international human rights standards;**

(h) **Establish robust systems for disaggregated data collection on mental health, taking into consideration intersections with race, gender and socioeconomic factors, and address disparities;**

(i) **Establish reparative justice mechanisms for survivors of coercive mental health practices, including financial compensation, public apologies, and community-led oversight, consistent with the principles of justice and reparations under international human rights law.**