

# Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors



World Health Organization



Guidance on policy and strategic actions  
**to protect and promote mental health  
and well-being across government sectors**



**World Health  
Organization**

Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors  
(Mental health and well-being across government sectors)

ISBN 978-92-4-011438-8 (electronic version)  
ISBN 978-92-4-011439-5 (print version)

© World Health Organization 2025

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules/>).

**Suggested citation.** Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors. Geneva: World Health Organization; 2025 (Mental health and well-being across government sectors).  
Licence: [CC BY-NC-SA 3.0 IGO](https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

**Cataloguing-in-Publication (CIP) data.** CIP data are available at <https://iris.who.int/>.

**Sales, rights and licensing.** To purchase WHO publications, see <https://www.who.int/publications/book-orders>.  
To submit requests for commercial use and queries on rights and licensing, see <https://www.who.int/copyright>.

**Third-party materials.** If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

**General disclaimers.** The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Design and layout: Jennifer Rose Fivefold Studio

Cover images ©iStockphoto; image credits are listed throughout the report.

# Contents

- Foreword..... viii**
- Acknowledgements ..... ix**
- Glossary ..... xii**
- Executive summary ..... xvi**
- Introduction..... 1**
- The Sustainable Development Goals (SDGs): the economic, human rights and development imperatives for addressing mental health..... 2**
- A whole-of-government approach to advancing mental health and well-being ..... 5**
- Development, implementation and evaluation of a whole-of-government approach ..... 7**
  - Cross-cutting principles..... 7
  - Requirements for policy development, implementation and evaluation ..... 8
  - Eight process steps ..... 9
- Purpose, scope, use and development of the Guidance ..... 12**
  - Purpose ..... 12
  - Scope..... 13
  - Using the Guidance..... 13
  - Development ..... 14
- Government-led cross sectoral mental health initiatives..... 19**
  - Overview ..... 20
  - Policy directive WG1** Prioritize mental health in the political agenda..... 23
  - Policy directive WG2** Provide leadership and accountability for national progress on mental health ..... 26
  - Policy directive WG3** Ensure financial commitment and appropriate budgeting for mental health..... 28
- Mental health and the culture, arts, and sport sector ..... 31**
  - Overview ..... 32
  - Policy directive CAS1** Use cultural heritage and culturally-based approaches to address the challenges affecting community mental health and well-being..... 34
  - Policy directive CAS2** Promote cultural and artistic activities to enhance social inclusion, mental health and well-being and raise awareness of mental health issues ..... 37
  - Policy directive CAS3** Support and encourage participation in sports and physical activities to promote mental health and well-being ..... 39

<b>Mental health and the defence and veterans sector .....</b>	<b>45</b>
Overview .....	46
<b>Policy directive DV1</b> Implement measures to prevent harassment, violence and abuse and fight stigma and discrimination .....	47
<b>Policy directive DV2</b> Address mental health issues and promote well-being for service members, veterans, and their families.....	50
<b>Policy Directive DV3</b> Provide a range of social benefits and community supports for veterans and families ...	56
<b>Mental health and the education sector.....</b>	<b>61</b>
Overview .....	62
<b>Policy directive Ed1</b> Implement system-level reforms to create safe environments, promote inclusion, non-discrimination, and mental health and well-being .....	63
<b>Policy directive Ed2</b> Create enabling environments and cultures in educational settings that promote inclusion, social emotional learning, life skills, mental health and well-being.....	68
<b>Policy directive Ed3</b> Provide all students and staff with a range of accessible and high-quality mental health and psychosocial support .....	71
<b>Mental health and the employment sector .....</b>	<b>73</b>
Overview .....	74
<b>Policy directive Em1</b> Promote inclusion, prevent discrimination, and uphold respect for human rights .....	76
<b>Policy directive Em2</b> Assess, prevent, and manage occupational risk factors in workplace environments across organizations, businesses, and enterprises.....	79
<b>Policy directive Em3</b> Develop employee and workplace cultures that foster mental health and well-being .....	81
<b>Policy directive Em4</b> Encourage and facilitate early help-seeking when workers experience emotional difficulties; and support their recovery.....	84
<b>Mental health and the environment, conservation, and climate protection sector .....</b>	<b>87</b>
Overview .....	88
<b>Policy directive ECC1</b> Enhance mental health considerations in leadership on protecting the environment and addressing climate change .....	90
<b>Policy directive ECC2</b> Implement measures to protect the environment, address climate change and foster mental health and well-being .....	93
<b>Policy directive ECC3</b> Collaborate with the mental health sector to create sustainable services and address climate and environmental challenges .....	96
<b>Policy directive ECC4</b> Collaborate with local communities to address mental health issues related to the environment and climate change.....	98
<b>Mental health and the health sector .....</b>	<b>101</b>
Overview .....	102
<b>Policy directive H1</b> Strengthening governance on mental health .....	103
<b>Policy directive H2</b> Make comprehensive mental health services and support an integral part of the health system .....	107
<b>Policy directive H3</b> Introduce and focus on mental health training for the general health service workforce .....	114

<b>Mental health and the interior sector .....</b>	<b>119</b>
Overview .....	120
<b>Policy directive Int1</b> Reform the roles of law enforcement and emergency responders who intervene in mental health crises.....	121
<b>Policy directive Int2</b> Promote mental health and well-being among police forces, fire services and other first responders .....	125
<b>Policy directive Int3</b> Protect and promote the mental health of migrants, refugees and asylum seekers.....	126
<b>Policy directive Int4</b> Take a multi-sectoral approach to mental health and psychosocial support in humanitarian crises and disasters .....	130
<b>Mental health and the justice sector.....</b>	<b>137</b>
Overview .....	138
<b>Policy directive J1</b> Implement comprehensive legal and policy reforms to promote access to justice and protect human rights.....	140
<b>Policy directive J2</b> Establish mechanisms to monitor rights violations and discrimination and provide pathways for redress and reparations.....	145
<b>Policy directive J3</b> Protect and promote mental health for people in custody and incarceration, as well as for staff.....	147
<b>Policy directive J4</b> Provide good-quality and rights-based mental health services and support for people imprisoned and in custody, and for staff in these detention facilities .....	151
<b>Policy directive J5</b> Facilitate community integration for people leaving jails, prisons and forensic facilities.....	153
<b>Mental health and the social protection sector.....</b>	<b>157</b>
Overview .....	158
<b>Policy directive SP1</b> Promote equal opportunities and social inclusion in order to protect and promote mental health.....	159
<b>Policy directive SP2</b> Implement measures to tackle poverty.....	162
<b>Policy directive SP3</b> Develop employment schemes and benefits to protect individuals throughout their lives including during crises .....	164
<b>Policy directive SP4</b> Build schemes to provide social care and mental health support.....	166
<b>Mental health and the urban and rural development sector .....</b>	<b>173</b>
Overview .....	174
<b>Policy directive UR1</b> Create safe, affordable and accessible housing.....	175
<b>Policy directive UR2</b> Create healthy, safe and inclusive environments that foster mental health and well-being in urban and rural areas.....	179
<b>Policy directive UR3</b> Planning that fosters community engagement, access to services, mental health awareness, and overall inclusion .....	182
<b>References.....</b>	<b>188</b>

# Foreword

This guidance is grounded in the principle that every sector has a role to play in protecting and promoting mental health. Whether in health; culture, arts and sport; defence and veterans; education; employment; the environment; the interior; justice; social protection; or urban and rural development, the choices made by leaders and institutions shape the environments in which people live and, in turn, the mental health of individuals and communities. And yet, mental health remains neglected, not only in health, but across many areas of government.

The cost of neglect is high. It undermines individual well-being, family stability, societal cohesion, and economic performance. By contrast, investing in mental health delivers wide-ranging benefits, boosting economic productivity, strengthening communities, improving well-being, and building more equitable and resilient societies.

A fundamental shift is needed: from viewing mental health as the sole responsibility of the health sector, to recognizing it as a shared priority across many sectors of government. This means actively embedding mental health considerations into sectoral policies, planning, and decision-making, from how programmes are designed, implemented and evaluated, through to how people are supported, included, and empowered.

This guidance, available as both an integrated whole and as sector-specific documents, provides a practical roadmap for action. It outlines evidence-based, rights-oriented, and equity-driven policy directions and strategic actions that each sector can adopt and adapt, whether individually or through coordinated, cross-sectoral collaboration.

In doing so, this guidance aims to catalyze lasting change, helping to bring mental health from the margins to the mainstream of public policy and making it a core priority in building healthier, fairer, and more resilient societies.



**Dr Tedros Adhanom Ghebreyesus**  
**Director-General**  
**World Health Organization**

# Acknowledgements

The development and coordination of this guidance was led by **Michelle Funk**, with the support of **Déavora Kestel**, of the Department of Mental Health, Brain Health and Substance Use of the World Health Organization (WHO).

## Writing team

This publication was written by **Michelle Funk**, **Natalie Drew Bold**, **Celline Cole**, and **Maria Francesca Moro**, Unit of Policy, Law and Human Rights in the Department of Mental Health, Brain Health and Substance Use (WHO).

## External contributors and reviewers

**Neid Acubo**, Department of Chronic Noncommunicable Diseases, Ministry of Health, Maputo, Mozambique; **Abdulhameed Alhabeeb**, National Center for Mental Health Promotion, Ministry of Health, Riyadh, Saudi Arabia; **Lujain Almubarak**, National Center for Mental Health Promotion, Ministry of Health, Riyadh, Saudi Arabia; **Mazeed Alosimi**, National Center for Mental Health Promotion, Ministry of Health, Riyadh, Saudi Arabia; **Celeste Amado**, Department of Chronic Noncommunicable Diseases, Ministry of Health, Maputo, Mozambique; **Rosanny Ángeles**, Department of Mental Health, Ministry of Public Health and Social Assistance, Santo Domingo, Dominican Republic; **Yutika Anindya**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Gina Anindyajati**, Indonesian Psychiatric Association, Indonesia; **Steven Appleton**, Global Leadership Exchange, the United Kingdom; **Husni Arbie**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Yunita Arihandayani**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Gregory Armstrong**, Nossal Institute for Global Health, University of Melbourne, Australia; **Sudi Astono**, Directorate of Labour Development and Supervision, Ministry of Manpower, Jakarta, Indonesia; **Nouf Bahattab**, General Directorate of the Mental Health and Social Services, Ministry of Health, Riyadh, Saudi Arabia; **Edita Bishop**, Mental Health Division, Ministry of Health, Vilnius, Lithuania; **Camille Boostrom**, Mental Health, Health Research Board, Government of Ireland, Dublin, Ireland; **Marit Borg**, World Association for Psychosocial Rehabilitation, and University of South-Eastern Norway, Drammen, Norway; **Liz Brosnan**, Recovery Experts by Experience, Galway, Ireland, and European Network of (Ex-)Users and Survivors of Psychiatry, Ireland; **Astuti Burhan**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Tina Camelia**, Directorate of Social Rehabilitation Service for Persons with Disabilities, Ministry of Social Affairs, Jakarta, Indonesia; **Tristan Carbuccia**, Ministry of the Interior and the Police, Santo Domingo, Dominican Republic; **Cristina Carreno**, Médecins sans Frontières, Barcelona, Catalonia, Spain; **Catherine Carty**, Munster Technological University, Tralee, Ireland; **Magda Casamitjana i Aguilà**, National Mental Health Pact of Catalonia, Catalonia, Spain; **Fatma Charfi**, Suicide Prevention Technical Committee, Ministry of Health, Tunis, Tunisia; **Cornelius Christiansen**, The National Association of Current and Former Psychiatric Users, Copenhagen, Denmark, and European Network of (Ex-)Users and Survivors of Psychiatry, Denmark; **Rudy Christianto**, Directorate of Labour Development and Supervision, Ministry of Manpower, Jakarta, Indonesia; **Lisete Chume**, Department of Chronic Noncommunicable

Diseases, Ministry of Health, Maputo, Mozambique; **Jarrod Clyne**, International Disability Alliance, Geneva, Switzerland; **Sarah Collinson**, Sightsavers, London, the United Kingdom; **Noely Couto**, Mental Health Program, Department of Mental Health, Ministry of Health, Maputo, Mozambique; **Kelvin Cruz**, Ministry of Sports and Recreation, Santo Domingo, Dominican Republic; **Johanna Cunningham**, The United Nations Children's Fund, New York, the United States; **Hervita Diatri**, Faculty of Medicine, University of Indonesia, and Cipto Mangunkusumo Hospital, Jakarta, Indonesia; **Ragnhild Dybdahl**, Africa CDC, and Norwegian Institute of Public Health, Oslo, Norway; **Julian Eaton**, CBM Global, London, the United Kingdom; **Yamuna Ellawela**, Directorate of Mental Health, Ministry of Health, Colombo, Sri Lanka; **John Farrelly**, Mental Health Commission, Dublin, Ireland; **Katherine Ford**, University of Oxford, Oxford, the United Kingdom; **Melvyn Freeman**, University of Stellenbosch, Stellenbosch, South Africa; **Wilza Fumo**, Mental Health Program, Department of Mental Health, Ministry of Health, Maputo, Mozambique; **Marina Garriga Carrizosa**, Bipolar and Depressive Disorders Unit, Institute of Neurosciences, Hospital Clínic of Barcelona, Catalonia, Spain; **Liliana González**, Department of Mental Health, Ministry of Health, Buenos Aires, Argentina; **Nijolė Goštautaitė-Midttun**, Lithuanian Prison Service, Ministry of Justice, Vilnius, Lithuania; **Elisabet Guillemat Marrugat**, Department of Research and Universities of Catalonia, Government of Catalonia, Catalonia, Spain; **Heba Hagrass**, Special Rapporteur on the Rights of Persons with Disabilities, Cairo, Egypt; **Tirion Havard**, Institute of Health and Social Care, London South Bank University, London, the United Kingdom; **Maha Helali**, Learning Resource Center, Cairo, Egypt; **Mark Horowitz**, University College London, the United Kingdom; **Peter Hughes**, University Hospital Lewisham, Lewisham, the United Kingdom; **Aulia Iskandarsyah**, Education Division, Indonesian Association of Clinical Psychologists, Indonesia; **Simon Njuguna Kahonge**, Mental Health, Ministry of Health, Nairobi, Kenya; **Olga Kalina**, Georgian Network of (Ex-)Users and Survivors of Psychiatry, Rustavi, Georgia, and European Network of (Ex-)Users and Survivors of Psychiatry, Georgia; **Timo Kallioaho**, European Network of (Ex-)Users and Survivors of Psychiatry, Pentimäki, Finland; **Clare Kambamettu**, Irish Prison Service, Government of Ireland, Dublin, Ireland; **Gregory Keane**, Médecins Sans Frontières, Paris, France; **Budi Anna Keliat**, Indonesian Association of Mental Health Nurses, Jakarta, Indonesia; **Hassan Khubrani**, General Directorate of the Mental Health and Social Services, Ministry of Health, Riyadh, Saudi Arabia; **Gary Kiernan**, Mental Health Commission, Dublin, Ireland; **Seongsu Kim**, Dawon Mental Health Clinic, Korean Open Dialogue Society, Suwon, Republic of Korea;

**Hasya Dwi Kinasih**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Eoin Kinnane**, Capability (People) Development and Support Branch, Department of Defence, Government of Ireland, Dublin, Ireland; **Adriana Krasinsky**, Department of Mental Health, Ministry of Health, Buenos Aires, Argentina; **Nia Kurniawati**, Directorate of Environmental Health, Ministry of Health, Jakarta, Indonesia; **Carol Labor**, Ministry of Health, Freetown, Sierra Leone; **Joanna Lai**, United Nations Children's Fund (UNICEF), New York, the United States; **Patricia Landinez**, United Nations Children's Fund (UNICEF), New York, the United States; **Valentina Lemmi**, School of Health and Social Care, University of Essex, Colchester, the United Kingdom; **Francisca Lopes**, Directorate for Employment Labour and Social Affairs, Health Division, Organisation for Economic Cooperation and Development, Paris, France; **Crick Lund**, Centre for Global Mental Health, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, the United Kingdom; **Paule Mannering**, Irish Prison Service, Government of Ireland, Dublin, Ireland; **Try Manullang**, The Indonesian National Commission on Disabilities (Komisi Nasional Disabilitas), Jakarta, Indonesia; **Bernat Carreras Marcos**, National Mental Health Pact of Catalonia, Spain; **Michael Marmot**, UCL International Institute for Society and Health, University College London, London, the United Kingdom; **Laura Masiulienė**, Foreigners Integration Group, Ministry of Social Affairs and Labour, Vilnius, Lithuania; **Celina Jonas Mate**, Cervical Cancer Program, Ministry of Health, Maputo, Mozambique; **Shari McDaid**, Mental Health Foundation, London, the United Kingdom; **Peter McGovern**, Modum Bad, Vikersund, Norway; **Deirdre McHugh**, Department of Education and Skills, Government of Ireland, Dublin, Ireland; **Rebecca Minch**, Department of Tourism, Culture Arts, Gaeltacht, Sport and Media, Government of Ireland, Dublin; **Cristina Molina Parrilla**, National Mental Health Pact of Catalonia, Spain; **Guadalupe Morales Cano**, Fundación Mundo Bipolar, Madrid, Spain, and European Network of (Ex-)Users and Survivors of Psychiatry, Spain; **Ivette Morilla Figueras**, Department of Adult Psychiatry and Psychology, Institute of Neurosciences, Hospital Clinic of Barcelona, Catalonia, Spain; **Natalia Muffel**, United Nations Children's Fund (UNICEF), New York, the United States; **August Munar**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Paola Michell Jose Muñoz**, Ministry of the Interior and the Police, Santo Domingo, Dominican Republic; **Caomhe Nic A Bhaird**, United Nations Children's Fund (UNICEF), New York, New York, the United States; **Linda Resta Ningrum**, Improvement of Access and Quality for Health Service, Coordinating Ministry of Human Empowerment and Culture, Jakarta, Indonesia; **Michael Njenga**, CBM Global, Nairobi, Kenya; **Luis Nocete**, Unidad de Interconsulta, Enlace y Urgencias, Área de Psiquiatría, Psicología Clínica y Salud Universitario La Paz, Madrid, Spain; **Fitri Nurani**, Directorate of Labour Development and Supervision, Ministry of Manpower, Jakarta, Indonesia; **Violia Paramadita**, Indonesian Association of Medical Social Workers, Indonesia; **Claudia Pellegrini Braga**, Faculty of Medicine, University of São Paulo, Brazil; **Idel Pereira Goveia**, Ministry of Public Administration, Administrative Reform, Employment, Vocational Training and Social Security, Bissau, Guinea Bissau; **Olga Puig Navarro**, Department of Child and Adolescent Psychiatry and Psychology, Institute of Neuroscience, Hospital Clinic of Barcelona, Catalonia, Spain; **Puji Pujiono**, Indonesian Association of Professional Social Workers, Jakarta, Indonesia; **Dainius Puras**, Department of Psychiatry, Faculty of Medicine, Vilnius University, Vilnius, Lithuania; **Manuel Gomes Raivoso**, Department of Chronic Noncommunicable Diseases, Ministry of Health, Maputo, Mozambique; **Diana Rayes**, United Nations Children's Fund (UNICEF), New York, the United States; **John Read**, University of East London, London, the United Kingdom; **Núria Ribas Bruguera**, National Mental Health Pact of Catalonia, Spain; **Dante Rigmalia**,

The Indonesian National Commission on Disabilities (Komisi Nasional Disabilitas), Jakarta, Indonesia; **Emilio Rojo Rodes**, National Mental Health Pact of Catalonia, Spain; **Ignas Rubikas**, Mental Health Division, Ministry of Health, Vilnius, Lithuania; **Maria Rubio-Valera**, Mental Health Pact, Parc Sanitari Sant Joan de Déu, Barcelona, Catalonia, Spain; **Yunita Restu Safitri**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Gédéon Samba Nkanda**, National Programme on Mental Health, Ministry of Health, Kinshasa, Democratic Republic of the Congo; **Chaerul Dwi Sapta**, Synchronization of Regional Government Affairs III, Directorate General of Regional Development, Ministry of Home Affairs, Jakarta, Indonesia; **Annelia Sari Sani**, Indonesian Association of Clinical Psychologists, Indonesia; **Renata Šarkanė**, Targeted Support Group, Ministry of Social Affairs and Labour, Vilnius, Lithuania; **Laura Shields-Zeeman**, Trimbos Institute, Utrecht, The Netherlands; **Stephanie Siahaan**, Directorate of Social Rehabilitation Service for Persons with Disabilities, Ministry of Social Affairs, Jakarta, Indonesia; **Herbet Sidabutar**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Donald Simanjuntak**, Directorate of Environmental Health, Ministry of Health, Jakarta, Indonesia; **Graciete Sinela**, Department of Chronic Noncommunicable Diseases, Ministry of Health, Maputo, Mozambique; **Josep Maria Solé**, Support Girona, Catalonia, Spain; **Greta Stonkute**, Mental Health Division, Ministry of Health, Vilnius, Lithuania; **Tone Vrhovnik Straka**, Ljubljana, Slovenia; **Teti Tejayanti**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Minerva Theodora**, Directorate of Primary Service for Vulnerable Population, Ministry of Health, Jakarta, Indonesia; **Murali Thyloth**, World Association for Psychosocial Rehabilitation, India; **Tor Helge Tjelta**, Centre for Development Mental Health and Addiction, the Norwegian Association for Mental Health and Addiction Care, and the European Community-based Mental Health Service Providers Network (EUCOMS), Norway; **Silvanie Tompodung**, Health Quality and Population Development, Coordinating Ministry of Human Empowerment and Culture, Jakarta, Indonesia; **Carla Torrent Font**, Bipolar and Depressive Disorders Unit, Institute of Neurosciences, Hospital Clínic of Barcelona, Catalonia, Spain; **Sheila Tualufo**, Department of Chronic Noncommunicable Diseases, Ministry of Health, Maputo, Mozambique; **Tomiris Valerio**, Department of Strategic Management, Ministry of Public Health and Social Assistance, Santo Domingo, Dominican Republic; **Carmen Valle Trabadelo**, IFRC Reference Centre for Psychosocial Support, Copenhagen, Denmark; **Alberto Vasquez Encalada**, Center for Inclusive Policy, Peru; **Simon Vasseur-Bacle**, Ministère de la Santé et de la Prévention, France, and Service de recherche et de formation en santé mentale, Etablissement Public de Santé Mentale Lille Métropole/Centre collaborateur de l'OMS pour la Recherche et la Formation en Santé mentale, Lille, France; **Eduard Vieta Pascual**, Department of Child and Adolescent Psychiatry and Psychology, Institute of Neuroscience, Hospital Clínic of Barcelona, Catalonia, Spain; **Alice Wainwright**, Department of Justice, Government of Ireland, Dublin, Ireland; **Kartika Weningtyas**, Directorate of Labour Development and Supervision, Ministry of Manpower, Jakarta, Indonesia; **Ciara Whelan**, The Housing Agency Ireland, Government of Ireland, Dublin, Ireland; **Henny Dwi Windarwati**, Indonesian Association of Mental Health Nurses, Malang city, East Java Province, Indonesia; **Miguel Xavier**, National Coordination of Mental Health Policies, Ministry of Health, Lisbon, Portugal; **Nova Riyanti Yusuf**, National Center for Mental Health, Marzoeiki Mahdi Mental Hospital, Bogor City, Indonesia; **Rebecca Zapata Guardiola**, Department of Research and Universities of Catalonia, Government of Catalonia, Catalonia, Spain; **Martin Zinkler**, Department of Psychiatry and Psychotherapy, Gesundheit Nord, Klinikverbund, Bremen, Germany.

**WHO would also like to acknowledge** the coordinated input received from the Department of Health and Aged Care of the Government of Australia; the Department of Environment, Climate and Communications, Government of Ireland; Aotearoa New Zealand's Ministry of Health – Manatū Hauora; the Philippines Department of Health, to this publication.

## WHO headquarters staff and consultants

Nicholas Banatvala; Kenneth Carswell; Daniel Chisholm; Scott Chiossi; Catarina Magalhães Dahl; Brandon Gray; Dzmitry Krupchanka; Aiysha Malik; Pauliina Nykanen-Rettaroli; Nathalie Roebbel; Alison Schafer; Tova Tampe; Tamitza Toroyan; Nicole Valentine; Mark Van Ommeren; and Inka Weissbecker.

## WHO reviewers and coordinators at regional and country level

**Nazish Arman**, WHO Regional Office for South-East Asia; **Anna-mariia Breysacher**, WHO Country Office for Ukraine; **Andrea Bruni**, WHO Regional Office for South-East Asia; **Claudina Cayetano**, WHO Regional Office for the Americas; **Eric Domingo**, WHO Regional Office for the Western Pacific; **Nils Fietje**, WHO Regional Office for Europe; **Jennifer Hall**, WHO Regional Office for Europe; **Matias Irarrazaval**, WHO Regional Office for the Americas; **Alisa Ladyk-Bryzgalova**, WHO Country Office for Ukraine; **Ledia Lazeri**, WHO Regional Office for Europe; **Carmen Martinez**, WHO Regional Office for the Americas;

**Jason Maurer**, WHO Regional Office for Europe; **Melita Murko**, WHO Regional Office for Europe; **Renato Oliveira e Souza**, WHO Regional Office for the Americas; **Cassie Redlich**, WHO Regional Office for Europe; **Chido Ratidzai Rwafa Madzvamutse**, WHO Regional Office for Africa; **Khalid Saeed**, WHO Regional Office for the Eastern Mediterranean; **Ana Maria Tijerino Inestroza**, WHO Regional Office for Europe; **Atsuro Tsutsumi**, WHO Regional Office for the Western Pacific; and **Jasmine Vergara**, WHO Regional Office for the Western Pacific.

## Contributors from members of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases

**Stefano Berterame**, International Narcotic Control Board Secretariat; **Catherine Carty**, United Nations Educational, Scientific and Cultural Organization (UNESCO); **Nazneen Damji**, United Nations Entity for Gender Equality and the Empowerment of Women; **Emma Ferguson**, United Nations Children's Fund (UNICEF); **Zeinab Hijazi**, United Nations Children's Fund (UNICEF); **Saurabh Mishra**, International Olympic Committee;

**Dafne Papandrea**, International Labor Office; **Maria Annunziata Pignataro**, World Intellectual Property Organization; **Rajnish Prasad**, United Nations Entity for Gender Equality and the Empowerment of Women; **Guglielmo Schinina**, International Organization for Migration; **Victoria Wise**, International Fund for Agricultural Development.

## Financial support

WHO gratefully acknowledges generous financial support towards this publication. The **Government of the Republic of Korea** provided much of the funding, alongside an additional contribution from the **Government of Portugal**.

# Glossary

## Accessibility

Article 9 of the Convention on the Rights of Persons with Disabilities (CRPD) recognizes accessibility as a fundamental principle enabling persons with disabilities to live independently and participate fully in all aspects of life. It requires that persons with disabilities have equal access to the physical environment, transportation, information and communications technologies, and other facilities and services open or provided to the public, both in urban and rural areas. States Parties have an obligation to identify and eliminate obstacles and barriers to accessibility, ensuring that services and environments are usable by all, without discrimination (1).

## Convention on the Rights of Persons with Disabilities (CRPD)

The CRPD is a United Nations human rights treaty adopted in 2006 that aims to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity”. It marks a shift in how persons with disabilities are viewed: not as objects of charity or care, but as rights-holders with legal capacity and agency. The CRPD applies to all persons with disabilities, including those with psychosocial disabilities and mental health conditions, and explicitly requires States to eliminate discrimination and support full inclusion and participation in society across all sectors, including those listed in this Guidance.

## Deinstitutionalization

Deinstitutionalization is the process of relocating people from institutional settings back into their communities and closing institutional beds to prevent further admissions. Successful deinstitutionalization requires comprehensive community-based services, sufficient financial and structural investment, and a shift in mindsets and practices to value people’s rights to community inclusion, liberty, and autonomy (2).

## Disability

The CRPD states that disability results from interactions between individuals who have impairments or health conditions and societal barriers that limit their full and equal participation. Article 1 of the CRPD defines “persons with disabilities” as those with long-term physical, mental, intellectual, or sensory impairments that, when combined with barriers, hinder their full and effective participation in society. This reflects both the social model of disability, which highlights how societal barriers drive disability, and the human rights model, which asserts that people with disabilities have the right to demand such barriers are removed so as to ensure equality and non-discrimination.

## Discrimination

According to the CRPD, discrimination is “...any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms ...”. Discrimination can occur on grounds of race, sex, gender, sexual orientation, identity or expression, age, disability, ethnic, indigenous or social origin, caste, and other status.

## Groups that face discrimination

This refers to groups of people within a culture, context or history who face, or are at risk of, discrimination and exclusion due to unequal power relationships. These groups may experience discrimination based on the range of factors mentioned above as well as others (3). Discrimination on any such ground is prohibited under international human rights law.

## Human rights-based approach

This is an approach grounded in international human rights law. In mental health, it involves adopting legal and policy frameworks that comply with State obligations under international law. The approach equips both State and non-State actors to identify, analyze, and address inequalities and discrimination, and to reach those who are marginalized. It also provides avenues for redress and accountability when necessary (4).

## LGBTIQ+

LGBTIQ+ is an acronym for lesbian, gay, bisexual, transgender, intersex and queer/questioning people. The plus sign represents people of diverse sexual orientation, gender identity, gender expression and sex characteristics who identify with other terms. This acronym, adopted from a Western (predominantly Anglophone) context, has become a term of convenience in public health and health research, including for some normative statements on human rights by WHO and other UN entities (5). While the acronym LGBTIQ+ (or a derivation of it, such as LGB or LGBT) is widely used globally and in UN publications, it does not encompass the full diversity of terms used to describe sexual orientation, gender identity and expression, and sex characteristics.

## Lived experience

Lived experience can refer to personal experience with mental health services, mental health conditions, or specific living conditions like poverty. It recognizes how someone's experience brings understanding of a particular situation, challenge, or health issue.

## Mental health

Mental health is a state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of a mental health condition (2).

## Peer support

Peer support refers to emotional, social, and practical support provided by people who have lived experience (see above) of similar mental health or life challenges. It can take place in one-to-one or group settings and is grounded in mutual respect, empathy, and shared understanding. It can be offered in various forms, such as through formal roles within mental health or social services, independent peer-led initiatives, or informal, non-hierarchical and unpaid arrangements. Peer supporters, who are experts by experience, offer judgment-free, person-centred support and serve as empathetic listeners, advocates, and partners in recovery (6).

## Person-centred care

Person-centred care focuses on aligning care with individuals' preferences, needs, values, and strengths, and with people's unique circumstances and goals in life. It requires that people actively participate in decisions about their treatment and care. It aims to foster trusting partnerships, dignity, respect, and autonomy, while also addressing social and structural factors affecting mental health, in order to provide holistic care (7).

## Psychosocial disability

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

## Reasonable accommodation

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

## Recovery

The recovery approach in mental health focuses on supporting people to regain or maintain control over their lives. Recovery is personal and different for each person, and can include finding meaning and purpose, living a self-directed life, strengthening self-worth, healing from trauma, and having hope for the future. Each person defines what recovery means for them and decides which areas of life to focus on as part of their recovery journey. Recovery views the person and their context as a whole, rather than aiming for the absence of symptoms or a so-called cure (8).

## Stigma (including self-stigma)

Stigma is a social process that occurs when someone is labelled, associated with negative stereotypes, or somehow separated as different and, as a consequence, may experience status loss, discrimination and exclusion. Stigma operates within contexts where power imbalances enable it, and has real consequences for people’s rights, well-being, and life opportunities (9). People may also internalize negative societal attitudes in a process known as self-stigma. This can lead to feelings of shame and self-blame and may prevent people from pursuing their goals or seeking support for their mental health and well-being (10).

## Structural and social determinants of mental health

Structural determinants encompass the socioeconomic and political context, including the norms, practices, policies and institutions that shape how power and resources are distributed, and how these contribute to social stratification within society, which in turn impacts population health. Social determinants refer to the various conditions in which people are born, grow, live, work, and age, all of which play a crucial role in influencing population health (11). They include (but are not limited to): stigma and discrimination; poverty; lack of, or lower levels of, education; unemployment or job insecurity; homelessness or housing insecurity; food insecurity; health emergencies; climate change; natural hazards; pollution and industrial disasters; humanitarian crises and forced displacement; vulnerable migration; violence and abuse; loneliness; and social isolation.

## Substitute decision-making

This refers to regimes where a person’s legal capacity is removed, and a substitute decision-maker is appointed to make decisions on their behalf, often based on what is perceived as the person’s best interests, rather than their own will and preferences (12).

### **Supported decision-making**

The CRPD describes supported decision-making as regimes that provide various support options enabling a person to exercise legal capacity and make decisions with support (13). Supported decision-making can take many forms but does not remove or restrict legal capacity. A supporter cannot be appointed by a third party without the person's consent, and support must align with the individual's will and preferences (14).

### **Sustainable Development Goals (SDGs)**

The Sustainable Development Goals (SDGs) are a universal set of 17 interlinked goals adopted by all United Nations Member States in 2015 as part of the 2030 Agenda for Sustainable Development. They aim to end poverty, protect the planet, and ensure peace and prosperity for all by 2030. Each goal includes specific targets and indicators to guide national and global efforts toward sustainable, inclusive development (15).

### **Universal Health Coverage (UHC)**

Universal health coverage (UHC) means that all people and communities have access to the health services they need, when and where they need them, without financial hardship. UHC is a core target of the Sustainable Development Goals (SDGs) and reflects the recognition of health care as a basic human right. UHC includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course (2).

### **Whole-of-government approach to mental health**

In a whole-of-government approach all government sectors collaborate to protect and promote mental health and well-being. This approach addresses mental health as a shared responsibility extending beyond the health sector alone, recognizing that mental health is foundational to individual and societal health, and is strongly influenced by social and structural determinants. A whole-of-government approach aims to ensure coherent, inclusive, and comprehensive responses to mental health challenges within a broad public policy framework.

# Executive summary

Mental health and well-being are vital to individual and societal health, and essential for sustainable development. They are shaped by structural and social determinants like poverty, discrimination, and violence: factors that extend beyond the health sector. Global crises such as climate change, conflict, and COVID-19 have further intensified these pressures.

Addressing mental health requires coordinated action across all sectors. A joint effort can improve population well-being, strengthen social cohesion, and advance inclusion, equity, human rights, and economic progress.

## The Sustainable Development Goals (SDGs): Economic, human rights and development imperatives

Mental health is deeply interconnected with social and economic development and is linked to many of the UN's Sustainable Development Goals (SDGs), which aim to end poverty, protect the planet, and ensure peace and prosperity for all by 2030. SDG 3 on health and well-being, SDG 8 on decent work and economic growth, SDG 10 on reduced inequalities, and SDG 16 on peace and justice are among the relevant goals.

Actions across sectors can support mental health while advancing progress toward the SDGs. For example, mental health promotion in employment can strengthen productivity, while rights-based approaches in justice and interior sectors can reduce inequalities and support peaceful, inclusive societies. The economic case is strong: global mental health costs are projected to reach US\$ 6 trillion by 2030, yet effective interventions offer clear returns.

Mental health is also a human right. Governments must uphold the right to the highest attainable standard of mental health, as recognized in treaties such as the UN Convention on the Rights of Persons with Disabilities (CRPD), and act to eliminate the discrimination and exclusion that people with mental health conditions often face across government sectors.

## Integrating mental health into all policies through a whole-of-government approach

Structural and social determinants that span all sectors shape mental health. Acting together, sectors can improve mental health while advancing their own goals. A whole-of-government approach – at all levels from national to local – is essential, requiring coordinated action across culture, arts and sport; defence and veterans; education; employment; environment, conservation and climate protection; health; interior; justice, social protection, urban and rural development; to advance the SDGs and address key determinants of mental health. The treasury and finance sector plays a critical role in promoting equity through budget and fiscal decisions.

Correspondingly, a whole-of-society approach is also vital. Engaging with people with lived experience, communities, and civil society ensures government policies are inclusive and grounded in real needs.

## Developing, implementing and evaluating whole-of-government approaches

### Cross-cutting principles

A human rights-based approach, a life-course perspective, and attention to structural and social determinants are central to protect and promote mental health. Efforts should focus on tackling root causes such as inequality, exclusion, and violence; and on promoting equity, dignity and inclusion, in line with international human rights obligations, including the CRPD.

Active engagement of all stakeholders and meaningful participation of people with lived experience, especially those facing systemic discrimination, is essential for relevance and accountability. Tackling stigma, shifting institutional cultures, and basing actions on evidence and context are key to making mental health a visible, shared responsibility across all sectors.

### Requirements for developing, implementing and evaluating policy

Strong political leadership, high-level endorsement, and action-oriented policy language are essential to drive lasting coordination and investment in mental health. Regular reporting and clear commitments help maintain visibility and momentum.

Policy directives and strategic actions must be fully costed, with adequate sector-specific budgets allocated from the start. Without dedicated funding, implementation risks stalling.

Defined roles, realistic targets and timelines are needed, along with robust accountability systems. Monitoring and evaluation should be built in from the beginning to track progress, support course correction, and ensure sustained impact.

## Eight process steps

The Guidance proposes eight flexible, adaptable, interlinked steps for integrating mental health into sectoral policies and plans:

- 1. Initiate high-level policy dialogue** to build commitment and engage senior leadership on the benefits of addressing mental health.
- 2. Raise awareness and shift mindsets** to integrate mental health into sector-specific policy, strategies and plans.
- 3. Review existing policies and strategies** to assess how well they support mental health, using this Guidance as a reference.
- 4. Form an inclusive drafting team** with broad representation from government sectors, affected communities, and people with lived experience.
- 5. Revise or develop policy content** based on gaps identified in the review and a situational analysis.
- 6. Consult stakeholders and the public** to gather feedback, address concerns, and refine the draft.
- 7. Implement the policy and plan** through updated procedures, training, and clear targets, timelines, budgets, and indicators.
- 8. Monitor and evaluate progress** continuously to ensure effectiveness, responsiveness, and accountability.

## Purpose, scope, use and development of the Guidance

This Guidance supports policy-makers in integrating mental health and well-being into sector-specific policies and plans, with attention to structural and social determinants. It highlights the broad relevance of mental health integration across all areas of government, and the enabling role of treasury and finance. Separate sections outline a menu of policy directives and strategic actions for key government sectors and include adaptable example indicators that could be adapted to support monitoring, evaluation, and accountability in various settings.

This Guidance is intended for policy-makers across various government sectors who are responsible for drafting, revising, and implementing sector-specific laws, policies, strategies, and plans, as well as for people involved in monitoring and evaluating those approaches. It is also relevant to mental health professionals, civil society, organizations of persons with disabilities (OPDs), and people with lived experience who contribute to, or are affected by, these government efforts. [A directory of key issues](#) (Fig. 1) helps users identify where to find discussions on specific topics.

Recognizing diverse governance systems, the Guidance is flexible. Countries can tailor and prioritize actions to fit their legal frameworks, existing policies, and local contexts. For example, sector responsibilities may differ depending on the country.

WHO developed the Guidance between February 2023 and August 2025 through an iterative, collaborative process involving literature reviews, analysis of international human rights frameworks, and extensive consultations with governments, experts, civil society organizations, and people with lived experience.

## Strategic roles of key sectors

Each sector has a distinct and essential role in advancing mental health and well-being that can be amplified when coordinated with actions from other sectors.

### Government-led mental health initiatives across sectors

Government-wide coordination, led where possible by heads of state and senior national authorities across diverse sectors, is foundational. These leaders are urged to drive multisectoral strategies, commit resources, and elevate mental health as a public and political priority. High-level government leadership is essential to embed mental health into national development priorities and drive coordinated action across ministries. The document suggests several policy directives and strategic actions that government can implement or adapt.

Prioritizing mental health in the political agenda is a key policy directive. Strategic actions could involve: establishing cross-sectoral coordination mechanisms; creating a whole-of-government strategy with dedicated programmes and budgets; and engaging national leaders in public communication and advocacy. Governments are also encouraged to learn from international best practices to strengthen their own responses.

Governance and accountability for mental health can be strengthened as a policy priority. Strategic actions include: promoting rights-based mental health policies and laws; raising public awareness to reduce stigma and discrimination; and establishing regular high-level reporting to track progress across sectors.

Financial commitment and securing and allocating adequate resources for mental health is a third key direction for policy. Strategic actions include: dedicating specific budgets for mental health across sectors; facilitating collaboration between finance and other sectors to ensure funding; and obtaining external resources to support mental health initiatives.

### Culture, arts and sports

Culture, arts and sports are powerful enablers of well-being, connection, and self-expression. This sector can support mental health through inclusive participation, creativity, and cultural expression.

Policy can address mental health and well-being by drawing on cultural heritage and culturally rooted approaches. Strategic actions under such a policy directive include: partnering with the mental health sector and local communities to better understand cultural perspectives on mental health; integrating mental health awareness into heritage programmes; supporting communities affected by the loss of cultural heritage; promoting research on how cultural beliefs influence mental health; and taking steps to eliminate harmful cultural practices.

Policy can leverage cultural and artistic activities in promoting mental health, well-being, and social inclusion, while also raising awareness of mental health issues. Strategic actions supporting such a policy directive include: providing accessible and affordable cultural and artistic programmes in community, workplace, and educational settings; integrating such activities into health and social care services; advancing social prescribing in collaboration with the health sector; and encouraging public figures to champion rights-based, recovery-oriented approaches to mental health.

Promoting mental health and well-being through greater participation in sports and physical activity is also an important policy direction. Strategic actions for such a directive include: ensuring inclusive access for all, including people with mental health conditions and psychosocial disabilities; creating tailored community programmes for groups that face discrimination; integrating physical activity into health and social services; training sports professionals in mental health awareness; embedding mental health into Sport for Development and Peace initiatives; and establishing safeguards against abuse and discrimination; and safeguards to combat substance misuse in sports.

## **Defence and veterans**

Defence institutions and veterans' services can play a vital role in addressing the mental health impacts of trauma, institutional culture, and reintegration into civilian life.

One key policy directive can be to act to prevent harassment, violence, and abuse during service, while tackling stigma and discrimination related to mental health. Strategic actions include: enforcing strong safeguards against all forms of abuse; transforming military culture through awareness and training to reduce stigma around mental health challenges; and implementing measures to prevent all forms of discrimination (including via monitoring, reporting and redress mechanisms).

Policy to address mental health challenges and promote well-being among service members, veterans, and their families is important. Strategic actions include offering pre-deployment training to build resilience; and providing post-deployment support for reintegration. Suicide prevention programmes and improved access to rights-based, trauma-informed mental health services are key, along with targeted support for families throughout the deployment cycle. Additional measures include training for military mental health professionals, leadership development, anti-stigma education, and peer support to strengthen help seeking and mental health literacy.

A further key policy direction is to ensure access to a broad range of social benefits and community support for veterans and their families. An important strategic action for such a policy directive is to provide efficient and accessible financial assistance, pensions, healthcare, and disability benefits. Other strategic actions focus on supporting access to housing, education, and career opportunities post service; as well as facilitating veterans' reintegration into civilian life and communities through social connection and volunteering initiatives.

## **Education**

Education systems shape mental health across the life course and are key to building safe, inclusive, and supportive environments for learning and growth.

A central policy priority in the education sector is to implement system-level reforms that foster safe environments, inclusion, non-discrimination, and support for mental health and well-being. Strategic actions for such a policy directive include introducing safeguarding measures to prevent violence and abuse; integrating rights-based mental health education into curricula; and addressing academic pressures like excessive coursework. Further actions involve mandating institutional mental health policies (to be created with the full participation of persons with lived experience); and improving access to education for learners from groups at risk of discrimination, including those with mental health conditions or psychosocial disabilities.

Creating enabling environments and cultures that promote inclusion, social-emotional learning, life skills, and mental health and well-being is another important policy direction to take. Strategic actions under such a directive include building educators' capacity to support both their own and their student's mental health and well-being; addressing issues such as bullying, harassment, and suicide, substance use and stigma and discrimination; and fostering peer connections and a sense of belonging to strengthen overall community and inclusion.

Ensuring access to high-quality mental health and psychosocial support for all students and staff is also a priority issue. Strategic actions under such a policy directive include: setting up dedicated mental health and well-being offices or appointing focal points in educational institutions; and implementing mentoring programmes to provide ongoing support and promote well-being across the learning environment.

## **Employment**

Workplaces strongly influence adult mental health because people spend such a significant proportion of their lives there. This sector can promote well-being by ensuring decent work, preventing exclusion, and supporting recovery. Policies must reach people in informal as well as formal employment if they are to be effective.

One key policy direction focuses on promoting inclusion, preventing discrimination, and ensuring respect for human rights in workplaces. Strategic actions under such a directive include: creating inclusive employment opportunities (in line with the CRPD) that support mental health and well-being; establishing protections against harassment and discrimination; ensuring access to fair working conditions, benefits and insurance that includes mental health coverage; and integrating mental health into occupational safety and health legislation equally with physical health.

Assessing, preventing and managing occupational risks is a crucial policy approach. Strategic actions can include: improving job design; managing workloads; clarifying roles; creating safe and healthy physical conditions; and ensuring opportunities for career development and flexibility.

Workplace culture can form another policy focus. Strategic actions under a directive on workplace cultures could include training for mental health literacy and anti-stigma programmes; individual and peer-based supports; leadership development programmes; mandatory training to prevent harassment, discrimination or abuse; and support for social connections and recreational events that strengthen workplace cultures.

Encouraging and facilitating early help-seeking and recovery for mental health challenges is also important. Policy can encourage strategic action such as establishing well-being units, implementing Employee Assistance Programmes; and instituting flexible, coordinated return-to-work opportunities.

## Environment, conservation and climate protection

Environmental degradation and climate change can worsen mental health, especially for marginalized groups. Conversely, this sector can promote well-being by integrating mental health into environmental planning and action.

Enhancing mental health considerations in leadership efforts for protecting the environment and addressing climate change forms one policy directive. Strategic actions can include: collaboratively embedding mental health in environmental laws, climate adaptation plans, and disaster preparedness; tracking and researching climate-related distress; and ensuring early warning systems and disaster response reach those at most risk of mental health impacts.

Policy that protects the environment and addresses climate change will also foster mental health. Strategic actions can include promoting urban nature; protecting natural habitats, including Indigenous lands; reducing pollution and expanding access to clean energy; and improving access to clean water, and sanitation and waste recycling and disposal systems.

Collaboration with the mental health sector to help create sustainable health services and train health and environmental workers on climate-related mental health impacts is another useful policy direction. Strategic actions might include creating low-carbon services; and capacity building through environmental education.

Community engagement is a valuable policy approach. Strategic actions under such a policy directive include co-developing local solutions to environmental problems linked to mental health concerns; promoting nature-based activities for all; and collaborating to help integrate social prescribing into health systems.

## Health

The health sector is central to delivering rights-based, person-centred and integrated mental health care. It is crucial to recognize that physical and mental health are closely intertwined. Many countries may have a distinct mental health sector. However, this Guidance deals with integrating mental health actions across other sectors. Recommended policies, strategies and actions for the mental health sector itself are comprehensively discussed in Modules 1–5 of [Guidance on mental health policy and strategic action plans](#).

A key policy directive for supporting a wider cross governmental approach is to establish strong mental health governance within the general health sector. Strategic governance actions include creating a team within the Ministry of Health to integrate mental health into all policies and initiatives; allocating sufficient funds; eliminating discriminatory practices in health insurance schemes (including those that favour hospital care over community services); and integrating mental health indicators into national health information systems.

Mental health needs to be an integral and comprehensive part of the national health system. A policy directive to achieve this could include actions such as: integrating mental health into primary care and specialized services; and making services more accessible for people with mental health conditions or disabilities, and those facing discrimination. Implementing a rights-based and recovery-orientated approach that addresses social and structural determinants is important. Health services should consider people's housing, income and social connections, and offer physical, lifestyle, social and economic interventions alongside careful drug prescribing.

Training the general health workforce will be crucial. A policy directive can propose actions to collaborate with the education sector; deploy mental health staff more widely (perhaps through task sharing); emphasize ongoing training, support and supervision for health workers; and train and collaborate with people in the community.

## Interior

Interior ministries influence mental health through many roles, including policing, emergency response, migration governance, and public safety.

Reforming the roles of law enforcement and emergency responders in mental health crisis intervention is an important policy directive. Strategic actions include broadening crisis response options beyond police involvement (for example, scaling up 24/7 crisis lines, mobile teams, peer support, and call diversion systems); comprehensively training emergency responders on managing mental health crises; and creating independent mechanisms for reporting abuse during crisis response.

Promoting mental health and well-being among emergency responders is equally important. Strategic actions under such a policy directive can implement mental health promotion measures at work; and can enhance access to support for first responders, for example through workplace peer support, and easy access to mental health services.

Protecting and promoting the mental health of migrants, refugees, and asylum seekers is also a responsibility that often falls to interior ministries. A policy directive here could ensure access to culturally appropriate, rights-based services regardless of legal status; could build capacity to provide health and mental health interventions to these communities; and could work to enhance social integration and reduce anti-migrant sentiment and discrimination. The interior sector can also advocate for and protect migrant workers' rights through cross-sector collaboration, and can act to improve living conditions for asylum seekers and refugees.

Emergency preparedness schemes should also take a multi-sectoral approach to mental health and psychosocial support. Within such a policy directive, strategic actions could cover: integrating mental health and psychosocial support into emergency planning; strengthening community and individual preparedness; building care workers' and first responders' capacity on mental health interventions; strengthening support for people with more complex needs; improving frontline workers' access to mental health services; and planning how to continue routine mental health services during emergencies.

## Justice

Justice systems are essential for upholding rights and reducing the harms of detention and coercion.

A key policy directive calls for legal reforms to improve access to justice and align laws with human rights standards, including the CRPD. Potential strategic actions are wide ranging and include: enhancing access to justice for people with mental health conditions and disabilities (such as through procedural accommodations); reviewing and revising law on legal capacity, mental health, forensic facilities, decriminalizing suicide, and on non-discrimination; training justice sector professionals on human rights and mental health; and exploring and expanding pre-trial diversion programmes and alternatives to incarceration.

Strengthening oversight and redress is important. A policy directive here might have strategic actions on: establishing independent monitoring and complaint mechanisms within mental health, social services and forensic facilities; supporting independent reporting and monitoring on discrimination and human rights violations; and establishing comprehensive redress and reparations procedures.

Policy directives should protect mental health in custodial settings. Strategic actions around this include staff training on mental health; suicide prevention programmes; reporting and redress mechanisms for harassment, violence, and abuse during arrest, custody, and incarceration; access to education, work, and income generation opportunities during custody and incarceration; improved living conditions for people in detention; and revising regulations on solitary confinement and punitive segregation.

Policy should ensure good-quality and rights-based mental health services and support is available for both staff and detainees. Strategic actions include providing mental health services within jails, prisons and custody facilities; establishing mental health units in prisons to serve people with mental health conditions and complex needs; and improving access to mental health support for detention facility staff.

Reintegration support for people leaving detention should also be a policy priority. A policy directive could have strategic actions to facilitate inter-sectoral collaboration on rehabilitation and reintegration; to enhance continuity of care; to facilitate peer networks and community engagement; and to educate, train and support community providers to serve people with a criminal/forensic background (working closely with parole officers).

## **Social protection**

Social protection supports mental health by reducing poverty, inequality, and exclusion.

Promoting equal opportunities and social inclusion in order to protect and promote mental health should be a policy priority. Strategic actions for such a directive could include: improving monitoring mechanisms for social equity and equal opportunities; working to transform mindsets and combat stigma and discrimination; providing education and support in local communities; and combatting social isolation and loneliness.

Poverty and housing insecurity is also critical and is addressed as a separate policy directive. Associated strategic actions include financial and social support for housing; and wider poverty alleviation measures. Emergency shelters, coordinated assistance like the Housing First model, cash transfers, disability benefits, and services for older adults, can all help ease stress and improve well-being.

Employment schemes and benefits that protect individuals throughout their lives and during economic and other crises are an important policy direction. Strategic actions for such a directive could include: widening eligibility for social protection schemes during economic crises; introducing minimum incomes, supporting employment opportunities and strengthening job seekers' skills; and ensuring access to pensions in older age.

Policy directives should also focus on building schemes that combine social care and mental health support. Strategic actions can include: mental health capacity building for social workers; developing home-based and community services for people with long-term needs; collaborating with mental health services to deinstitutionalize psychiatric and social care facilities; collaboratively funding social activities prescribed to people at high risk of poor health; funding and supporting people to participate fully in society (for example via care vouchers and mobility allowances); and protecting survivors of violence (especially children and survivors of gender-based violence) through safe housing, helplines, and access to psychosocial and legal support.

## Urban and rural development

Urban and rural development has significant impacts on mental health. While poor planning can worsen exclusion, inequality, and pollution, well-designed environments foster inclusion, resilience, and well-being.

Expanding access to safe, affordable, and non-discriminatory housing forms a key policy directive because housing problems are closely tied to psychological distress. Strategic actions include: rent subsidies for low-income households; fair, non-discriminatory housing laws with associated reporting and redress mechanisms; addressing housing health and safety risks for low-income or vulnerable people; creating assistance programmes for houselessness and housing insecurity; and developing accessible housing for people with disabilities and mental health conditions.

A separate policy directive focuses on creating safe and inclusive environments in urban and rural areas. Strategic actions include: incorporating access to urban nature; creating opportunities for physical activity; enhancing overall neighborhood safety in urban and rural areas; and mitigating pollution and improving access to sustainable water and sanitation systems. These measures all promote better mental health, especially when they actively accommodate people with disabilities.

Planning that fosters community engagement, access to services, mental health awareness, and overall inclusion can form another policy directive. Strategic actions include: expanding inclusive, accessible commuting and navigation options; creating well-maintained community spaces to support social interaction; addressing inequities (within cities and between urban and rural areas) with needs-based funding for services such as mobile outreach, co-located services, and accessible transport; and implementing tailored suicide prevention programmes for at-risk populations (such as farmers and Indigenous Peoples).

## Driving change towards impact: a shared government responsibility

Mental health and well-being are essential to inclusive development, peace, and social progress. Every government sector has a role to play. Heads of state, ministers, and sector leaders are urged to prioritize mental health in all policies; establish coordinated, multisectoral initiatives with defined targets and budgets; actively engage affected populations and people with lived experience; and commit to monitoring, evaluation, and ongoing learning.

By embedding mental health and well-being into their core operations, government sectors can drive lasting change, build more equitable, inclusive, and resilient societies, and deliver on a vision of development that leaves no one behind.

“Across all sectors, mental health and social determinants are inseparable – improving one requires addressing the other, and both are essential for every sector to achieve its goals.”

Professor Sir Michael Marmot,

Director of the Institute of Health Equity, University College London

# Introduction



Mental health and well-being are foundational to both individual and societal health and overall development. No society can truly prosper without them, as mental health is central to all areas of life and essential for communities to thrive. Elevating mental health requires tackling broad societal challenges, given that mental health and overall well-being are strongly influenced by structural and social determinants that shape both the prevalence and the severity of mental health conditions and psychosocial disabilities.

The unprecedented convergence of multiple global crises and shocks, including climate change, conflict, and epidemics/pandemics, is having profound direct effects on mental health and well-being worldwide, as well as exacerbating and compounding social and structural determinants that undermine mental health and well-being (2, 16, 17). Responsibility for tackling this situation extends beyond the mental health sector. Importantly, joint efforts across sectors will not only improve mental health and societal well-being but will also foster overall development, promoting social inclusion, equity, universal healthcare, human rights, and sustainable economic progress.

## The Sustainable Development Goals (SDGs): the economic, human rights and development imperatives for addressing mental health

Mental health is closely interlinked with social and economic development factors such as poverty, education, employment, economic growth, and peace (2). As a result, it intersects with most of the Sustainable Development Goals (Table 1), making cross-governmental efforts to advance mental health and well-being crucial to achieving these goals (15). SDG 3 specifically and directly highlights mental health and well-being promotion, along with mental healthcare inclusion in universal health coverage and broad public health strategies. Other goals, such as SDG 8 on decent work and economic growth, are also closely connected to mental health. For example, initiatives within the employment sector that promote mental health, and well-being can enhance employee health, productivity, and motivation, ultimately benefiting both workers and organizations and contributing to national economic growth. Similarly, integrating provisions for mental health into the justice sector is essential to reducing inequalities (SDG 10) and fostering peaceful and just societies (SDG 16). Efforts by the interior sector to respond to conflicts and violence, for example by providing psychological first aid, also contribute to mental health, which is crucial for long-term peacebuilding and social cohesion (SDG 16).

Addressing mental health improves and even saves lives, and supports sectors to achieve the SDGs. However, mental health also offers a strong return on investment. In 2010, the global cost of mental health conditions was estimated at US\$2.5 trillion annually, with projections rising to US\$6 trillion by 2030 (18). Effective interventions to protect and promote mental health and well-being have demonstrated economic benefits across multiple sectors, both in the short and long term.

In addition to affecting overall development and economic growth, promoting mental health and well-being across sectors is also a human rights issue. Every individual has the right to attain the highest standard of physical and mental health, as recognized by international human rights frameworks such as the International Bill of Human Rights and the United Nations Convention on the Rights of Persons with Disabilities (1, 19). These and other human rights treaties (see Module 3 of *Guidance on mental health policy and strategic action plans* (20) for a full list of treaties and conventions) serve as a foundation for the SDGs.

Government sectors have a responsibility to support human rights-based actions that protect population mental health. They are also key to delivering rights-based interventions for individuals with mental health conditions and for other groups that face discrimination. Without government action, discrimination, inequality, and violations of human dignity and rights persist. For example, in the labour market, people with mental health conditions or psychosocial disabilities experience limited opportunities, workplace discrimination, or outright exclusion. Similarly, in education they encounter stigma and barriers to access, limiting their academic success. Such systemic issues perpetuate inequality and social marginalization. Addressing these challenges requires coordinated efforts across all sectors to ensure equal opportunities and to uphold everyone’s rights to mental health.

While the links between mental health, social and structural determinants and the SDGs are already well studied with a solid evidence base (2), more research and evaluation is needed to understand and implement sector-specific actions to improve mental health outcomes.

**Table 1. Links between mental health and the Sustainable Development Goals<sup>a</sup>**

SDG	Links with mental health
1 No poverty	<ul style="list-style-type: none"> <li>• There is a close and self-reinforcing relationship between poor mental health and poverty. Poor mental health can contribute to or exacerbate poverty, while poverty can lead to or worsen outcomes for people with mental health conditions.</li> </ul>
2 Zero hunger	<ul style="list-style-type: none"> <li>• Poor nutrition impairs cognitive and emotional development in children.</li> <li>• Food insecurity is a significant risk factor for poor mental health outcomes across populations. Communities facing severe food shortages often experience heightened tensions, further breaking social cohesion and impacting collective mental health.</li> </ul>
3 Good health and well-being	<ul style="list-style-type: none"> <li>• Mental health is an integral part of general health and well-being.</li> </ul>
4 Quality education	<ul style="list-style-type: none"> <li>• Mental health is closely tied to cognition, concentration, and motivation. Improving mental health can remove barriers to early learning and education and lets students achieve more.</li> <li>• People with mental health conditions and other groups that face discrimination experience educational barriers. They may have difficulty accessing quality early learning and education or they may face stigma that limits their ability to succeed academically.</li> </ul>
5 Gender equality	<ul style="list-style-type: none"> <li>• Gender inequalities and gender-based violence damage mental health and well-being.</li> </ul>

<sup>a</sup> These links are not exhaustive. Rather, they indicate how mental health is intricately connected to various development factors and plays a crucial role in achieving the Sustainable Development Goals.

SDG	Links with mental health
<b>6</b> Clean water and sanitation	<ul style="list-style-type: none"> <li>• Socioeconomic deprivation and poor access to facilities creates multiple stressors and is linked with poor population health, including poor mental health.</li> </ul>
<b>7</b> Affordable and clean energy	
<b>8</b> Decent work and economic growth	<ul style="list-style-type: none"> <li>• Promoting mental health and well-being in workplaces leads to improved employee health, increased productivity, and greater motivation. This benefits both workers and their organizations, while contributing to national economic growth.</li> <li>• People with mental health conditions and people from groups that face discrimination experience barriers in accessing decent work and securing stable jobs.</li> </ul>
<b>9</b> Industry, innovation and infrastructure	<ul style="list-style-type: none"> <li>• Innovations such as digital mental health platforms can advance mental healthcare and support. All digital mental health services and support need to be accessible, safe, secure and ensure confidentiality and privacy.</li> </ul>
<b>10</b> Reduced inequalities	<ul style="list-style-type: none"> <li>• Incorporating provisions for mental health in government sectors' policies and strategic plans is essential to reducing inequalities.</li> <li>• Inequitable treatment of people with mental health conditions and people from groups that face discrimination are pervasive and cause psychological stress.</li> </ul>
<b>11</b> Sustainable cities and communities	<ul style="list-style-type: none"> <li>• Well-planned urbanization can benefit mental health through improved access to work, education, and housing as well as to safe environments and green spaces that foster social interaction and encourage physical activity. These factors enhance individuals' mental health and contribute to the overall population well-being.</li> </ul>
<b>12</b> Responsible consumption and production	<ul style="list-style-type: none"> <li>• Socioeconomic deprivation and poor access to resources undermines populations' mental health and well-being.</li> </ul>
<b>13</b> Climate action	<ul style="list-style-type: none"> <li>• Climate change and associated environmental events cause human suffering and can undermine mental health.</li> <li>• Communities with strong mental well-being are better equipped to collaborate, adapt, and respond to climate-related challenges.</li> </ul>

SDG	Links with mental health
<b>14</b> Life below water	<ul style="list-style-type: none"> <li>• The availability of natural resources on land and at sea affects population health, including mental health.</li> </ul>
<b>15</b> Life on land	
<b>16</b> Peace, justice and strong institutions	<ul style="list-style-type: none"> <li>• Conflicts and violence are major threats to mental health and well-being.</li> <li>• Addressing mental health is crucial for long-term peace building efforts, as psychological recovery from trauma helps communities rebuild trust, resilience, and social cohesion, which are essential for sustainable peace.</li> </ul>
<b>17</b> Partnerships for the goals	<ul style="list-style-type: none"> <li>• Mental health is a universal concern and a shared responsibility across sectors.</li> <li>• Partnerships between the mental health and other government sectors are necessary for achieving the goals and targets in the SDGs agenda.</li> </ul>

Sources: This table is adapted from the WHO mental health report (2) and Lund et al. (2018) (21).

## A whole-of-government approach to advancing mental health and well-being

Given the interconnectedness of mental health and well-being with structural and social determinants, as well as with the SDGs, a comprehensive and coordinated response requires intersectoral collaboration through a whole-of-government and whole-of-society approach (2, 17). Many countries may have a distinct mental health sector. However, this document deals with integrating mental health actions across other sectors. Recommended policies, strategies and actions for the mental health sector itself are comprehensively discussed in Modules 1–5 of [Guidance on mental health policy and strategic action plans](#). Certainly, mental health is not solely a health issue: it demands significant policy attention and investment across government sectors on levels from national to municipal. Key sectors include general health, but also education; employment; urban and rural development; social protection; justice; culture, art, and sports; defence and veterans; environment, conservation, and climate protection; and interior (Box 1). Essentially, all government sectors must work closely together to address mental health and well-being holistically, integrating responses to structural and social determinants into every policy, strategy, and plan. In particular, the treasury and financing sector should keep equity in health and well-being at the heart of its decisions, whether setting tax rates or allocating funds for welfare and benefits, since doing so will yield substantial gains in mental health outcomes. By prioritizing mental health and putting into practice the policy directives and strategic actions outlined in this Guidance, government sectors not only bolster societal well-being and sustainable development but also accelerate progress toward their own objectives and targets.

### **Box 1. List of key government sectors for a whole-of-government approach to mental health and well-being**

- Financing and treasury (plays an over-arching cross-government role)
- Culture, arts, and sport
- Defence and veterans
- Education
- Employment
- Environment, conservation and climate protection
- Health
- Interior
- Justice
- Social protection
- Urban and rural development

# Development, implementation and evaluation of a whole-of-government approach

## Cross-cutting principles

When planning a whole-of-government approach or sector-specific policy to advance mental health and well-being, following some key cross-cutting principles provides direction. While the specific guiding principles may vary depending on cultural, social, and economic contexts, common cross-cutting principles include:

- **Taking a human rights-based approach.** This refers to implementing a framework grounded in international human rights law, aimed at promoting and protecting human rights. It involves adopting legal and policy frameworks that comply with State obligations under international law. It equips both State and non-State actors to identify, analyze, and address inequalities and discrimination, and to reach those who are marginalized. It also provides avenues for redress and accountability when necessary (4).
- **Taking a life-course approach.** This principle considers an individual's experiences and influences at all ages, recognizing how early-life factors, social environments, and life transitions shape long-term outcomes. This approach emphasizes that stages of life are interconnected. Events or conditions at one stage can affect future development and well-being across various domains, including education, employment, social relationships, and mental health. The life-course approach seeks to create policies and interventions that support individuals at key transitions, and that promote long-term societal progress (4).
- **Responding to structural and social determinants of mental health.** Structural determinants encompass the socioeconomic and political context. They include the norms, practices, policies, and institutions that shape how power and resources are distributed, and that contribute to social stratification, which in turn impacts population health. Social determinants are the various conditions in which people are born, grow, live, work, and age. These all influence population health (11). They include (but are not limited to): stigma and discrimination; poverty; lack of, or lower levels of, education; unemployment or job insecurity; homelessness or housing insecurity; food insecurity; health emergencies; climate change; natural hazards; pollution and industrial disasters; humanitarian crises and forced displacement; vulnerable migration; violence and abuse; loneliness and social isolation.
- **Ensuring meaningful participation of people with lived experience.** People with lived experience, whether of mental health conditions, mental health services, poverty, or of belonging to groups at risk of discrimination and exclusion, are well placed to understand key challenges and offer concrete, context-specific suggestions for change. Their insights help ensure that solutions truly address the needs of those affected.
- **Eliminating stigma and discrimination and changing mindsets and culture around mental health.** This involves actively reducing negative stereotypes, misconceptions, and prejudices associated with mental health conditions or psychosocial disabilities (2). It requires shifting attitudes within government sectors so that mental health is prioritized and integrated into all policies, strategies and plans. This shift aims to ensure that mental health is seen as a shared responsibility across government sectors.
- **Taking an evidence-based approach.** Sector-specific policy reform or development should be guided by scientific evidence and/or good practice, taking cost and cost-effectiveness, as well as cultural considerations, into account.

## Requirements for policy development, implementation and evaluation

Effectively integrating mental health into sector-specific policies, strategies and plans requires strong political commitment, inclusive stakeholder engagement, adequate financial resources, and clear accountability mechanisms. This has several foundational requirements:

- **Political will.** Sustained political will is essential for developing and effectively implementing a whole-of-government approach or any sector specific actions. Policy documents should demonstrate strong commitment through clear, action-oriented language in policy documents (for example, using “will” instead of “should”). High-level political endorsement and commitment is necessary. As a minimum the minister responsible for the sector must endorse the approach. In high-level cross-sectoral initiatives that require long-term investment, coordination, and accountability, political will should extend to the head of government. Establishing mechanisms for regular high-level progress reporting is key to maintaining momentum and visibility. An example of high-level initiative with reporting mechanisms at the head of government level is Ireland’s [National Mental Health Promotion Plan \(22\)](#).
- **Stakeholder engagement.** Broad stakeholder endorsement and support are crucial for policy success (see Box 2 for a list of key actors and groups/organizations to engage). This requires active engagement of stakeholders throughout development, implementation and evaluation. Special attention should be given to engaging people with lived experience of the issue being tackled, including people with mental health conditions or psychosocial disabilities, as well as groups facing discrimination. Stakeholder engagement is essential to ensure that policies strategies and plans are contextualized, and reflect the social, cultural, and economic circumstances of the region or country.
- **Financial resources.** Costing policy directives and strategic actions to advance mental health is essential in order to advocate for the necessary budget. Insufficient resources can demotivate stakeholders involved in implementation and hinder intended outcomes. A less ambitious policy, strategy or plan with adequate funding can lead to greater commitment than under-funded ambition, and may be a more effective use of resources. To increase the likelihood of successful implementation, the budget should be developed alongside the policy development process.
- **Accountability mechanisms.** The policy and associated strategy and/or plan should include clear implementation mechanisms and timelines, and measurable targets. Roles and responsibilities of stakeholder groups should be carefully considered and clearly defined, recognizing that various stakeholders may be best positioned to deliver specific strategies and actions. As well as targets, policies need mechanisms for monitoring and reporting implementation, outputs and outcomes. Generating and using reliable, up-to-date data helps identify needs, track progress, and ensures that the policy addresses real-world challenges. This supports accountability and helps identify and address barriers.

## Eight process steps

Establishing a comprehensive, inclusive, evidence and rights-aligned process for developing, implementing and evaluating policy is crucial. Eight process steps emerge from the requirements discussed above. These are flexible and can be re-ordered. Some may need to be revisited and updated periodically as circumstances change or as gaps are identified during the policy drafting process. The steps are discussed below, and summarized in Box 3.

Countries will have varying starting points, and each country (and each sector) should first assess what has already been done. For instance, if a situational analysis is in progress or already completed for certain sectors, it may be sufficient to review such an analysis for relevance, and address any gaps.

However, it is important to recognize that many policies, strategies and plans are unimplemented or ineffective, due to factors such as lack of political will, insufficient stakeholder engagement and consensus, poor awareness and understanding of policy directives, unrealistic funding, and an under-appreciation of how social and structural determinant affect mental health. Appreciating this can help planners and implementers avoid common pitfalls and surmount hurdles.

- 1. Conduct high level policy dialogue to establish commitment and engagement for protecting and promoting mental health and well-being within each sector.** It is essential to convene senior leadership and staff to discuss the benefits of protecting and promoting mental health. Sector-specific policy will be needed, together with associated strategies and/or plans. It is crucial to develop sector-specific position papers on mental health. Each should be a concise, evidence-based analysis. They can combine international research and evidence with local data to make the case for sectoral investments. A good starting point is to map the key social and structural determinants in a sector, identifying both the harms they cause and any protective factors. Then propose clear, actionable policy recommendations to mitigate risk and promote well-being. Each recommendation can illustrate direct benefits. For example, within the education sector life- and social-skills curricula and teacher training can reduce student dropout rates, build resilience, and prevent suicides. Cross-sectoral gains should also be identified. For example, better support for mental health via the education sector will improve employment prospects, will strengthen community health, and may lower future burdens on the justice system. This Guidance offers evidence and recommendations that sector-specific analyses can draw on.
- 2. Raise awareness and shift mindsets to integrate mental health into sector-specific policy, strategies and plans.** Each sector is encouraged to liaise with the mental health sector to implement awareness strategies. These should aim to transform mindsets, improve understanding of mental health, and combat stigma and discrimination among sector staff and leadership. Including representatives from organizations of people with lived experience of mental health conditions and psychosocial disabilities, and from other groups facing discrimination, is crucial to an inclusive and informed approach.
- 3. Review current sector-specific policy, strategies and plans.** A working group within the sector should be established to convene sector-specific policy experts, mental health experts, and civil society representatives, including those who have experienced the issues being discussed. This working group should review current sector-specific policies and associated strategies and/or plans. It should examine how mental health and well-being is addressed, identify what is already well covered, highlight any gaps, suggest what can be strengthened, and flag where current policy or actions might be harmful to mental health. The menu of policy directives and strategic actions outlined in this Guidance can inform this process. Findings from this review should be documented in a situational analysis for each of the sectors.

**4. Establish a drafting team to integrate mental health into sector-specific policy, strategies and plans.**

The drafting team should include stakeholders from within the sector, from the mental health sector, and from other relevant sectors as well as representatives from organizations of people with lived experience of mental health conditions and psychosocial disabilities and from other groups facing discrimination. People who have directly experienced the issues being discussed should be actively engaged. They can provide valuable first-hand insights. For example, when discussing mental health within the justice system, engage people working in policing, prisons and courts.

**5. Revise or draft policy, strategies and plans to protect and promote mental health.** Base revisions on the situational analysis from Step 3. This Guidance can form a menu of options to select and adapt to fit the context. Ensure that policy changes are both meaningful and actionable.

**6. Hold wider consultations with stakeholder groups and the public.** Consulting with stakeholder groups and the public generates feedback, giving opportunities to address suggestions, concerns, and objections, and then refine accordingly. Discussions also raise public awareness, helping ensure that the final result is inclusive and widely supported.

**7. Implement policy and associated strategies and/or plans.** Policy reform will likely be multifaceted, requiring changes to administrative processes and regulations, including forms and documentation. Training will be essential to help stakeholders understand the required actions, including educating leaders, managers, and other key players on the reasons for and specifics of the reforms. Sectors are encouraged to establish a concrete programme of work outlining the policy directives and strategic actions to be implemented, including indicators of success, budgets, targets and timeframes.

**8. Monitor and evaluate implementation.** Establishing mechanisms for tracking progress will help identify challenges and necessary adjustments. Regular monitoring and evaluation will ensure that the policy reforms remain effective and responsive to emerging needs. Periodic reporting, including on indicators, achievements and barriers, will promote accountability, and allow for ongoing adjustments. For example, resources may need reallocation or mobilization. This Guidance gives examples of key mental health indicators for each sector, linked to strategic actions. For more general health and equity indicators for government sectors see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## Box 2. Key actors and groups/organizations to engage

### Key actors:

- policy-makers and managers from each sector;
- politicians (for example, ministers, city and town mayors);
- people who have directly experienced the issues being discussed including people with lived experience of mental health conditions and psychosocial disabilities and representatives from groups that face discrimination;
- affected communities;
- community leaders and gatekeepers, such as local chiefs or village leaders, traditional, and faith-based healers or leaders;
- mental health and general health practitioners as well as other relevant and allied professionals at all levels of health care;
- families and other caregivers;
- legal and human rights experts and professionals;
- academics and researchers; and
- philanthropists.

### Key groups and organizations:

- relevant government sectors/departments;
- organizations of people with disabilities;
- organizations of people with lived experience;
- other organizations of groups that face discrimination;
- local civil society groups;
- nongovernmental organizations (NGOs);
- charity and voluntary based organizations;
- faith-based organizations;
- organizations representing mental health practitioners, general health practitioners, and other multidisciplinary practitioners;
- organizations representing families and caregivers;
- academic and research institutions; and
- legal aid and human rights organizations.

### Box 3. Summarized process steps for protecting and promoting mental health and well-being

- 1. Conduct high-level policy dialogue** with senior leadership within the sector(s).
- 2. Raise awareness and shift mindsets** to integrate mental health into sector-specific policy, strategies and plans.
- 3. Review** policy and associated strategies and/or plans in tandem with this Guidance.
- 4. Establish a drafting team** including stakeholders from all relevant sectors, affected communities and persons with lived experience.
- 5. Revise or draft** new provisions based on the review.
- 6. Consult** with stakeholder groups and the public to gather feedback, address suggestions, and concerns, and to refine accordingly.
- 7. Implement** policy and associated strategies and/or plans including updating administrative processes, providing training, and establishing clear targets, timelines, budgets, and indicators of success.
- 8. Monitor and evaluate** implementation by continuous tracking progress, reporting on outcomes, and making adjustments to ensure effectiveness, responsiveness, and accountability.

## Purpose, scope, use and development of the Guidance

### Purpose

This Guidance intends to help key government sectors ensure that mental health and well-being are addressed comprehensively and that all sector policies consider the structural and social determinants of mental health.

It highlights opportunities for intersectoral partnerships and actions that can leverage comprehensive mental health and well-being, thereby advancing Sustainable Development Goal (SDG) targets, while also upholding human rights and benefitting from the return on investment that mental health initiatives offer.

This Guidance is intended for policy-makers across various government sectors who are responsible for drafting, revising, and implementing sector-specific frameworks, policies, associated strategies and/or plans, as well as for those involved in monitoring and evaluation.

It is also a valuable resource for policy-makers in the mental health sector, who will need to collaborate with colleagues from other sectors to embed mental health and well-being into all policies.

It can be used by government sectors at all levels (national, regional, provincial, district, and even sub-district levels depending on the context).

Additionally, the Guidance is relevant to people with lived experience and their families, health and mental health service providers, professionals, national human rights institutions, nongovernmental organizations (NGOs), organizations of persons with disabilities (OPDs), and others engaged in policy reform and/or development, and advocacy. This Guidance can help these stakeholders better understand government roles and responsibilities for advancing mental health and well-being, as well as key issues that sector-specific policies and associated strategies and/or plans should address.

## Scope

This Guidance leads with a section on government-led mental health initiatives across all sectors. It highlights the need for high-level government commitment and coordination. The discussion includes key aspects such as financing and budgeting, which rely heavily on the decision-making in the treasury and finance sector. The Guidance then offers recommendations for policy directives and strategic actions for 10 government sectors: culture, art and sport; defence and veterans; education; employment; environment, conservation and climate protection; health; interior; justice; social protection; and urban and rural development. It also includes example indicators for each strategic action. These can support monitoring and evaluation to ensure accountability and continuous improvement. They are illustrative, and should be adapted and modified to meet each context.

The sectors are not exhaustive, but are consistently represented across countries. They are selected for their potential impact on promoting mental health and well-being. It is important to note that mental health awareness and understanding should be integrated across all government sectors, including those not explicitly covered in this Guidance.

Importantly, many of the policy directives and strategic actions outlined are already part of the respective sector's mandate and role. Their inclusion underscores their value in addressing mental health and their potential as areas of collaboration with other sectors.

Several countries have already developed dedicated policies, strategies and/or plans to address key issues outlined in this Guidance. Selected examples of promising policies and practices are included, but other valuable national or regional efforts and resources not included in this Guidance may also be meaningfully advancing mental health and well-being.

## Using the Guidance

This Guidance provides a menu of policy directives and strategic actions for each sector. These are not exhaustive but focus on the most relevant issues. Countries do not need to act on all the policy directives and strategies. Rather, they should select those most suited to their context, based on national priorities and gaps identified in Step 3. Review of the process steps. For example, if a country already has a Health in all Policies (HiAP) approach in place, government can build on that, ensuring that mental health and well-being are addressed alongside physical health.

Importantly, government sectors can change, adapt and prioritize directives and strategies and indicators. Actions may need to be implemented concurrently or adjusted to fit a country's specific circumstances.

Roles and responsibilities may vary from country to country, and some topics discussed under one sector in this Guidance might sometimes fall under another sector in a specific country. For instance, in some countries the police are part of the justice sector, while in others, they fall within the interior sector. Similarly, issues around accessible and affordable housing might fall under both the social protection and the urban and rural development sectors. Therefore, Fig. 1 offers a [directory of key issues](#) to help readers find the relevant discussions.

## Development

WHO developed this Guidance between February 2023 and August 2025 through an iterative, collaborative process. This included targeted literature reviews, drawing on peer-reviewed publications, international human rights frameworks, and relevant policy documents from the mental health and other government sectors. While not a systematic review, the literature search was exploratory and guided by practical relevance to the subject areas under consideration. Search terms were selected to reflect key policy domains and emerging practices, and aimed to capture diverse international experiences and sectoral perspectives.

In addition, the development process included analysis of existing national policies, strategies, and action plans from a range of countries, with attention to geographic, economic, and cultural diversity.

WHO conducted multiple rounds of consultation with policy-makers from mental health and other sectors, UN experts, people with lived experience, practitioners, researchers, and civil society representatives, including organizations of persons with disabilities (OPDs). In October 2024, WHO requested written feedback on the full draft from a broad network of international experts, government officials, and civil society organizations.

All feedback received during the development of this Guidance was carefully reviewed and considered. Where comments were unclear or where additional input was needed, WHO followed up directly with contributors to clarify intent, request further material, or conduct additional research. Feedback that aligned with the focus and purpose of the document and contributed to its clarity, relevance, or usefulness was incorporated. Where suggestions were outside the scope or too detailed for inclusion, they were acknowledged, and where relevant, readers were referred to additional resources. The development process did not involve significant disagreements or controversies requiring formal resolution procedures. Instead, it was marked by constructive engagement and a shared commitment to strengthening the Guidance.

All external experts submitted to WHO a declaration of interest disclosing potential conflicts of interest that might affect, or might reasonably be perceived to affect, their objectivity and independence in relation to the subject matter of this guidance. WHO reviewed each of the declarations and concluded that none could give rise to a potential or reasonably perceived conflict of interest related to the subjects discussed at the meeting or covered by the guidance.

## SPOTLIGHT on guidance for the mental health sector itself

While the current document discusses mental health actions across wide-reaching government sectors, WHO has also produced detailed guidance specifically for the mental health sector.

[\*Guidance on mental health policy and strategic action plans\*](#), provides a clear framework for strengthening leadership, governance, service delivery, and workforce capacity. It highlights mental health's connection to social and structural determinants (such as poverty, housing, education, and employment), offering actionable strategies to address these, to combat stigma and discrimination, and to expand access to care. It emphasizes the crucial role of people with lived experience in shaping inclusive, responsive systems and advocates for cross-sector collaboration to deliver holistic support, integrating lifestyle, and physical health, psychological, social, and economic interventions while promoting well-being and prevention.

### The Guidance comprises five modules

[\*Module 1 \(24\) Introduction, purpose and use of the guidance\*](#) explores key mental health policy considerations, addressing the urgent need for reform to tackle social and structural determinants and emphasizing the need to align with international human rights frameworks.

[\*Module 2 \(25\) Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans\*](#) details five policy areas for reform, starting each discussion with an overview of challenges and providing a menu of policy directives, strategies for achieving them, and potential implementation actions.

[\*Module 3 \(20\) Process for developing, implementing, and evaluating mental health policy and strategic action plans\*](#) proposes an inclusive, country-led process that prioritizes and tailors policy options and strategic planning to national contexts.

[\*Module 4 \(26\) Country case scenarios\*](#) presents three examples that highlight varied approaches to mental health policy reform.

[\*Module 5 \(27\) Comprehensive directory of policy areas, directives, strategies and actions\*](#) helps stakeholders navigate material from Module 2. It can facilitate discussions with staff and stakeholders. Its summary approach helps policy-makers quickly assess what is present, missing, or needs strengthening in their mental health system or policies.

**Fig. 1 Directory of key issues**

This figure will help readers find discussions linked to the issues listed. Some issues are discussed across all sectors. For other topics, a cross (x) indicates discussions under that sector. A blue highlight signifies that the issue is substantially addressed in that sector (for example through a proposed strategic action).

**Addressed across all sectors**

Issue	Government-led cross-sector initiatives	Culture, arts, and sports	Defence and veterans	Education	Employment	Environment, conservation and climate protection	Health	Interior	Justice	Social protection	Urban and rural development
Awareness raising and training on mental health	x	x	x	x	x	x	x	x	x	x	x
Person-centred, rights-based approaches	x	x	x	x	x	x	x	x	x	x	x
Stigma and discrimination	x	x	x	x	x	x	x	x	x	x	x
Suicide prevention	x	x	x	x	x	x	x	x	x	x	x
Social isolation, loneliness, connection and inclusion	x	x	x	x	x	x	x	x	x	x	x
Poverty	x	x	x	x	x	x	x	x	x	x	x

## Addressed in one or more sectors

Issue	Government-led cross-sector initiatives	Culture, arts, and sports	Defence and veterans	Education	Employment	Environment, conservation and climate protection	Health	Interior	Justice	Social protection	Urban and rural development
Housing			X							X	X
Transport and infrastructure						X					X
Physical activity, including active transport and leisure activities		X		X		X	X				X
Early childhood development and parenting programmes				X						X	
Digital technologies				X			X	X			X
Pollution						X					X
Water, sanitation and hygiene						X					X
Food insecurity and access to healthy food options				X		X				X	X
Jails and prisons									X		
Conflict, war and humanitarian emergencies			X			X		X			
Migrants, refugees and asylum seekers		X				X	X	X		X	
Natural hazards and climate change impacts						X	X	X			X
First responders					X	X	X	X			
Social protection					X					X	
Violence, abuse, harassment including bullying and gender-based violence		X	X	X	X		X	X	X	X	X



# Government-led cross sectoral mental health initiatives



## Overview

Prioritizing mental health in the political agenda, along with strong leadership and clear and ambitious goals, is essential. This includes securing the necessary resources and funding to support mental health initiatives.

Importantly, mental health is not just a health issue. It requires considerable policy attention from other key government sectors. Incorporating mental health in to all policies ensures that mental health and well-being are addressed comprehensively and holistically, and the social and structural factors that affect mental health are considered in all sector policies and strategic actions (28).

To achieve commitment for investing in mental health across sectors, decision-makers must understand the cost of inaction as well as the potential benefits. For example, decision-makers within the employment sector should understand the costs of poor mental health, such as work days lost, reduced productivity, and high turn-over. They need to understand the expected outcomes of interventions in relation to their sector, as well as the overall economic and social return of investing in mental health. For example, investments that benefit the employment sector through reducing the number of sick days, will also benefit other sectors, such as by reducing healthcare pressure, lowering disability payments, minimizing family conflict, and enhancing children's well-being and learning. Impacts may take time to manifest and can be complex to measure, but cumulative cross-sectoral action can yield substantial benefits. Guidance on how to make an investment case for mental health can be found in [Investing in mental health: evidence for action \(29\)](#) and in [Mental health investment case: a guidance note \(30\)](#).

Heads of state or heads of government<sup>1</sup> and other high-profile national figures can greatly influence public attitudes by raising awareness and combating stigma and discrimination around mental health through, for example, involvement in national anti-stigma campaigns and by publicly speaking about the importance of mental health.

Heads of state or heads of government can also play a key leadership role in convening and facilitating dialogue on advancing mental health and well-being between government sectors. This is particularly important when it comes to understanding likely returns on investment. Sectors may hesitate to invest if they only see limited or delayed economic impacts within their own sector (31, 32). Governments can demonstrate high-level commitment by creating a dedicated government-led initiative focused on mental health and well-being, with clear accountabilities and specific priorities based on the population's needs. This raises the profile of mental health and sends the strong messages that every sector has an important role, and that the government/head of state is committed to the issue.

Mental health should be central to all countries' development policies as it plays a significant role in achieving the Sustainable Development Goals (15) (see discussion in the Introduction and [Table 1](#)).

Finance and treasury plays a critical role in protecting and promoting mental health beyond simply allocating funds across government. By embedding equity in health and well-being into every financial decision, whether setting tax policies or distributing welfare and benefits, financing can drive substantial improvements in population mental health outcomes.

<sup>1</sup> This Guidance uses the terms head of state or head of government when referring to the highest level of government. This can be on national, regional, district, municipal and other levels depending on the administrative and governance structure of the country. As political systems are structured differently in each country, the terminology used for the highest-level actors might differ depending on context and circumstances.

For some initiatives, engagement from all sectors will be essential, such as efforts to address stigma and discrimination. For more specific guidance on this see Module 2 of [Guidance on mental health policy and strategic action plans \(25\)](#).

For other initiatives, not every sector will be involved, but many will still need to play a role (see Spotlight on inter-sectorial solutions for society-wide mental health challenges below). An example of successful cross-sectoral collaboration is the Un chez soi d'abord initiative in France, adapted from the Housing First model used in New York in the 1990s, which provides people in precarious situations and with challenging mental health conditions direct access to stable and supported housing, leading to overall cost savings compared with traditional care. The initiative is supported through collaboration and joint financing from various French government sectors, including health, housing, and territorial cohesion (l'agence régionale de santé, la direction régionale et interdépartementale de l'hébergement et du logement, et les collectivités territoriales) [\(33\)](#).

This Guidance offers heads of state, government sectors, and other high-level stakeholders a menu of policy directives and strategic actions to implement a whole-of-government approach to mental health and well-being. The numbering uses the prefix WG (whole of government) to help avoid confusion when discussing policy directives for specific sectors or from other documents. The Guidance also includes adaptable examples of indicators for achieving strategic actions. Clear, measurable indicators enable government to track progress, assess impact, determine whether intended outcomes are being achieved, and drive continuous improvement. For more general health and equity indicators related to the work and responsibilities of various sectors see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## **SPOTLIGHT** on inter-sectorial solutions for society-wide mental health challenges

The following is adapted from [Guidance on mental health policy and strategic action plans: module 2: key reform areas, directives, strategies, and actions for mental health policy and strategic action plans \(25\)](#).

**Discrimination.** Collaborations across sectors could launch campaigns that educate the public on stereotypes and misconceptions, that address the mental health impact of discrimination by motivating attitude and behaviour changes, and that analyze and revise discriminatory policies within each sector.

**Gender-based violence.** Collaborations could involve sectors such as gender affairs, justice, and health. Actions could create safe houses and provide psychological support to survivors of violence, educate the public on mental health issues related to gender-based violence, engage violent men in rehabilitation programmes, and train law enforcers and other relevant professionals to support survivors.

**Climate change.** Collaborations could involve sectors such as environment, education, and health. For example, campaigns could recognize eco-anxiety as a common reaction to environmental decline, and underpin coping techniques, such as taking breaks from constant news feeds, and taking individual or collective action over something controllable.

**Student debt and poverty among young people.** Collaborations between sectors such as education, finance, treasury, and health could provide resources such as financial workshops to improve literacy, hotlines, and information on student loan cancellation and financial entitlements. Self-care resources could include stress management techniques during financial strain, work-life balance, and support for young people who don't yet feel confident in their place in the world (so-called imposter syndrome).

**Child abuse.** Collaborations between sectors such as child protection, education, justice, and health could train educators and school staff on identifying victims of abuse and children at risk, and to provide emotional support.

**Child poverty.** Collaborations between sectors such as education, child protection, social protection, nutrition, and health could increase social benefits for children and their families (for example, cash transfers, integrated support systems); could educate families about children's entitlements and about programmes for children living in poverty; and could monitor and address factors contributing to childhood poverty (for example, health conditions, medical expenses, food shortages, migration).

**Early childhood development.** Collaborations between education, food and nutrition, child protection, and health sectors could introduce early childhood development programmes that promote psychosocial development across the entire population, including groups facing discrimination. Programmes can also address childhood adversity issues such as maltreatment and household dysfunction.

**Social isolation and loneliness.** Collaborations between sectors such as social protection, health, older people's affairs, sports, and culture, entertainment and the arts could map opportunities for building social connections and reducing loneliness.

**Humanitarian emergencies.** Collaborations between sectors such as health, social protection, interior affairs, and humanitarian organizations could ensure disadvantaged people, especially institutionalized individuals, have their basic needs met during crises (for example, their needs for water, food, clothing, sanitation, mental and physical health treatment, and medications). During infectious disease outbreaks, mental health and psychosocial support considerations should be integrated into clinical case management and also into the broader public health emergency response.

**Suicide.** Collaborations could involve sectors such as agriculture, industry, education, justice, labour, media, social welfare, transport, energy, construction, youth, minority affairs, defence, and food and drug authorities to reduce access to means for self-harm or suicide. This includes promoting responsible media reporting, decriminalizing suicide, reducing school pressures and introducing socio-emotional skills training in schools, and providing poverty alleviation schemes and mental health support for farmers.

## Policy directive WG1 Prioritize mental health in the political agenda

### Strategic actions

#### 1. Establish a multisectoral coordinating body to discuss the importance of mental health and the need to integrate it into all policies and programmes.

While the health and mental health sectors are vital in developing and implementing policies to promote and protect the population's mental health and well-being, many mental health issues stem from structural and social determinants that extend beyond these sectors (2, 16). For example, school and work environments, as well as urban and rural development and housing policies, significantly impact mental health and well-being. However, such sectors often fail to integrate mental health into their areas of responsibility. Convening sectors through a multisectoral coordinating body for mental health allows for dialogue and collaboration, emphasizing the importance of incorporating mental health considerations into all sector policies and strategic action plans (34).

When facilitating these discussions it is important to emphasize the benefits of investing in rights-based mental health interventions. This includes recognizing the cost of inaction, as well as the potential benefits for that sector, other sectors, and society as a whole, both in the short and long term. Sectors can be encouraged to use this Guidance alongside [Guidance on mental health policy and strategic action plans](#), particularly Module 2 (25).

The more senior the participants and the more prominent the coordinating body, the greater the likelihood of meaningful impact.

#### Example indicator

**Name** Establishment, and inaugural meeting, of the multisectoral mental health coordinating body.

**Definition** Achieved if a formal legal or administrative instrument has created the body and its inaugural meeting has been held.

**Data source(s)** Official gazette/meeting minutes.

## **2. Establish a whole-of-government initiative or strategy on mental health and well-being with specific focus areas, a dedicated programme of work, and a budget for each sector.**

Engaging multiple sectors, such as education, employment, rural and urban development, and social protection, is essential for advancing mental health and addressing its social and structural determinants. The strategy or initiative should be informed by, and aligned with, established mental health needs and priorities. These should be identified through comprehensive consultations with government sectors and civil society, NGOs, OPDs, community leaders, and individuals with lived experience and their families. Meaningful engagement with these groups will amplify diverse voices throughout the planning, development, and implementation stages, ensuring that the initiative is inclusive and comprehensive.

Each sector that participates should develop a work programme outlining the policy directives and strategic actions to be implemented, complete with sector-specific success indicators, targets, timeframes and the necessary funds. A thorough cost analysis for each sector's programme should be conducted, and a realistic budget allocated. Setting up monitoring and evaluation mechanisms, including periodic reporting on each sector's programme of work, indicators, achievements and barriers will promote accountability, and allow for ongoing adjustments, including the reallocation or mobilization of additional resources if needed. Reporting should be at the highest level possible, ideally directly to the head of state.

Once the initiative is planned and ready for implementation, a high-level launch could be held to raise awareness and bring nationwide attention to the initiative. This launch could include public events, media coverage, and a website to highlight strategies, actions, and planned collaborations between sectors.

For more detailed information on planning, monitoring and evaluation refer to Module 3 of the [Guidance on mental health policy and strategic action plans \(20\)](#).

### **Example indicator**

**Name** Formal approval and publication of a whole-of-government mental-health and well-being strategy.

**Definition** Achieved if the cabinet has officially approved the initiative or strategy and it has been publicly published.

**Data source(s)** Official gazette cabinet document; government website or official publication announcing the initiative/strategy.

### 3. Speak publicly about the importance of addressing and investing in mental health.

Establishing mental health and well-being as a central focus of public discourse is a powerful signal of political commitment. Heads of state, government sector leaders, and other high-level stakeholders should articulate policy, framed through a rights-based lens. Bringing mental health into the public spotlight can raise public awareness, reduce stigma and discrimination and rights violations, and encourage stakeholders at every level and across all sectors to engage more openly and collaboratively on this critical but chronically underrepresented topic.

#### Example indicator

**Name** High-level public statements on mental health importance.

**Definition** Number of official public statements by heads of state, ministers or equivalent sector leaders that explicitly address the importance of mental health and the need for investment.

**Data source(s)** Text of speeches or remarks published in government archives; press releases from heads of state/ministries; official social-media posts on verified government accounts.

### 4. Reach out to other countries to learn and share best practices on mental health and well-being.

Creating opportunities for international cooperation, both multilateral and bilateral, allows countries to exchange and share experiences in mental health, enabling mutual learning on good practices. Many countries have made significant progress in developing and implementing rights-based mental health policies, laws, and services across various settings, including hospital-based care, community mental health centres and peer support services. Additionally, some countries have integrated mental health and well-being into broader sector policies and strategic actions, establishing social protection schemes, supported housing services for people with psychosocial disabilities, programmes to support mental health during early childhood development, schools and universities, and more. Cooperating with other countries offers opportunities to learn from their successes and share one's own. This exchange can inspire valuable reforms and improvements. For comprehensive examples, refer to the [World mental health report: transforming mental health for all \(2\)](#), [Guidance and technical packages on community mental health services \(35\)](#) and the [Guidance on mental health policy and strategic action plans \(24\)](#).

#### Example indicator

**Name** Formal international collaborations on mental-health and well-being best practices.

**Definition** Total number of formal Memoranda of Understanding (MOUs) signed with other countries or study-visit delegations completed, specifically focused on sharing and learning best practices in mental health and well-being.

**Data source(s)** Ministry of Foreign Affairs (or equivalent) records of signed MOUs; Ministry of Health (or equivalent) logs of official study-visit delegations and mission reports.

## Policy directive WG2 Provide leadership and accountability for national progress on mental health

### Strategic actions

#### 1. Encourage the development of rights-based mental health policy and law and the incorporation of mental health into sectors' policies.

Heads of state or government can encourage the mental health sector to create rights-based policies and laws, that better align with broader national priorities such as poverty reduction, employment, and human rights. In addition, provisions directly related to mental health, or provisions that can indirectly act to promote and protect mental health, can be integrated into many government sector's policy and laws. For example, policy and legal provisions that discriminate against people with mental health conditions or psychosocial disabilities should be removed. This includes, but is not limited to, employment (including standing for public office), education and housing. Reforms need to align with international human rights standards including the Convention on the Rights of Persons with Disabilities (1).

Providing clear direction and leadership from the head of state or government can increase commitment within government sectors and can give ministries the necessary support and political backing to follow through with policy and law development and implementation.

For detailed guidance on rights-based policy development and reform, as well as sector-specific guidance on mental health, see the guidance for each government sector within this document, [Guidance on mental health policy and strategic action plans \(24\)](#) and [Mental health, human rights, and legislation: guidance and practice \(36\)](#).

#### Example indicator

**Name** Enactment or amendment of rights-based policies and laws for mental health.

**Definition** Number of new or amended policies, laws or regulations that explicitly embed a rights-based approach to mental health and/or incorporate mental-health provisions in government sectors.

**Data source(s)** Official legal gazette entries for new or amended statutes and regulations; government policy archives or ministry publications detailing cross-sector policy revisions.

#### 2. Raise public awareness and combat stigma and discrimination around mental health through high-profile campaigns and initiatives.

Stigma surrounding mental health, often due to a lack of knowledge and understanding, is widespread and leads to significant human rights violations and negative mental health outcomes. For instance, stigma drives discriminatory attitudes in society, workplaces, and the health system, reduces help-seeking behaviour, and limits support options for people experiencing mental health issues (37). In many cases, people experiencing emotional distress or a mental health crisis are subjected to violence and abuse, either in the community or within services (38, 39). To address these challenges, many countries have begun implementing high-level national or regional anti-stigma campaigns (32). These campaigns can be tailored to different segments of the population, such as young people, working-age adults, healthcare workers, and the media.

For example, some countries provide targeted training and information for journalists to change the negative and stigmatizing language and portrayal of mental health issues in the media (32). Others involve celebrities and influential public figures as ambassadors, who share their own stories of emotional distress or mental health conditions (40). It is vital to avoid the common pitfall of medicalizing mental health issues when rolling out these campaigns as it frequently results in over-medication while failing to address the root causes of a person's distress, ultimately making the treatment ineffective and potentially harmful (41). Equally, securing high-level leadership and political commitment is essential for their success and sustainability. Therefore, heads of state or government and other senior political figures across sectors should spearhead national and regional anti-stigma initiatives focused on mental health, well-being, and social inclusion. These campaigns must engage all relevant stakeholders, particularly people with lived experience, their families and representative organizations, OPDs, celebrities, community and religious leaders, and other public figures whose involvement will amplify the message, raise awareness, and help dismantle stigma and discrimination.

**Example indicator**

**Name** National (or large-scale) public campaigns or initiatives launched to raise awareness and combat mental-health stigma and discrimination.

**Definition** Number of officially launched high-profile public awareness campaigns or initiatives that explicitly target mental-health stigma and discrimination.

**Data source(s)** Records and announcements from government communications departments (for example, press releases or launch briefs); Ministry of Health or equivalent social-media analytics and campaign evaluation summaries.

**3. Establish periodic reporting and meetings at the head of state level to discuss and evaluate progress in mental health across sectors.**

After initiating a whole-of-government initiative on mental health and well-being, it is crucial to continuously monitor and evaluate progress within each sector. Biannual reviews establish accountability by requiring sectors to report on their programmes of work, assess progress against strategic targets, and identify barriers and successes encountered during implementation. These reviews also provide an opportunity to revisit initial costing analyses and budgets to determine whether they remain realistic or require adjustments and additional resource mobilization. Successes reported by one sector can inform and enhance the work of others. A prioritized set of indicators should be defined for each sector, allowing progress to be measured consistently over time. Periodic reporting can incorporate qualitative measures and draw on systems and policy research approaches to better understand the levers of change.

**Example indicator**

**Name** Multisectoral head of state mental health progress meetings held.

**Definition** Total number of high-level meetings convened by the head of state (or head of government) to review and evaluate multi-sectoral implementation of the national mental health strategy.

**Data source(s)** Official calendar or meeting schedule from the President's or Prime Minister's office; meeting minutes; agendas or official communiqués announcing and recording each meeting.

## Policy directive WG3 Ensure financial commitment and appropriate budgeting for mental health

### Strategic actions

#### 1. Define and dedicate a budget, including sector-specific and joint-sector elements, to implement the whole-of-government initiative or strategy.

An essential part of planning a whole-of-government initiative on mental health and well-being is conducting a thorough and realistic costing analysis to determine the financial resources required to implement strategic actions. This analysis should be based on evidence and good practice in each involved sector. The process includes developing sector-specific budgets as well as joint budgets and co-financing arrangements between sectors that collaborate closely on joint initiatives. For example, the health and housing sectors might establish a joint initiative to provide supported housing for people with psychosocial disabilities. Ensuring that each sector has a defined budget dedicated to these efforts will facilitate implementation of the whole-of-government initiative.

In some countries, individual sectors can establish satellite accounts that are dedicated tracking frameworks running alongside their core national accounts. These can show exactly how the sector invests in mental health and well-being. For example, the education sector could record spending on school-based counselling, psychosocial support training, mental-health curricula, peer-support programmes and safe spaces. Employment could capture budgets for employee assistance programmes, stress-management workshops, paid mental-health leave and anti-harassment measures. Social protection could monitor cash benefits linked to psychosocial support, community rehabilitation grants and inclusion projects.

Anchored to standard national-account categories (for example education or social services) and using consistent definitions, these accounts can be aggregated and compared across sectors. Annual templates would collect both financial data and key outputs (such as counsellor-hours or beneficiary numbers). A cross-sectoral oversight group would agree definitions, and review and audit figures to maintain data integrity. The results could then inform policy reviews, budget allocations (such as ring-fenced funding for school-based services) and feed into regular reports on mental health and well-being, ensuring transparency and accountability for each sector's contribution.

#### Example indicator

**Name** Coverage of dedicated budgets for the whole-of-government mental health strategy.

**Definition** Percentage of all government sectors involved in the whole-of-government mental health and well-being initiative or strategy that have an explicitly defined budget for its implementation, either as sector-specific line items or jointly financed allocations.

**Data source(s)** National budget law or annual appropriation act (budget schedules/annexes); Ministry/department budget documents or budget circulars specifying mental health allocations across sectors.

## **2. Facilitate dialogue and collaboration between the financing sector and all other sectors to ensure sufficient funds for mental health.**

The head of state or government should prioritize mental health and well-being across all sectors by ensuring sufficient financial resources are allocated to implement policies and strategic actions. To achieve this, it is crucial to facilitate dialogue and collaboration between the financing sector and all other sectors. During fiscal planning and when setting national budgets for upcoming years, the head of state or government can emphasize the importance of mental health financing as a priority for domestic funding. Encouraging the finance and treasury sector to work closely with all other sectors has the goal of providing budgets adequate for implementing sector specific mental health and well-being initiatives as effectively as possible. A percentage of the budget allocated to sectors should be dedicated for monitoring and evaluation to allow continuous improvement and to identify and manage any unintended consequences.

### **Example indicator**

**Name** Finance sector mental health-financing dialogue rounds.

**Definition** Number of structured meetings convened by the Treasury or Ministry of Finance with other government sectors specifically to discuss and secure financing for mental health initiatives.

**Data source(s)** Treasury or Ministry of Finance meeting logs and calendars; official records or minutes of inter-sectoral financing discussions.

## **3. Secure external funds to ensure sufficient resources for mental health in all sectors.**

If domestic funding is insufficient to cover the budget needed for sector-specific mental health policies and strategic actions, seeking additional funds from external sources can be vital. These sources may include multinational or bilateral donors, foundations, philanthropists, lottery funds, or pay-for-success mechanisms like social impact bonds (42) and corporate social responsibility initiatives. Heads of state or government can play a key facilitation role in securing these funds and ensuring they are appropriately allocated across different sectors. Additionally, donor governments should integrate mental health into their aid strategies and use their collaborations with governments to encourage increased domestic spending on mental health (43).

### **Example indicator**

**Name** External grants and loans secured for mental health initiatives.

**Definition** Number of new external funding agreements (grants or loans) signed with external donors specifically to support mental health programmes and activities across government sectors.

**Data source(s)** National donor agreements registry or database; Treasury/Ministry of Finance records of external financing agreements.

Box 4 offers further resources for implementing government-led cross sectoral mental health initiatives.

#### **Box 4. Resources for implementing government-led cross sectoral mental health initiatives**

- Financing of mental health: the current situation and ways forward.  
<https://unitedgmh.org/app/uploads/2023/10/Financing-of-mental-health-V2.pdf> (43)
- Guidance on mental health policy and strategic action plans. Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans.  
<https://iris.who.int/handle/10665/380466> (25)
- Health in all policies: training manual  
<https://www.who.int/publications/i/item/9789241507981> (44)
- Implementing health in all policies: a pilot toolkit.  
<https://iris.who.int/handle/10665/366435> (45)
- LIVE LIFE: an implementation guide for suicide prevention in countries.  
(<https://iris.who.int/handle/10665/341726>). (46)
- Mental health and wellbeing strategy 2025 to 2035.  
<https://www.gov.wales/mental-health-and-wellbeing-strategy-2025-2035> (47)
- Operational framework for monitoring social determinants of health equity.  
<https://iris.who.int/handle/10665/375732> (23)
- Pathways to well-being – National Mental Health Promotion Plan.  
<https://www.gov.ie/en/department-of-health/publications/pathways-to-wellbeing-national-mental-health-promotion-plan/> (22)
- WHO policy brief on the health aspects of decriminalization of suicide and suicide attempts.  
<https://iris.who.int/handle/10665/372848> (48)

# Mental health and the **culture, arts, and sport** sector



## Overview

Culture, arts, and sport can greatly contribute to healthier, more inclusive, and equitable communities. These areas should be central to development policies, as they play a significant role in achieving the Sustainable Development Goals (15) (and see also [Table 1](#)). They help make cities and communities safer, more resilient, and sustainable (SDG 11), promote healthy lives and well-being for all (SDG 3), reduce inequalities (SDG 10), ensure inclusive and quality education (SDG 4), and foster just and peaceful societies (SDG 16).

In addition to their broad societal benefits, culture, arts, and sport have a profound impact on mental health. However, despite the growing evidence of these benefits, the potential of culture, arts, and sports to support mental health remains underexplored (49). Cultural backgrounds, local contexts, and heritage values influence how communities understand and respond to mental health issues (50). Engaging in the arts involves a wide array of active components, including emotional expression, cognitive stimulation, and social interaction, and is known to enhance mental health and well-being (51). Arts also provide opportunities to address themes related to mental health, encouraging dialogue and reducing stigma. Similarly, participation in sports and physical activities can lower stress, improve physical fitness and cognitive function, and strengthen social connections, all of which contribute positively to mental health (52, 53). However, despite global efforts, one in four adults and three in four adolescents do not meet the recommended levels of physical activity (52).

This Guidance highlights the crucial links between mental health and the culture, arts and sports sector, recognizing that many core activities of the sector already protect and promote mental health. Additionally, it proposes a menu of policy directives and strategic actions that can be integrated into sectoral policies, supporting both improved mental health outcomes and the broader objectives of the sector. The numbering uses the prefix CAS (culture, arts and sport) to help avoid confusion when discussing policy directives for specific sectors or from other guidance. In particular, this Guidance provides a menu of strategic actions that highlight how cultural heritage and culturally-based approaches can address problems that affect the mental health of local communities. Another focus is on providing cultural, artistic, and sports activities to promote and protect mental health and well-being both within local communities and in services for health, mental health, and social care. Promoting inclusion and non-discrimination for people with mental health conditions or psychosocial disabilities, as well as for other groups that face discrimination, is also key. Additionally, guidelines and monitoring mechanisms are important to eliminate harmful cultural practices, and to prevent harassment and abuse in sports, all of which are crucial for protecting and promoting mental health.

It is important to note that the roles and responsibilities of sectors might vary from country to country and that therefore, some areas covered in this Guidance might fall under the responsibility of a different sector. For example, issues related to culture, arts, and sports may fall under sectors such as education, youth, tourism or heritage, depending on the national context and structures. Conversely, issues considered as heritage in one country might be discussed under arts within this Guidance. To support navigation and help the reader find all relevant information, Fig. 1 in the Introduction section offers a [directory of key issues](#), indicating where each is covered throughout the Guidance.

This Guidance includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators let sectors track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity](#) (23).

## **SPOTLIGHT** on decolonizing mental health practices

**Cultural heritage** includes tangible assets such as artifacts, monuments, buildings, sites, and museums and also intangible elements such as spiritual, symbolic, historical, artistic, aesthetic, ethnological, and anthropological values that a group or society inherits from previous generations (54).

**Decolonizing mental health practices** involves promoting mental health and well-being through culturally grounded approaches that challenge dominant ideas and ways of thinking. For example, mental health practices have often followed biomedical (focused on diagnosis and medication), Western (based on Euro-American values), heteronormative (assuming heterosexuality as the norm), and patriarchal (centering on male experiences and authority) frameworks. Decolonization processes aim to foster healing, meaning, and connection within diverse cultural contexts by drawing on the strengths, knowledge systems, and practices of communities (55).

# Policy directive CAS1 Use cultural heritage and culturally-based approaches to address the challenges affecting community mental health and well-being

## Strategic actions

### 1. Collaborate with the mental health sector to organize meetings and discussions that use culturally-based approaches to better-understand how communities address mental health and key societal issues.

Collaboration is essential for decolonizing mental health practices. Solutions should be co-developed and implemented in partnership with communities. Cultural backgrounds, local contexts, and heritage values play a vital role in shaping how communities define and address mental health (50). However, power imbalances and cultural oppression are often perpetuated when practices rely on dominant frameworks such as Western-centric, White, patriarchal, or biomedical approaches (55). To address these issues, it is important to create partnerships between cultural heritage experts and mental health professionals. These collaborations can promote culturally-sensitive methods like talking circles, elders' gatherings, and public forums as safe spaces for dialogue. Culturally-informed approaches can identify key societal issues affecting mental health and well-being, leading to sustainable, community-driven solutions.

#### Example indicator

**Name** Culturally-grounded community mental health dialogue sessions organized.

**Definition** Number of structured dialogue sessions co-convened by mental health authorities and community cultural leaders that employ culturally-based approaches to explore local perspectives on mental health and related societal issues.

**Data source(s)** Community engagement reports and summary briefs; session agendas and minutes; mental health sector consultation logs; documentation from cultural organizations or traditional leadership bodies.

### 2. Partner with local communities to integrate mental health awareness, promotion and well-being interventions into local heritage programmes, drawing on and preserving community knowledge.

Many communities face barriers when accessing mental health services and support. Difficulties include stigma, geographic limitations, high costs, and expensive and inaccessible transportation. People from groups that face discrimination may also distrust mental health services or not know what services can offer. Embedding mental health interventions into local heritage programmes that are already respected and meaningful can increase engagement, particularly among groups that face discrimination. Engaging local stakeholders (for example, civil society organizations, museums, cultural foundations) in designing and delivering actions can be very successful. For example, in Türkiye combining mental health support with traditional Sufi music and breathing techniques has helped reduce anxiety, stress, and depression (56). In India, theatre and storytelling (57) have facilitated discussions on mental health issues (58). In the United Kingdom, the Human Henge project gathered people with mental health conditions or psychosocial disabilities to explore archaeology and historic landscapes around the Stonehenge heritage site, and generated a national radio programme to raise awareness of culture heritage and mental health (59). In Canada, hocokahs (healing circles), purification ceremonies, and sun dance have been used to gather Indigenous Peoples to discuss mental health issues (58). In some countries artistic and creative events have spurred action against racism and promoted recovery from collective trauma among Black communities (60).

**Example indicator**

**Name** Integrated heritage and mental health partnerships.

**Definition** Total number of local heritage programmes that have formalized partnerships with community mental health organizations, practitioners, or cultural leaders to co-design and embed mental health awareness, promotion, or well-being activities.

**Data source(s)** Memoranda of understanding or partnership agreements; heritage programme implementation reports; community engagement and mental health sector consultation logs; documentation from cultural agencies or heritage organizations.

**3. Promote research on how cultural beliefs and values affect mental health and well-being in order to develop culturally sensitive approaches and interventions.**

Cultural beliefs and values, such as traditions, norms, knowledge systems, and spirituality, are fundamental aspects of groups and societies, and they are closely linked to mental health and well-being. These beliefs shape how people understand and cope with life challenges and mental health issues, as well as when and where they seek help and support (61). However, these interactions are under-researched, limiting the development of culturally sensitive approaches and interventions. Even when such approaches are developed, they often differ from one community to another due to their bottom-up nature. This makes it more complicated to document and consolidate the evidence. The culture, arts, and sport sector has a crucial role in gathering together the evidence base, working in collaboration with the mental health and other sectors.

**Example indicator**

**Name** Funded research projects on cultural determinants of mental health.

**Definition** Total number of officially funded or endorsed research projects initiated during the reporting period that explicitly examine how cultural beliefs, values, or practices influence mental health and well-being.

**Data source(s)** National research funding agency grants database; Ministry of Health or Science and Technology research approval records; institutional research registries and ethics committee approvals; university or public research institute databases.

#### 4. Work with the mental health sector to support communities and individuals affected by the destruction of cultural heritage.

Tangible cultural heritage, such as artifacts, monuments, buildings, sites, and museums, brings people together and fosters a sense of community, which strengthens mental health and well-being (62). Conversely, destruction of cultural heritage can damage communities' mental health (62). Cultural heritage first responders – heritage professionals who secure cultural heritage in emergencies – are particularly vulnerable to the emotional impact of heritage destruction (63). However, both communities and cultural heritage professionals lack awareness of these issues and rarely receive support for the mental health consequences of heritage loss. Collaboration between the mental health sector and local communities can raise awareness, and interventions can be developed, such as tailored mental health care, emotional support, rebuilding lost heritage, and, when rebuilding is not possible, creating remembrance monuments.

##### Example indicator

**Name** Co-designed psychosocial support initiatives for communities affected by heritage loss.

**Definition** Number of distinct programmes or interventions jointly organized by mental health authorities and cultural heritage bodies during the reporting period that provide psychosocial support, community healing or reconstruction activities, or culturally adapted mental health services to individuals and communities affected by cultural heritage destruction.

**Data source(s)** Partnership agreements or memoranda of understanding; programme implementation and evaluation reports; service delivery records from mental health and cultural heritage agencies.

#### 5. Develop and implement measures to eliminate harmful cultural practices.

Practices such as child marriage, forced marriage, female genital mutilation, sexual orientation conversion therapy, scarification, chaining people with mental health conditions, using toxic herbal remedies as healing methods are forms of violence and discrimination that target specific groups. However, they are often considered acceptable due to long-standing traditions. Measures are needed to eliminate these harmful practices, including public education and awareness campaigns to change attitudes, support for grass roots initiatives against them, and the development and implementation of specific policies and laws to prevent abuses. Continuous monitoring that collects and analyses relevant data is also essential. It is important to ensure that survivors have access to justice and support. This can involve working with the justice sector to improve access to legal aid for survivors and collaborating with the mental health sector to refer people to appropriate services.

##### Example indicator

**Name** Measures to eliminate harmful cultural practices are formulated and implemented.

**Definition** Number of distinct legally- or administratively-binding measures (such as laws, regulations, policies, or community protocols to prevent and eliminate specified harmful cultural practices) that are actively implemented during the reporting period.

**Data source(s)** Official legal gazette; Ministry of Culture or Justice policy registers; enforcement agency implementation and compliance reports; documentation from monitoring committees.

## Policy directive CAS2 Promote cultural and artistic activities to enhance social inclusion, mental health and well-being and raise awareness of mental health issues

### Strategic actions

#### 1. Offer a variety of affordable and accessible cultural and artistic activities to promote mental health and well-being within local communities, workplaces and educational settings.

Cultural and artistic activities improve mental health (51, 64, 65). They can address both individual needs and structural and social determinants of mental health, such as discrimination and loneliness (51, 65). Cultural activities can help people express emotions and reduce stress, give voice to marginalized groups, foster empathy, stimulate cognitive development, encourage new skills, and create a sense of community cohesion. All of these are closely linked to improved mental health and well-being. Examples of successful activities in the community include music to alleviate stress (66), drama to facilitate personal storytelling and social interactions to discuss mental health issues (57), theatre and comic book creation to enhance employee well-being (65), and photography as a tool for self-expression and promoting mental health (67).

Groups that face discrimination, including people with mental health conditions or psychosocial disabilities, are often excluded from mainstream cultural and artistic activities due to barriers such as a lack of available activities, high costs, inaccessible buildings, language differences and atmospheres that make them feel unwelcome. Therefore, mainstream cultural and artistic activities in communities or offered at the workplace or educational settings should be made accessible to groups that face discrimination. For example, interpretation could be provided for migrants, refugees and asylum seekers. People with disabilities could be offered personal support and information in accessible formats. Physical accessibility to buildings where activities take place should be considered. Additionally, targeted cultural and artistic activities can be designed specifically for such groups. Tactile galleries can help people with visual impairments. Dedicated museum itineraries can be designed for children. Cultural activities can showcase how the national traditions of migrants, refugees and asylum seekers can enrich the host community, and can foster a sense of belonging. Arts and crafts workshops can enrich disadvantaged neighbourhoods. Free entry, reduced rates or other financial supports could also improve access for disadvantaged groups.

#### Example indicator

**Name** Affordable and accessible cultural and artistic programmes offered.

**Definition** Number of distinct cultural or artistic activities intended to promote mental health and well-being implemented during the reporting period that are affordable (free or subsidized) and accessible (with inclusive scheduling and making reasonable accommodations).

**Data source(s)** Programme monitoring database and reports; community centre activity logs; workplace wellness programme records; educational institution event schedules; subsidy and accessibility compliance documents.

## **2. Collaborate with the health and social sectors to integrate cultural and artistic activities into health, mental health, and social care services.**

Many existing health and mental health services are primarily grounded in a narrow biomedical approach, focusing on diagnosis, medication, and symptom management, rather than a holistic recovery approach that considers all aspects of a person's life, including relationships, meaning, and leisure. Introducing cultural and artistic activities, which naturally engage with existential issues, self-reflection, self-expression, and social cohesion, can broaden healthcare and complement conventional interventions. A growing body of research indicates how cultural and artistic activities benefit mental health and well-being for people using health and social services ([51](#), [65](#)). Examples include clown interventions to reduce anxiety in children in hospitals, artistic sensory experiences and music to evoke memories in people with dementia, and group singing for women in maternity wards ([65](#)).

### **Example indicator**

**Name** Integration of cultural and artistic activities into health and social care services.

**Definition** Achieved if at least one officially adopted health or social care service guideline or programme explicitly includes culturally-based or artistic activities (for example, art therapy, music, dance workshops, or storytelling sessions) to promote mental health and well-being.

**Data source(s)** Ministry of Health and Ministry of Social Welfare service protocols and programme manuals; service-level implementation plans and programme reports.

## **3. Collaborate with the health sector to promote social prescribing of cultural and artistic activities.**

This approach allows health professionals to prescribe selected cultural activities to individuals at high risk of poor health outcomes. In some countries health professionals refer people to link workers in the culture and arts sector, who can then connect them to programmes that promote mental health and well-being. Examples of social prescribing activities include volunteering in museums, participating in musical performances or artistic competitions, and engaging in art-making or photography sessions. Social prescribing can increase people's awareness of activities in local communities, reduce pressure on the healthcare system, and foster mental health and well-being ([59](#)). Although more research is needed to fully understand its potential, studies suggest that social prescribing can provide an economic return on investment. For example, a study from the United Kingdom showed a return of £1.20 to £3.10 for every £1 invested in social prescribing within the first year ([68](#)).

### **Example indicator**

**Name** Social prescribing referrals to cultural and artistic activities.

**Definition** Number of formal referrals health professionals make to social prescribing pathways offering culturally-based or artistic activities (for example art therapy workshops, community music groups, theatre programmes) during the reporting period.

**Data source(s)** Health system social prescribing registry or referral logs; electronic medical record referral modules; programme monitoring and evaluation reports from cultural organizations; aggregated data from link workers.

#### **4. Create incentives for artists, cultural professionals, athletes and other public figures to promote a human rights-based, recovery-oriented approach to mental health and well-being.**

Encouraging and motivating people to use their creative talents to support mental health initiatives is crucial. Incentives can be both monetary or non-monetary, such as official recognition and public profiling of work that improves mental health and well-being. Examples include scholarships or grants for storytelling on mental health, awards for movies, television series, radio programmes, or campaigns that raise awareness, reduce stigma, and promote a human rights-based approach to mental health.

##### **Example indicator**

**Name** Incentive awards disbursed, and advocacy activities completed by public figures.

**Definition** Number of formal incentive awards (for example, grants, honours, fellowships, tax credits) made to artists, cultural professionals, athletes, or other public figures linked to at least one documented mental health advocacy activity that is completed during the reporting period.

**Data source(s)** Official award and incentive programme logs; disbursement records from Culture/Health/Sports ministries; documented advocacy activity reports or media logs verifying completion of required events.

## **Policy directive CAS3 Support and encourage participation in sports and physical activities to promote mental health and well-being**

### **Strategic actions**

#### **1. Facilitate wide participation in sports and physical activities for everyone and for all ages, including people with mental health conditions and with psychosocial disabilities.**

Engaging stakeholders to provide tailored sports and physical activities for specific groups within local communities is essential, and collaboration across sectors can greatly enhance these efforts. For example, partnering with urban development can promote walking, cycling, and other forms of mobility, including wheelchairs, scooters, and skates, as key modes of transportation. Working with the education sector can ensure quality physical education and supportive school environments that promote lifelong active lifestyles from early childhood. Engaging the social care sector can help overcome barriers that prevent discriminated-against groups from being physically active. For example, identifying and repurposing areas for sport could overcome a lack of recreational spaces in disadvantaged neighbourhoods. These spaces should use universal design concepts to ensure both physical accessibility (such as of sports equipment and venues) and organizational accessibility (for example offering welcoming policies and trained staff). Targeted campaigns in collaboration with the media sector, or with media departments within various sectors, can raise awareness of the many health benefits regular physical activity offers. See the further discussions across this Guidance, notably in the sections for the urban and rural development, education and social protection sectors.

**Example indicator**

**Name** Inclusive community sports and physical activity programmes delivered.

**Definition** Number of community-based sports or physical activity programmes implemented during the reporting period that are designed for all and that include some of the following: adapted activities and trained facilitators, targeted outreach, reduced fees for people with mental health conditions, psychosocial disabilities, or other at-risk groups.

**Data source(s)** Community sports/activity registries; programme monitoring databases; attendance records disaggregated by participant group; reports from sport agencies.

**2. Create community programmes, both elite and recreational, that specifically increase sport and activity opportunities for groups facing discrimination, including people with mental health conditions or psychosocial disabilities.**

People from groups that face discrimination are often excluded from physical activity and sport. Barriers include lack of awareness about available options, cultural and gender insensitivity in activities offered, limited understanding among sports coaches and trainers (particularly regarding suitable types and intensities of physical activity for specific groups), and inadequate funding for sports that are particularly relevant to certain communities (such as local gyms, fitness clubs, or culturally meaningful activities in disadvantaged neighborhoods). To address these issues, targeted and tailored sports and physical activity programmes can be created. Efforts are also needed to connect such programmes to populations that are not accessing them. This approach has been successfully implemented in various contexts. For example, sport activities for displaced young people in Uganda (69) and dance clubs for older adults in the Republic of Korea (70) have promoted physical fitness while fostering social relationships and improving mental well-being. In Norway (71), partnerships between top-level football clubs and community mental health and substance use services have delivered football initiatives for people with mental health conditions or psychosocial disabilities. In Italy, sailing programmes for people with mental health conditions or psychosocial disabilities have been used to boost self-confidence and help manage stress and anxiety (72). At a global level, Special Olympics programmes promote both elite and recreational sports for people with disabilities (73).

**Example indicator**

**Name** Community physical activity and sport programmes for at-risk groups are delivered.

**Definition** Number of distinct community sport or physical activity programmes (elite and recreational) implemented during the reporting period that are specifically tailored to increase access for groups at risk of discrimination (for example, programmes that have adapted activities, trained facilitators, or targeted outreach that encompasses people with mental-health conditions or psychosocial disabilities).

**Data source(s)** Community sports programme registry; municipal and NGO programme monitoring databases; attendance and implementation reports disaggregated by participant group; reports from sports agencies.

### 3. Promote physical activity and sport within health, mental health, and social care services.

Collaboration between sport, health and social sectors is vital for integrating sports and physical activity into health, mental health, and social care services. Despite the well-documented benefits for mental health and well-being, these activities are often underrepresented in health and social care education, leaving professionals without the knowledge and tools to promote participation. Partnerships between the sports and health sectors can offer financial support, concessions, and pathways to connect people with appropriate physical activity. They also enable health professionals to recommend appropriate and effective activities, especially for people at higher risk of poor health.

To encourage active lifestyles, it is essential to train health and social care professionals on the benefits of sports and physical activity. Working with these professions can enhance interventions that reduce sedentary behaviours and promote mental health. For example, offering people weekly sessions like yoga or tai chi can build self-esteem and improve physical functioning. The key is finding something that people enjoy, can do regularly, and that is safe for them. Efforts should extend beyond inpatient or outpatient care, encouraging ongoing participation in community programmes.

Successful collaborations include equipping health professionals with information on the benefits of specific physical activities for various health conditions, identifying suitable activity options for various communities, and engaging local stakeholders to support effective implementation (74). Programmes that encourage 'exercise prescription' enable health professionals to refer individuals to activities that promote mental health and well-being, such as walking groups, running clubs, swimming, gym classes, and outdoor recreation. Developing individualized programmes that reflect people's unique needs and preferences is essential. Co-creating interventions with service users not only ensures relevance and safety but also empowers individuals in their recovery and well-being.

#### Example indicator

**Name** Health and social care facilities offering sport and physical activity programmes for mental health.

**Definition** Number of health, mental health, or social care service facilities that offer sport or physical activity programmes specifically aimed at promoting mental health and well-being.

**Data source(s)** Service programme registers or activity schedules; service monitoring reports; health information system records.

#### **4. Train sports managers, coaches and physical activity providers to address mental health issues and refer individuals to appropriate mental health support.**

Training programmes should provide sports managers, coaches and physical activity trainers with a solid understanding of their role in supporting mental health and well-being. Training should also cover safeguarding participants and preventing harm, and should reach people working in schools, gyms, local clubs, nursing homes, and those working with either elite or recreational athletes. Sports personnel should be able to recognize signs and symptoms of mental distress, suicidal thoughts, and common mental health conditions. They should be equipped with strategies and tools to discuss mental health concerns and make appropriate referrals to mental health services and support when necessary. This should include support for people who may be about to leave the sport, for example people forced to end their sporting careers or activities, either temporarily or permanently.

##### **Example indicator**

**Name** Sports personnel training on mental-health identification and referral.

**Definition** Number of training programmes delivered during the reporting period to sports managers, coaches, and physical activity trainers that cover how to identify mental health issues and refer individuals to appropriate services.

**Data source(s)** Training programme reports; attendance and certification records from sports federations and training providers.

#### **5. Integrate mental health and well-being into all Sport for Development and Peace (S4D/SDP) programmes at national and regional levels.**

Sport for Development and Peace (S4D/SDP) and other similar programmes systematically incorporate sporting activities into humanitarian and development projects and peacebuilding interventions (75). These programmes contribute to life skills development, promote gender equality, foster disability inclusion, reduce poverty, and support socio-emotional development and education through sports, particularly among youth from groups that face discrimination. Integrating mental health aspects into S4D/SDP programmes is a promising way to raise awareness and promote mental health and well-being among children and adolescents, leveraging the positive link between physical and mental health. While some existing S4D/SDP programmes have already shown positive impacts on mental health and well-being (76), mental health aspects have not been systematically integrated into these programmes. To maximize the benefits, ongoing and newly developed S4D/SDP initiatives should incorporate mental health and well-being into their programming. This could include efforts to improve mental health literacy, enhance social-emotional learning, and create activities that actively support participants' mental health.

##### **Example indicator**

**Name** Mental health integration in Sport for Development and Peace programmes.

**Definition** Percentage of national and regional S4D/SDP that explicitly incorporate mental health and well-being objectives, activities, or referral/support mechanisms.

**Data source(s)** S4D/SDP programme registry or database; programme design and implementation documents; monitoring and evaluation reports.

## **6. Implement safeguarding guidelines, reporting systems and monitoring mechanisms to eliminate all forms of harassment, discrimination based on identity, and physical, sexual, verbal or emotional abuse in sports.**

Harassment, sexual, physical, verbal and emotional abuse, along with identity-based discrimination, are prevalent in sports at all levels, from elite to recreational (77-79). Disturbingly, intersecting forms of discrimination, including racism, sexism, homophobia, transphobia, ableism, and hate speech are widespread, both during sports events and within sport-related online spaces. These all harm mental health. To combat these issues, every sports organization should be required to establish safeguarding guidelines, transparent reporting systems, and monitoring mechanisms aimed at eliminating these forms of violence and supporting the mental health of those affected, while also ensuring accountability and appropriate consequences for perpetrators. The guidelines should clearly outline who they apply to (for example, elite and recreational athletes, volunteers, administrative staff, sporting events audiences). They should define what constitutes harassment, abuse, and discrimination, and describe the procedures for preventing violence, reporting abuse and seeking redress. These guidelines and mechanisms must consider the insights and experiences of survivors, ensuring they are treated with dignity and respect throughout the process to safeguard their mental health and prevent re-victimization. Mandatory safeguarding training for all involved in sports is crucial to equip individuals with the knowledge and skills to recognize, prevent, and respond to abuse, while also understanding its impact on mental health. The International Olympic Committee's Toolkit (80) and UNESCO and UN Women's *Handbook on tackling violence against women and girls in sport* (81) provide useful examples for understanding this complex and multi-faceted problem and developing guidelines to safeguard athletes from harassment and abuse (80).

### **Example indicator**

**Name** Proportion of sports organizations actively implementing safeguarding measures.

**Definition** Percentage of registered national and regional sports organizations that have implemented and operationalized safeguarding policies, as evidenced by publicly accessible guidelines, an active incident reporting system, mandatory staff training on the policy, and at least one compliance audit during the reporting period.

**Data source(s)** National sports organization registry; safeguarding policy repository; training attendance logs; incident reporting system analytics; safeguarding audit reports.

## **7. Implement guidelines and monitoring mechanisms to combat doping and substance use among elite and recreational athletes.**

Since the World Anti-Doping Agency was established in 1999, there have been restrictions on using certain substances in sports that may enhance physical performance, violate the spirit of sport, or pose potential or well-established risks to health and mental health. Despite these restrictions, doping and substance use remain prevalent among elite and recreational athletes, as well as among gym and fitness enthusiasts (82, 83).

To address this issue, it is crucial for sports organizations to collaborate with the health sector to raise awareness among athletes and the public about the potential damage these substances do to both physical and mental health. Developing and implementing comprehensive guidelines presents an opportunity to promote a culture change in sports, emphasizing the importance of physical and mental health. Additionally, these guidelines should ensure that athletes who test positive for doping are provided with access to appropriate healthcare and support services, fostering a healthier and more ethical sporting environment.

### Example indicator

**Name** Proportion of sports organizations fully implementing anti-doping guidelines and monitoring.

**Definition** Percentage of registered elite and recreational sports organizations with operational anti-doping policies aligned with international standards during the reporting period. Organizations should have at least one structured drug-testing cycle, mandatory athlete substance-use and anti-doping education programme, or documented test-result reporting during the reporting period.

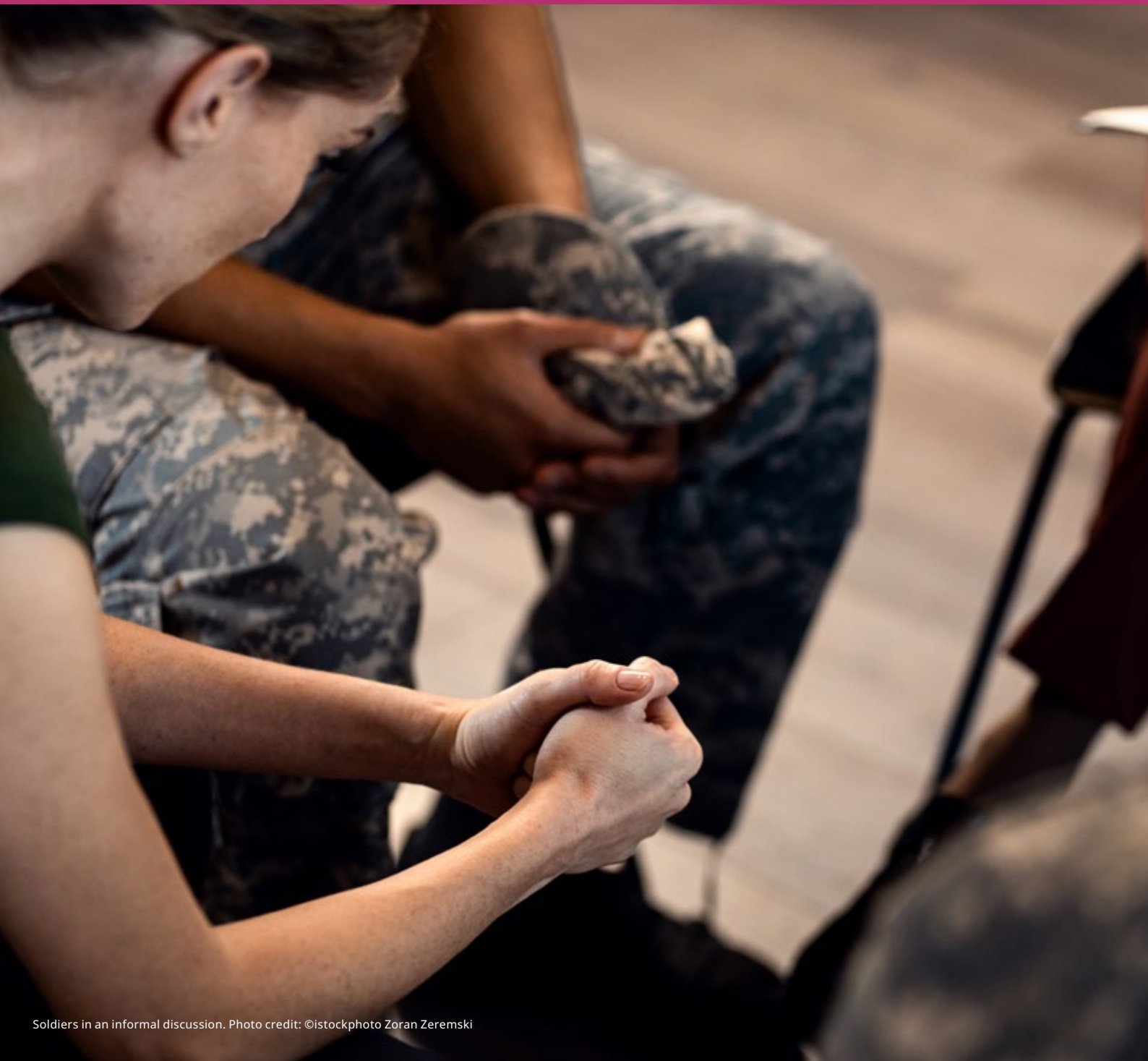
**Data source(s)** National Anti-Doping Agency accreditation and testing records; athlete education sessions attendance logs; sports organization annual compliance and monitoring reports.

Box 5 offers further resources for addressing mental health from within the culture, arts and sport sector.

### Box 5. Resources for addressing mental health from within the culture arts and sport sector

- From loneliness to social connection: charting a path to healthier societies: report of the WHO Commission on Social Connection. <https://iris.who.int/handle/10665/381746>.
- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)
- Performing Anxiety - a resource for audience-facing arts projects about mental health. <https://www.mhfestival.com/2024/06/performing-anxiety-smhaf-launches-an-ambitious-new-good-practice-resource/> (84)
- Safeguarding athletes from harassment and abuse in sport : IOC toolkit for IFs and NOCs <https://library.olympics.com/Default/doc/SYRACUSE/171450/safeguarding-athletes-from-harassment-and-abuse-in-sport-ioc-toolkit-for-ifs-and-nocs-related-to-cre> (80)
- Sport Coach+. Safe and supportive sport to promote the mental health of young people affected by displacement. <https://www.sportcoachplus.org/> (85)
- Tackling violence against women and girls in sport: a handbook for policy makers and sports practitioners. <https://www.unwomen.org/en/digital-library/publications/2023/07/tackling-violence-against-women-and-girls-in-sport-a-handbook-for-policy-makers-and-sports-practitioners> (81)

# Mental health and the **defence and veterans** sector



## Overview

Around the world, more than 27 million people are serving in their country's armed forces. Veterans who have left active service can also make up a substantial proportion of society. In the United States of America alone there are more than 18 million veterans representing around 7% of the country's adult population (86). Given these figures, comprehensive policies and actions in the defence and veterans sector can influence a large segment of the population. If implemented comprehensively, they can significantly improve the mental health and well-being of both active-duty service members and veterans.

The military context is a unique working environment with strict rules, hierarchies, and chains of command. Military service personnel are exposed to challenging situations during missions and deployment, including separations from families and exposure to hardship, suffering, adversity, and the risk of death and serious injury. These professionally and personally demanding situations can lead to emotional strain, psychological trauma and mental health crises and can contribute to the development of a mental health condition, including anxiety, depression, PTSD and substance use.

Policy and actions within the defence and veterans sector can implement support structures to provide accessible, good-quality, rights-based mental health and psychosocial support for service members, veterans and their families. However, it is crucial to address the substantial barriers military culture can pose to seeking support for mental health. These include pervasive institutional- and self-stigma, concerns about confidentiality and widespread discrimination and harassment, including sexual harassment.

Veterans transitioning from active service to civilian lives and careers face challenges adjusting to new communities and building a life outside the active military context. Family circumstances, age at time of transition, financial instability, housing insecurity and difficulties finding employment, education or retraining opportunities can all affect mental health. So too can the struggle to find purpose, respect, and recognition in civilian society.

This Guidance highlights the critical links between mental health and the defence and veterans sector, and offers three policy directives, and a menu of associated strategic actions. The numbering uses the prefix DV (defence and veterans sector) to help avoid confusion when discussing policy directives for specific sectors or from other guidance. The strategic actions can be integrated into sectoral policies, supporting both improved mental health outcomes and the sector's broader objectives. In particular, implementing these strategic actions can help to prevent harassment and violence, eliminate stigma and discrimination, and ensure access to social benefits and community support for veterans and their families.

Some areas covered under this sector in the Guidance might fall under the responsibility of a different sector in some countries. For example, in some countries veterans' affairs have dedicated ministries, and in others veterans' affairs might fall under social protection or health. Conversely, areas relevant to defence and veterans will likely be covered elsewhere in this Guidance too. To support navigation, Fig. 1 in the Introduction section offers a [directory of key issues](#), indicating where each is covered throughout the Guidance.

This Guidance includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators let sectors track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity](#) (23).

## Policy directive DV1 Implement measures to prevent harassment, violence and abuse and fight stigma and discrimination

### Strategic actions

#### 1. Implement robust measures against all forms of harassment, violence, and abuse, particularly sexual assault, and ensure effective, accessible mechanisms for monitoring, reporting, and redress.

Service members continue to experience harms from harassment, violence and abuse at high rates, with impacts on mental health and well-being, even many years after an incident occurred. Sexual harassment and assault often causes mental health conditions, emotional distress and even suicidal ideation (87) lasting well beyond people's transition to civilian life. Within the military context, several studies report prevalence rates of up to 9% for women experiencing sexual harassment (3% for men) and up to 7% for sexual assault of women (2% for men) (88-90). Yet studies have found that underreporting is common, with perhaps only 30% of affected women and 17% of affected men reporting an incident (91, 92). Personnel who do make reports often face ostracism, maltreatment and professional reprisals.

It is crucial that the defence and veterans sector implements robust measures and mandatory training at all operational levels to prevent harassment and abuse, particularly sexual forms of violence. Such interventions must be specifically tailored to the unique structures, hierarchies, and culture of military environments, and should be informed by consultations with those affected to ensure they are both relevant and effective. In addition, strong and independent monitoring and reporting mechanisms must be established to ensure that incidents can be reported confidentially and without fear of retaliation. Creating a culture of accountability and support is essential to building a safe and respectful environment for all personnel.

#### Example indicator

**Name** Defence and veterans units operationalizing harassment prevention and redress systems.

**Definition** Number of defence and veterans units with fully operationalized comprehensive prevention measures that include a published anti-harassment and abuse policies, completed mandatory training, and established and confidential reporting channels. At least 10 investigation/redress actions in designated pilot units should have been completed within the reporting period.

**Data source(s)** Defence forces and veterans affairs implementation logs; policy approval records; training attendance registers; incident-reporting system logs; investigation and resolution reports.

## **2. Transform armed forces culture by raising awareness, providing in-depth training, and developing interventions to combat stigma and discrimination attached to mental health issues.**

Stigma around mental health is strongly grounded in military culture. Up to 60% of military personnel experiencing emotional distress or mental health problems avoid seeking help and support, with concerns about stigma being an important barrier (93). People fear and experience bullying from peers and superiors when they seek help. They also fear not being taken seriously by military clinicians. These factors delay treatment and support, resulting in worse mental health outcomes.

It is crucial to transform the stigma-laden culture around mental health within service roles, military health provision, family networks, and veterans' services. Providing targeted resources and support activities for military personnel, their families, and veterans can be highly beneficial. Topics can be wide ranging, including alcohol and other psychoactive substance use, and the early signs and symptoms of emotional distress or mental health conditions (including depression, anxiety and PTSD). The Real Warriors Campaign (94) from the United States Department of Defense takes this approach. In addition, contact-based education and training involving direct interaction with individuals who have lived experience of a particular issue, can be particularly effective at reducing stigma.

It is also vital to make it easier for people to seek help. Complicated request procedures, long wait times and uncertainties about the career consequences of seeking support for mental health issues can exacerbate stigma (95, 96). Minimizing barriers to accessing mental health care within the military can be an integral part of overall stigma reduction efforts. To do this effectively, health and mental health professionals working with military and veterans need to understand how stigma affects help-seeking behaviours, so they can actively address these perceptions (97). They also need to understand the values and practices required to ensure person-centred, holistic and rights-based approaches to treatment, care and support. Establishing networks of lived experience across health, mental health, and wellbeing services can help achieve this. The community and peer programme run by Open Arms – Veterans and Families Counselling (98) in Australia is an example of how veterans with lived experience are supported to collaborate with mental health clinicians (and other agencies) to provide individual and group peer support services.

### **Example indicator**

**Name** Implementation of anti-stigma campaigns and in-depth training by armed forces units.

**Definition** Percentage of registered armed forces units that have conducted both a formal mental-health stigma awareness campaign and at least one in-depth stigma-reduction training for personnel during the reporting period.

**Data source(s)** Ministry of Defence training division records; unit-level campaign and training attendance registers; central programme monitoring databases.

### **3. Prevent discrimination within the armed forces and provide for effective and accessible monitoring, reporting and redress.**

Exposure to discrimination drives poor mental health outcomes and a decreased sense of well-being, including lower self-esteem; life satisfaction; and increased hopelessness, anxiety, depression, and anger (99, 100). Around 30% of Black/African service members in the USA's military have experienced racial discrimination or harassment (99). Discrimination based on sexual orientation is also widespread within the military context (101, 102).

To effectively prevent discrimination within the armed forces, it is essential to implement confidential and accessible reporting systems, strengthen oversight and accountability mechanisms, and ensure fair, transparent processes for redress. Training across all levels should promote awareness of discrimination, inclusion, and mental health impacts. Where operational requirements necessitate exclusion from certain roles, criteria should be evidence-based and balanced with efforts to promote inclusion elsewhere. Fostering a culture of dignity and respect, integrating anti-discrimination goals into institutional strategies, and engaging affected communities in the design and evaluation of policies are also critical for long-term change.

#### **Example indicator**

**Name** Perceived safety and trust in discrimination reporting mechanisms.

**Definition** Proportion of armed forces personnel who report confidence in the confidentiality, fairness, and effectiveness of mechanisms for reporting discrimination and harassment.

**Data source(s)** Focus groups; internal monitoring and evaluation reports; feedback from ombudpersons or grievance systems.

## Policy directive DV2 Address mental health issues and promote well-being for service members, veterans, and their families

### Strategic actions

#### 1. Implement pre-deployment training, aligned with UN peacekeeping standards, for all personnel and include strategies for managing stress and psychological trauma and information on other cross-cutting issues such as civilian protection and conflict-related sexual violence.

Managing and preparing for a deployment, whether to a routine tour, active combat, peacekeeping role or humanitarian emergency response, involves being separated from home, family and loved ones as well as the possibility of injury, death and exposure to human suffering. This can lead to high levels of distress, anxiety and insecurity among service members and their families.

The defence and veterans sector should train personnel before deployment to manage their responses to such issues, and should also offer support schemes. Such programmes should be evidence based and include strategies for keeping healthy routines, building resilience, managing emotional distress and feeling equipped and supported to manage potential psychological trauma.

Family members should also have access to support, including mental health and psychosocial support, parenting support and community programmes connecting families in similar situations.

Additionally, service members should receive comprehensive dedicated pre-deployment training on what is expected of them, including ethical conduct and discipline, upholding human rights, and civilian protection. This training should include how to respond to the specific vulnerabilities of women, children, and older adults, and how to prevent and respond to harassment, abuse and exploitation of local populations, including sexual violence. It should also cover environmental protection [\(103\)](#).

#### Example indicator

**Name** Enhanced pre-deployment preparedness training completed by deploying personnel.

**Definition** Percentage of service members scheduled for deployment, active combat, or peacekeeping missions who have completed training on stress management, trauma mitigation, civilian protection, and conflict-related sexual violence.

**Data source(s)** Training division completion records; deployment readiness rosters; peacekeeping training compliance audits.

## **2. Implement post-deployment support, for example support for reuniting and reintegrating with families and community, individual or group peer support or mentoring and access to psychotherapy and counselling.**

Returning from deployment can be an exciting but also very challenging time for service members and their families. Readjusting to everyday life at home and in the community, and managing potential changes in family routines or living situations, often leads to high levels of emotional distress and anxiety. Conversely, people who are single and do not have a family to come home to can experience social isolation and loneliness. Some service members returning from active combat may have experienced considerable emotional distress or psychological trauma, including witnessing or experiencing torture and/or being in captivity (104). Some will also be experiencing physical disability or injury after deployment, and will need mental health and psychosocial support for this. The defence and veterans sector should implement structures that facilitate the challenges of reintegration, including mental health and psychosocial support. Individual or group peer support, (peer) mentoring programmes, volunteering programmes and access to trauma-informed individual and group psychotherapy and counselling should be available to service members, their families and communities. Substance use is a common challenge among the military and veteran community, particularly after deployment, and specialized programmes designed to prevent harm should also be offered.

### **Example indicator**

**Name** Post-deployment support services accessed by returning service members.

**Definition** Percentage of service members returning from deployment who accessed at least one formal post-deployment support service, such as for family reintegration assistance, peer support or mentoring, psychotherapy, counselling, or mental health care.

**Data source(s)** Defence forces post-deployment support logs; veterans affairs reintegration programme databases; medical and social support service records; counselling and mental health referral systems.

## **3. Introduce suicide prevention interventions for military personnel, veterans and their families, including awareness-raising and anti-stigma campaigns, confidential crisis hotlines, peer support and counselling.**

Suicide is a major public health concern in the general population, particularly among young and middle-aged men. This demographic group also makes up the majority of active-duty service members and veterans. Aspects of military service, potentially including experiencing psychological trauma or brain damage caused by blast exposure, raise people's risk of emotional distress, anxiety, depression, post traumatic stress disorder and decreased cognitive function. Such factors can contribute to elevated suicidal ideation among the military community. Stigma surrounding mental health, and other barriers to accessing support and treatment, can make people reluctant to seek help, further increasing the risk of suicide (105, 106). It is crucial to implement suicide prevention programmes for active-duty military personnel, veterans and family members. These should be evidence-based and tailored to the military and veteran contexts and culture. Suicide prevention efforts should also include the strengthening of mental health and psychosocial support such as confidential 24/7 crisis hotlines, peer support, counselling and psychotherapy. Facilitating access to these services for active-duty service members, veterans and family members is also discussed in the next strategy.

**Example indicator**

**Name** Comprehensive suicide prevention interventions implemented by defence and veteran support units.

**Definition** Percentage of defence and veteran support units that have fully operationalized all core components of a suicide prevention programme, including awareness-raising and anti-stigma campaigns, confidential crisis hotlines, peer-support programmes, and accessible counselling services.

**Data source(s)** Defence forces and veterans affairs programme implementation logs; campaign launch briefs and communication materials; crisis-hotline operational and anonymized usage records; peer-support attendance registers; counselling referral databases.

**4. Improve access to good quality, rights-based, trauma informed mental health and psychosocial support for service members and veterans.**

Good-quality, rights-based and trauma-informed mental health services and support should be accessible and wide-ranging, including confidential crisis hotlines and services, peer support schemes, individual or group psychotherapy and counselling (including grief counselling) and specialized therapies such as for post-traumatic stress disorder and substance use. People providing services and supports to service members or veterans should either have military experience themselves, or be specifically trained in providing services to the military and veteran population. Practitioners need to be well-informed on military context and culture as this strengthens acceptance and use of services (see also the strategy on training for military mental health professionals).

Actions will be needed to ensure that individuals can access these services when they need them. Studies from the USA's Department of Defense have found that 60–70% of service members who experience mental health problems do not seek mental health care. This may be due to barriers specific to the military culture, especially mental health related stigma (93) (see above), but also practical/logistical barriers, for example, scheduling issues, not knowing what was available or where services are located. Personal barriers might include negative attitudes towards mental health and concerns about confidentiality. Institutional or social barriers can include fear of public disclosure and institutional stigma related to military culture, rules, and experiences while in service (107).

**Example indicator**

**Name** Access to trauma-informed mental health and psychosocial support services.

**Definition** Percentage of defence and veteran support units that have implemented at least two trauma-informed mental health and psychosocial support services, such as a confidential crisis hotline, peer-support scheme, individual or group psychotherapy or counselling (including grief counselling), or specialized therapies such as for post traumatic stress disorder or substance-use.

**Data source(s)** Defence forces and veterans affairs implementation logs; crisis-hotline operational records; peer-support attendance registers; counselling and therapy programme reports and referral databases.

## **5. Improve mental health, well-being and resilience of families, including by providing services while military personnel are deployed, returning from deployment, or transitioning to civilian life.**

Families of military personnel can face challenges that lead to high levels of emotional distress and potentially a mental health condition or psychosocial disability. These challenges include lengthy separations from loved ones, worries and uncertainty about a family member's health and well-being; family instability and frequent home moves after re-deployment; supporting a family member who is experiencing emotional distress or a mental health condition or psychosocial disability after deployment, and coping with the loss or serious injury of a loved one. It is crucial to provide good-quality, rights-based and trauma-informed mental health services and support for family members, including confidential crisis hotlines and services, peer support schemes, individual or group psychotherapy and counselling, grief counselling, suicide prevention and substance use prevention, treatment and rehabilitation programmes. Services should be easily accessible and free of cost. Opportunities to connect with other families in similar situations can be helpful.

### **Example indicator**

**Name** Access to family mental health and psychosocial support services.

**Definition** Percentage of defence and veteran support units that have implemented structured family support programmes offering mental health, psychosocial, or related services (such as family counselling and mental health support, peer-support networks for spouses and children, psychoeducation workshops) to families of personnel who are currently deployed, returning from deployment, or transitioning to civilian life.

**Data source(s)** Defence forces and veterans affairs family support programme logs; programme attendance registers; service evaluation reports.

## **6. Provide specialized training and support for mental health professionals, and address the dilemmas that can arise from combining their clinical and military roles.**

Military mental health professionals routinely face clinical and ethical challenges that stem from the dynamics and structures of the military environment. In small and closely-knit military communities, contact or encounters between clinician and patient are more common than in civilian settings. Furthermore, military psychologists, psychiatrists and other mental health professionals often occupy varying and changing roles and so may interact with their patients in non-therapy contexts, for example as a supervising officer or comrade on deployment. Being involved in both therapeutic roles and also evaluative roles with patients can lead to ethical dilemmas and boundary violations. For example, a clinician who is providing therapy sessions to an individual might also be instructed to perform a fitness-for-duty evaluation for the patient. It is crucial to develop clear guidance for military mental health professionals that address multiple-role dilemmas and ethically challenging scenarios. It is also important that military mental health professionals receive appropriate support and guidance to avoid moral distress and to protect and promote their own mental health and well-being ([108](#)).

Military mental health professionals should receive training on mental health-related stigma and how it affects both the people seeking their help and the military community as a whole. They need to help address this important issue, as described in Policy directive DV1, second strategy, on transforming the culture around mental health and combating stigma ([97](#)).

**Example indicator**

**Name** Coverage of specialized role-dilemma training and support for military mental health professionals.

**Definition** Percentage of defence and veterans' mental health professionals who have completed specialized training on managing ethical and professional challenges associated with dual clinical and military roles (for example, challenges of confidentiality, command obligations, and operational readiness versus clinical care) and are enrolled in ongoing peer-consultation or clinical supervision programmes that provide professional support and ethical guidance.

**Data source(s)** Defence forces medical training records; human-resources professional registry; peer-consultation and supervision programme logs.

**7. Provide leadership training for supervisory personnel to foster healthy work environments, support staff facing mental health challenges, and manage conflict situations.**

Numerous studies have shown that a supportive and positive leadership style is associated with improved mental health outcomes in the workforce (109, 110). Fast-paced and demanding work environments like the military can lead to high levels of stress and anxiety. Effective leadership, grounded in open, realistic communication, is critical to safeguarding the mental health and well-being of personnel and resolving conflict. Managers and supervisors should receive coaching and mentoring programmes to support them in creating psychologically healthy work environments, to strengthen their leadership in challenging situations, and to promote ongoing learning and professional growth.

Military personnel often risk their physical health through excessive physical training in order to prove that they fit in with the culture of being tough and strong. Supervisory personnel should be aware of this overlooked problem, which often leads to serious and chronic injury, and in turn undermines mental health. Policy should specify requirements and guidelines around physical training and incorporate provisions to address hazardous and excessive physical training.

For more discussion refer to Mental health and the employment sector in this Guidance.

**Example indicator**

**Name** Supervisory leadership training coverage for a culture that supports mental health.

**Definition** Percentage of service members in supervisory roles who have completed a formal leadership training programme covering positive and inclusive leadership skills, healthy work environments, supporting subordinates' mental health, and workplace conflict resolution.

**Data source(s)** Training records from human resources departments; leadership training programme attendance registers; training completion certificates; course evaluation reports.

## **8. Implement mental health promotion and protection interventions for stress management, self-care, relaxation, and building personal resilience among military personnel and veterans.**

Service personnel generally work in a high-paced and demanding work environment where challenging situations are commonplace. This has significant impacts that can persist throughout an individual's service, and even into civilian life. These challenges should be acknowledged when people access mental health and well-being support. The defence and veterans sector should implement routine measures to promote and strengthen the general mental health and well-being of all service members and veterans. Interventions for individuals at the workplace might include sports or interventions focused on self-care, stress management and relaxation. For example, mindfulness-based or cognitive-behavioural approaches or psychoeducation, can benefit mental health outcomes (2, 111, 112). Interventions for veterans could include building resilience skills through self-help tools, as well as support on how to build trusted support networks. In both the serving and veteran contexts, interventions can build personal resilience through peer support schemes, psychoeducation, counselling and other interventions as appropriate. For more detailed information on workplace interventions, refer to Mental health and the employment sector in this Guidance.

### **Example indicator**

**Name** Proportion of service members and veterans completing mental health promotion and prevention interventions.

**Definition** Percentage of service members and veterans who have completed at least one stress-management, self-care, relaxation, or resilience-building course or intervention.

**Data source(s)** Defence forces and veterans affairs programme completion registers; intervention attendance logs; programme monitoring reports.

## Policy Directive DV3 Provide a range of social benefits and community supports for veterans and families

### Strategic actions

#### 1. Introduce efficient and accessible financial assistance schemes, pensions, healthcare and disability benefits for veterans and their families.

Access to financial assistance, pensions, healthcare and disability benefits is a key component in facilitating the transition from active service to a financially stable and meaningful life in the community. Defence and veterans sectors need a pension scheme that provides financial protection for veterans meeting certain age- and disability- and income-related criteria. Pensions schemes should be available to families of people who died while in service. Disability benefits and compensation should be available for all veterans whose disabilities relate to their military service, including psychosocial disabilities. All veterans should also be entitled to comprehensive health insurance that covers general health as well as mental health services and support.

Stories about administrative flaws in claims systems for veterans are commonplace in many countries. Veterans' poor experiences can damage their mental health, including by causing huge frustration, and even despair due to financial insecurities (105, 113). Administrative shortcomings may even be a contributing factor to suicidality among veterans (105). It is crucial that veterans' claims systems are reviewed for efficiency and accessibility and that sufficient resources are allocated where improvements are needed. Veterans and their families also need support mechanisms that help them file claims and navigate through what are often complex legal and administrative requirements.

#### Example indicator

**Name** Allocation of financial assistance and benefits to veterans and their families.

**Definition** Percentage of eligible veterans and their families who received at least one form of official support, including financial assistance, pension disbursement, healthcare coverage or insurance enrolment, or disability benefit.

**Data source(s)** National veterans' benefits registry; defence forces and veterans' affairs payment and enrolment records; national healthcare insurance enrolment database; social protection programme administrative data.

## 2. Support veterans and their families to access housing, education and career opportunities after their service.

Houselessness and housing insecurity are significant concerns among the veteran population. In the USA, about 10% of military veterans experience homelessness or housing insecurity at some point in their lives, with the first episode often occurring shortly after discharge from their military service (114). Veterans facing mental health or substance use problems, low incomes or unemployment, are at particularly high risk of experiencing houselessness or housing insecurity (115). Housing assistance programmes for veterans are therefore crucial, particularly for people who have recently returned to civilian life.

Housing assistance programmes should be closely coordinated with mental health and psychosocial support. Veterans experiencing mental health or substance use problems should not face disadvantage when accessing housing assistance or related benefits. In addition, the sector should implement initiatives that support veterans to take up education opportunities, whether that be secondary education, higher education, or vocational courses. Education counselling services can guide and support veterans through application processes and transitions into learning settings. Partnerships with schools, colleges and universities could offer programmes tailored for veterans (116). Veterans may also benefit from programmes that provide guidance and support for retraining and civilian career transitions including small business development. These efforts should be complemented by policies and legislation that explicitly prohibit employment discrimination based on past, current, or prospective military service (117).

### Example indicator

**Name** Veteran housing, education, and career-transition support programmes.

**Definition** Percentage of eligible veterans and their family members who have received support from at least one official programme providing housing assistance, education support, vocational training or skills upgrading, or career-transition services.

**Data source(s)** Veterans' affairs beneficiary registry; defence forces transition support service logs; education and vocational training attendance records; employment and reintegration programme evaluation reports.

### 3. Support veterans in returning to civilian life and reconnecting with their families and communities including opportunities for social connection and volunteering.

Transitioning from military service and readjusting to community life can be a challenging time for veterans and their families. Veterans need to regain a sense of connectedness and feel socially included within their communities to avoid disconnection, loneliness, social withdrawal, and the associated mental health harms (118). Programmes to facilitate community reintegration can include volunteering opportunities and a range of community events for veterans and their families. These help people to connect with civilian community members and also other veterans and their families in similar situations.

#### Example indicator

**Name** Veterans' reintegration and community engagement programmes.

**Definition** Number of veterans or their family members who have participated in at least one official programme offering reintegration support, family reconnection services and relationship support, community-based social activities, or volunteering or civic engagement opportunities.

**Data source(s)** Veterans' affairs programme participation registry; Defence forces transition support logs; community and volunteering organization records; family services and reintegration programme reports.

Box 6 offers further resources for addressing mental health from within the defence and veterans sector.

## Box 6. Resources for addressing mental health from within the defence and veterans sector

Several countries have developed dedicated resources addressing key issues covered in this Guidance. Examples provided here are not exhaustive, and other valuable national efforts may exist.

### Australia

- Defence and veteran mental health and wellbeing strategy 2024–2029. <https://www.dva.gov.au/sites/default/files/2024-12/exposure-draft-defence-and-veteran-mental-health-and-wellbeing-strategy-2024-2029.pdf> (119)
- Mental Health First Aid Australia. Mental Health Protect (Training to support veteran mental health). <https://www.mhfa.com.au/mental-health-protect/> (120)
- Open Arms - Veterans and Families Counselling. <https://www.openarms.gov.au/> (98)
- Veteran transition strategy and action plan. <https://www.defence.gov.au/about/strategic-planning/veterans-transition-strategy> (116)

### Canada

- Sexual misconduct support and resource centre. <https://www.canada.ca/en/department-national-defence/services/benefits-military/health-support/sexual-misconduct-response.html> (121)
- Suicide prevention and intervention guide for CAF leadership. <https://www.canada.ca/en/department-national-defence/corporate/reports-publications/health/suicide-prevention-intervention-guide-caf-leadership.html> (122)
- Veterans transition action plan. <https://www.veterans.gc.ca/en/about-vac/reports-policies-and-legislation/departmental-reports/veterans-transition-action-plan> (123)

### United States of America

- Prevention plan of action 2.0 (2022–2024). [https://www.prevention.mil/Portals/130/Documents/PPoA\\_2.0.pdf?ver=BROSEoYyqVnF9ATV8mLb\\_Q%3d%3d](https://www.prevention.mil/Portals/130/Documents/PPoA_2.0.pdf?ver=BROSEoYyqVnF9ATV8mLb_Q%3d%3d) (124)
- Veterans Transition Assistance Program (TAP). <https://discover.va.gov/transition-programs/transition-assistance-program> (125)

### United Kingdom

- Defence people health and wellbeing strategy 2022–2027. <https://www.gov.uk/government/publications/defence-people-health-and-wellbeing-strategy-2022-to-2027> (126)
- Veterans' strategy action plan 2022–2024. <https://www.gov.uk/government/publications/veterans-strategy-action-plan-2022-to-2024/veterans-strategy-action-plan-2022-to-2024-html> (127)

### Resources for general health indicators for different government sectors

- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)



# Mental health and the **education** sector



## Overview

Childhood, adolescence, and early adulthood are crucial periods for developing social and emotional connections, establishing relationships with peers and family, and laying the groundwork for academic success and future employment opportunities.

It is also a time when mental health conditions and emotional crises are likely to emerge (128, 129). There is substantial evidence linking early childhood development to mental health outcomes later in life. Positive early experiences and stable, nurturing environments are essential for healthy mental development, while adverse childhood experiences significantly increase the risk of developing mental health conditions (130).

Children, adolescents, and young adults spend a significant time in educational settings that play a crucial role in their development. These environments offer numerous opportunities to protect and promote students' mental health, leading to better health, mental health, and social outcomes later in life (131, 132).

Globally, children with mental-health conditions or psychosocial disabilities face significant barriers in accessing early-childhood learning and primary education, while youth and young adults with these conditions face barriers in accessing secondary, tertiary, and adult learning. Decision-makers frequently fail to include disability provisions in national laws and policies, denying many their right to education (133, 134). People often encounter stigma, discrimination, and human rights violations in educational settings. The harms are perpetuated by a lack of inclusion, accessibility, and by discriminatory withdrawal policies during mental health crises. Furthermore, teachers' mental health is unaddressed in many educational settings, despite studies showing that school teachers and staff in higher education are more likely to experience mental health problems than the average population (135).

This Guidance highlights the urgent need for system-wide reforms in education and a whole-school approach to ensure full inclusion, accessibility, and non-discrimination, and to promote mental health and well-being in all educational settings. It offers policy directives for the sector, and a menu of associated strategic actions to address pressing issues affecting mental health and well-being. The numbering uses the prefix Ed (education) to help avoid confusion when discussing policy directives for specific sectors or from other guidance. The strategic actions include creating supportive environments, combatting bullying (including online bullying), addressing suicide (a leading cause of death among these age groups (136)), revising rigid assessment and evaluation frameworks, and promoting social networks and connectedness.

Additionally, the Guidance details how educational institutions can collaborate with stakeholders from other sectors. This includes collaborating with the mental health and social sectors to establish structures and connections to community mental health and psychosocial services and support. Such links can directly support the mental health of students, teachers, staff and caregivers. It also explores how the education sector can collaborate with institutions to reform mental health curricula for college and university students, particularly those entering fields where mental health knowledge is essential, such as healthcare, social care, law, law enforcement, and education.

The Guidance highlights the critical links between mental health and education, recognizing that many core activities of the sector already contribute to protecting and promoting mental health. It is important to note that some areas covered under this sector in the Guidance might fall under the responsibility of a different

sector in some countries. For example, in some countries vocational training might come under the employment sector. Conversely, areas relevant to education will likely be covered elsewhere in this Guidance too. To support navigation, Fig. 1 in the Introduction section offers a [directory of key issues](#), indicating where each is covered throughout the Guidance.

The Guidance also includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators let sectors track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## **Policy directive Ed1 Implement system-level reforms to create safe environments, promote inclusion, non-discrimination, and mental health and well-being**

### **Strategic actions**

#### **1. Implement safeguarding to eliminate violence and abuse in educational settings and ensure early identification and support for students affected by violence, including domestic and gender-based violence.**

Educational institutions have a duty of care to ensure that all students are protected from harm, including abuse, violence, and harassment perpetrated by teachers, educators, and other school staff as well as by other students.

In collaboration with stakeholders from the social, mental health, and justice sectors, education ministries should support the implementation of school-wide programmes to prevent all forms of violence and harassment. These programmes should emphasize prevention, early detection, and timely intervention. They should offer safe and anonymous reporting mechanisms and clear pathways to support and protection that are accessible to students ([137](#)).

Safeguarding measures should be implemented that include clear and enforced codes of conduct for school personnel. Staff need comprehensive training on child protection and non-violent classroom management. Corporal punishment should be prohibited.

Schools must adopt a zero-tolerance approach to violence and abuse and ensure that students, particularly those from groups that face discrimination, are protected and heard ([137](#)).

Equally important is establishing clear protocols that protect educators and other staff, particularly as they are at high risk of facing retaliation, intimidation or threats by parents, caregivers or others within the community ([137](#), [138](#)).

In addition to action within schools, it is essential to establish programmes that identify support students who are victims of any form of abuse, violence or harassment outside of school, including domestic violence, sexual abuse, and gender-based violence. These efforts should involve parents and caregivers to ensure early detection, appropriate support, and strong protective environments both at home and in school.

**Example indicator**

**Name** Educational institutions' safeguarding and support protocols.

**Definition** Number of registered educational institutions that have adopted formal safeguarding strategies to prevent violence and abuse, and have applied early identification and support protocols for students affected by violence, including domestic and gender-based violence.

**Data source(s)** Ministry of Education policy implementation records; school safeguarding policy registers; student support and referral service logs.

## **2. Collaborate to develop, implement and strengthen age- and culturally-appropriate rights-aligned curricula on mental health and psychosocial well-being that eliminate discrimination.**

**In early childhood, primary, and secondary education**, integrating age-appropriate mental health literacy and social-emotional learning into existing school curricula, or establishing new programmes with a rights-based approach, can benefit students' social, emotional, and physical development, as well as their overall mental health and well-being (139). Key topics might include building trusting relationships, empathy, respect, self-esteem, resilience, managing challenges and stress, accepting differences and diversity, how to discuss and care for one's mental health, and promoting healthy lifestyles, including nutrition, sleep, and physical exercise. These curricula should be tailored to the specific setting and student population, with active involvement from students, teachers and parents/caregivers in the development and delivery.

It is also important to revise physical education (PE) curricula to position mental health and well-being as core components, recognizing that PE supports both physical and emotional health. PE programmes should be inclusive and accessible to all students, including those with disabilities or mental health conditions, who often face barriers to participation (140). To ensure equitable access, policy-makers must prioritize developing safe, inclusive and equitable infrastructures, designing PE programmes that accommodate diverse needs.

**In higher education**, reviewing, updating, or developing and implementing mental health curricula is essential for all professions preparing to work in the mental health, healthcare, education and social care sectors. Training should encompass psychiatrists; nurses; medical doctors; psychologists; peer supporters and workers; social workers; community health workers; occupational therapists; counsellors; clinical staff; and community volunteers as well as teachers, early childhood educators, employment and education specialists; and others.

Such curricula should establish core-competencies and ensure that all staff in these fields are equipped with the knowledge and skills to practice evidence-based, rights- and recovery-oriented approaches. For example, a rights-based curriculum on mental health can help eliminate discriminatory attitudes and practices against people with mental health conditions or psychosocial disabilities. Key topics should include human rights, recovery approaches, legal capacity, eliminating coercive practices, rights-based assessments of support needs, and social and structural determinants of mental health. For more detailed information refer to Policy Area 3 of [Guidance on mental health policies and strategic action plans](#) (25).

To ensure a truly inclusive educational experience, the process of reviewing, updating, or developing and implementing the curriculum should involve people with lived experience of mental health conditions and psychosocial disabilities, alongside professionals from the mental health sector, academic institutions, and training colleges.

Many other sectors have significant impacts on population mental health. It is also essential to incorporate mental health content into the higher education curricula for professions such as judges, lawyers, police, emergency responders, and others. In all cases, curricula development should collaborate with people with lived experience. Curricula should cover the broad range of topics mentioned above but be tailored to the specific work content, roles and needs of the workforce in each sector.

**Example indicator**

**Name** Educational settings implement age- and culturally-appropriate mental health curricula.

**Definition** Percentage of educational institutions that have adopted and are delivering age- and culturally-tailored mental health and psychosocial well-being curricula aligned with international human rights standards and anti-discrimination objectives.

**Data source(s)** Ministry of Education curriculum approval records; institutional syllabus and lesson-plan repositories; training and delivery logs.

### 3. Address excessive coursework and rigid assessment and evaluation frameworks.

Excessive coursework and high-stakes assessments and evaluations can place students under intense psychological pressure, contributing to anxiety, depression, burnout, and suicidal ideation (141). For example, one-off exams that determine acceptance to higher education, and inflexible systems that fail to accommodate legitimate absences or unforeseen challenges can have devastating consequences for students. Those from economically disadvantaged backgrounds are put under particular pressure. They often feel a deep sense of responsibility to succeed, not only for themselves but also for their families and communities, who might have made significant financial sacrifices to support their education.

Assessment frameworks can be reviewed and modified in all educational institutions to reduce the pressure students face and ensure that mental health risks are minimized. Rigid assessment frameworks can be made more flexible, allowing students higher chances to succeed. This includes considering alternative forms of assessment, such as project-based evaluations, regular quizzes, or continuous assessments, all of which can provide a more balanced and comprehensive evaluation of students' abilities. Additionally, flexibility can be introduced for students who face personal challenges or health issues, ensuring that such challenges do not result in permanent academic failure. For example, supplementary exams could mitigate the pressure of rigid exam dates, or marking or entrance policies could take into account personal and academic challenges. Some educational settings might offer foundational courses for students who did not achieve the entrance requirements but who are academically able. Such changes could help more students progress in education while maintaining their mental health and well-being. See also Strategic actions 4 and 5 within this policy directive for recommendations on reasonable accommodations and non-discriminatory ways to allow withdrawal and re-application processes during mental health crises.

**Example indicator**

**Name** Educational institutions reform coursework load and assessment frameworks.

**Definition** Number of registered educational institutions that have adopted formal policies to cap excessive coursework and modify rigid evaluation systems with flexible, formative assessment methods.

**Data source(s)** Ministry of Education policy implementation records; institutional academic regulation documents; curriculum review committee minutes.

#### **4. Require educational institutions to develop a policy and strategy for mental health and well-being, co-created by people with lived experience.**

Education sector policy should include provisions for mental health protection and promotion, as well as for non-discriminatory access to high-quality, rights-based supports for all students and staff (see also Policy directives Ed2 and Ed3 below).

In higher education settings, it is not uncommon to encounter discriminatory policies, particularly concerning withdrawal and re-application processes for students in mental health crises. Such provisions can exacerbate mental health issues and should be revoked and revised, with full participation of people with lived experience of mental health conditions and psychosocial disabilities.

Education sector policy should require all educational institutions to allow students and staff to take a voluntary leave of absence during a mental health crisis, and should ensure continued health insurance coverage throughout. Flexible supports and accommodations tailored to individual needs should facilitate a person's return to education. Additionally, every educational institution should have a mechanism for students and staff to report discriminatory practices and seek redress.

##### **Example indicator**

**Name** Participatory mental-health policy and strategy in educational institutions.

**Definition** Number of registered educational institutions that have developed and formally adopted a mental health and well-being policy and strategy through a process involving full participation of people with lived experience of mental health conditions.

**Data source(s)** Ministry of Education policy implementation registers; institutional policy documents; stakeholder consultation and engagement records.

## **5. Widen access to the education system by implementing systems to promote inclusion and accessibility and respond to inequalities.**

Ensuring the fundamental right to education for all will lead to improved health, social, and economic outcomes. This requires action across the educational landscape: from pre-school to higher education; for children, adolescents, and adults with mental health conditions or psychosocial disabilities; for people experiencing short- or long-term mental health crises or emotional distress; and for other groups that face discrimination.

**For early childhood, primary, and secondary education**, processes that actively identify children living in difficult circumstances, and support them to access education, are crucial. This includes children living with disadvantage or vulnerability, with disabilities (including learning disabilities and psychosocial disabilities), those exposed to violence, affected by humanitarian emergencies, and displacement or belonging to groups that face discrimination.

In primary education, it is particularly important that all youth, including those with mental health conditions or psychosocial disabilities, as well as those with learning disabilities, are supported in accessing all available routes into secondary education, including identifying and following paths that can lead to higher education.

**For higher education**, application processes for all subjects and degree levels must be inclusive and non-discriminatory. They should encourage applications from people with mental health conditions or psychosocial disabilities, as well as from people with learning disabilities.

All educational settings, from early childhood to higher education, should implement guidelines to ensure accessibility, reasonable accommodations, and other support. This should be available for all students experiencing mental health conditions, psychosocial disabilities, or short- or long-term mental health crises and emotional distress. Accommodations should include flexibility for workloads, schedules, and completion requirements, as well as options for repeating grades/classes, different modes of learning (full-time/part-time), learning materials in accessible formats, home schooling, and other individualized needs. Information about reasonable accommodations and other support can be provided to students (and parents/caregivers) in accessible formats before they start school, during orientation events, and through a dedicated inclusion/disability focal point or office within the school, college, or university.

### **Example indicator**

**Name** Accessibility and inclusion measures for learners with mental health conditions and at-risk groups, across all educational levels.

**Definition** Percentage of registered educational institutions (from pre-school through higher education) that have implemented formal accessibility and inclusion measures (such as reasonable accommodation policies, flexible assessment frameworks, counselling and support services, and targeted outreach) for learners with mental health conditions, psychosocial disabilities, or other at-risk groups.

**Data source(s)** Ministry of Education inclusion policy registry; institutional accreditation and implementation reports; national accessibility audit records.

## Policy directive Ed2 Create enabling environments and cultures in educational settings that promote inclusion, social emotional learning, life skills, mental health and well-being

### Strategic actions

#### 1. Train and encourage educators to implement classroom activities that promote students' mental health, well-being and self-care skills.

Educators can be offered training to understand developmental stages during childhood and adolescence and the diversity that exists within these; to recognize signs of distress, suicidal thoughts, and common age-related mental health conditions; and to talk about mental health with students and their parents or carers. Educators can be trained on techniques to foster resilience, emotional regulation, social and emotional learning, and healthy coping strategies that promote long-term mental well-being among students. Educators must also understand the social and structural factors influencing mental health and how to address these holistically. They should be prepared to refer students to appropriate mentoring, counseling, or mental health supports within the school, college, university, or in the community (see Policy directive WG4) ([128](#), [132](#)). In early childhood and primary education, educators must carefully balance the risk of labelling a child (which can lead to external stigma, internalized self-stigma, and even discrimination) against the benefits of early identification for developmental, behavioural and emotional difficulties, which enables timely support and tailored interventions ([128](#)).

For efforts and interventions to be effective and implemented consistently, they must be adequately resourced, with training delivered during paid working hours (see also Mental health and the employment sector within this Guidance), and sufficient time within the academic curriculum for implementation. Furthermore, although educators play important roles in supporting mental health, it is important that they are not expected to take on the role of trained mental health professionals. Professional mental health services and support should also be available for the student population ([142](#)).

In addition, educators' own mental health and well-being should be actively promoted in all educational settings, through measures such as: peer support networks; support groups; social and emotional learning workshops; training on stress management and coping skills; and by ensuring timely access to high-quality mental health and psychosocial services (see also Policy directive Ed3, Strategic action 1).

#### Example indicator

**Name** Educators' capacity for promoting mental health.

**Definition** Percentage of educators who have completed accredited training programmes focused on promoting student mental health.

**Data source(s)** Professional development attendance logs; teacher accreditation and training records.

## **2. Address pressing issues affecting students, including bullying, suicide, violence, (sexual) harassment and substance use, and change attitudes to mental health, eliminating stigma and discrimination.**

Bullying, including online forms, can lead to severe mental health issues, and even suicide. Every educational setting should implement a programme to prevent and detect bullying, tailored to the specific age group. Programmes should draw on evidence-based anti-bullying curricula or activities (143). Every setting should have clear policies on expected behavior, consequences for violations, and a focus on protecting students with disabilities including psychosocial disabilities, who are at higher risk of bullying (144). Each institution should also have effective reporting and support systems for those affected by bullying. Training must reach all stakeholders involved in implementing such programmes.

Suicide prevention is another crucial issue, requiring a comprehensive approach that includes awareness-raising, encouraging help-seeking, training staff and students to identify and assist people at-risk, developing crisis response mechanisms, and reducing access to lethal means, such as by prohibiting items that could be used as weapons and restricting access to rooftops (145, 146). For more detailed guidance, see [LIVE LIFE: an implementation guide for suicide prevention in countries \(46\)](#), [Guidelines on mental health promotive and preventive interventions for adolescents: helping adolescents thrive \(147\)](#) and [WHO menu of cost-effective interventions for mental health \(148\)](#).

Secondary and higher education settings should also dedicate programmes or initiatives to address issues including: alcohol and drug safety; reproductive health and age-appropriate sexual education; eating disorder awareness and prevention; sexual harassment awareness; racism; gender diversity; body image pressures; online safety and data protection, as well as fostering healthy nutrition and active lifestyles. It is essential that programmes are relatable and age-appropriate, ensuring they resonate with students' experiences and developmental stages, while also being engaging and accessible.

Parents and caregivers should be actively included in such programmes. They need the knowledge and skills to identify concerning behaviours early, initiate supportive conversations, and, where necessary, seek professional help. This strengthens prevention and response efforts across both home and educational settings.

To eliminate the stigma and discrimination surrounding mental health challenges, age and culturally appropriate initiatives and campaigns can be implemented at all educational levels. They should involve students, educators, parents/caregivers and the wider community. One example of an anti-stigma initiative involving all of these stakeholders is the [See Me See Change](#) approach in Scotland (149). In Ireland, the Jigsaw Peer Education programme offers peer education (150). [WHO QualityRights in person training \(151\)](#) and [WHO QualityRights e-training on mental health, recovery, and community inclusion \(152\)](#) can be introduced to educators, caregivers, and advanced secondary and higher education students as an evidence-based tool to tackle stigma and change discriminatory attitudes towards mental health.

### **Example indicator**

**Name** Evidence-based student mental-health programmes.

**Definition** Percentage of educational institutions offering at least one accredited programme addressing key student mental health issues, such as bullying, suicide prevention, violence, harassment, substance use, and implementing at least one anti-stigma initiative.

**Data source(s)** Ministry of Education programme registry; school implementation reports; programme evaluation summaries.

### **3. Strengthen schools' sense of belonging and community by facilitating peer-to-peer and staff-to-student interactions, and social networking opportunities.**

A sense of school belonging, defined as how well students feel personally accepted, respected, included, and supported by others (153), is linked to positive mental health outcomes. Belonging, and a strong school sense of community can help reduce symptoms of mental health conditions, such as anxiety and depression, as well as fostering overall well-being in young adulthood (154).

Educational institutions can develop and implement initiatives that foster school belonging, such as regular cultural, recreational, and social events, mentor or buddy programmes for new students, and guided orientation phases. It is important to facilitate good and trusting relationships between educators and students, as well as among students of different age groups. These in turn can foster core social skills like trust and responsibility, positively influencing social-emotional learning and connectedness. Such relationships have also been associated with better achievements and reduced classroom tensions (128). Initiatives and programmes should welcome all students, including those with mental health conditions or psychosocial disabilities. Cultural, recreational, and social events may inadvertently foster exclusion if not thoughtfully planned.

In early childhood and primary education, parents/caregivers can be encouraged to participate in the school experience. It is valuable to create opportunities for connection and exchange among parents, educators, and students. For the primary school age group, dedicated after school programmes in the afternoons and activities during school holidays are particularly useful in providing opportunities for connecting with peers while also providing respite for parents and carers (132). After school programmes can also be an opportunity to provide additional academic support for students if needed.

For secondary and higher education settings, additional opportunities for connection include student and faculty associations and various social, recreational, political, or economic clubs. To ensure engagement and successful implementation, it is crucial that children and young adults play a key role in co-developing and implementing strategies for building social networks and connections within educational settings.

#### **Example indicator**

**Name** Peer-to-peer connections and community-building initiatives in educational institutions.

**Definition** Percentage of educational institutions that have adopted and implemented structured peer-to-peer relationship programmes, social networking activities, or connection events for students and staff.

**Data source(s)** Ministry of Education programme registry; institutional activity reports; peer-support attendance records.

## Policy directive Ed3 Provide all students and staff with a range of accessible and high-quality mental health and psychosocial support

### Strategic actions

#### 1. Establish a mental health and well-being office or center for students and staff, led by trained mental health, social or educational professionals, or appoint mental health focal points.

A well-being office should provide age-appropriate mental health and social support to students and staff and/or refer them to community-based services available locally and online (132). Where possible, it should be staffed by trained mental health, social or educational professionals. Referrals should always align with what the student or staff member seeking support wants, and should be to services and support that are specialized for the respective age group, for example to psychologists and psychiatrists with child or adolescent expertise.

If an office is not feasible, the education institution should still appoint someone as a mental health focal point to provide brief support and manage referrals. It is crucial that all educators, students, and parents are informed about the office or focal point, understand how to access support, and receive assistance discreetly and confidentially. The mental health and wellbeing office should follow a systemic approach to engaging families and carers, who may benefit from referral to appropriate services, support or dedicated parenting programmes in the community.

#### Example indicator

**Name** Mental health and well-being offices or focal points in educational institutions.

**Definition** Percentage of educational institutions with a dedicated mental health and well-being office, staffed by mental health professionals or trained social or education professionals, or an appointed mental health focal point.

**Data source(s)** Institutional administrative records; Ministry of Education accreditation lists; staff assignment registers.

#### 2. Implement mentoring programmes in educational settings to support mental health and well-being.

Mentoring can support various student groups, such as recent joiners needing to adjust to a new environment. Programmes can also reach students at risk of academic failure or dropping out, providing support to prevent the negative mental health impacts of academic struggles or early school leaving. Mentoring can also benefit students at risk of substance use or developing mental health issues, offering prevention and early intervention (155). For students struggling to connect with peers, mentoring helps to build social ties, reducing isolation and related mental health challenges (156). Depending on the age group, involving parents, caregivers, and families may be important. Mentoring formats include one-to-one support for personalized guidance; group mentoring to reduce loneliness and promote well-being; peer-to-peer mentoring to foster community; and mentoring by older students or adults for added support (157). Programmes should be adapted to the specific context and resources, whether delivered on campus or through community services.

**Example indicator**

**Name** Mentoring programmes for student mental health support.

**Definition** Percentage of educational institutions that offer structured mentoring programmes that pair which trained mentors with students to provide mental health and well-being support.

**Data source(s)** Ministry of Education mentoring programme database; institutional mentorship logs; mentorship participation registers.

Box 7 offers further resources for addressing mental health from within the education sector.

### Box 7. Resources for addressing mental health from within the education sector

- Bullying: what is it and how to stop it. How to prevent and deal with bullying. <https://www.unicef.org/parenting/child-care/bullying> (158)
- Five essential pillars for promoting and protecting mental health and psychosocial well-being in schools and learning environments. <https://www.unicef.org/reports/promoting-and-protecting-mental-health-schools-and-learning-environments> (142)
- Guidelines on mental health promotive and preventive interventions for adolescents. <https://www.who.int/publications/i/item/9789240011854> (147)
- LIVE LIFE: An implementation guide for suicide prevention in countries. <https://iris.who.int/handle/10665/341726> (46)
- Mental Health Foundation Scotland. Professional learning resource for school staff. <https://www.mentalhealth.org.uk/our-work/programmes/families-children-and-young-people/professional-learning-resource-school-staff> (159)
- Mental health in schools training package. <https://www.emro.who.int/mnh/publications/mental-health-in-schools-training-package.html> (128)
- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)
- School-based violence prevention: a practical handbook. <https://iris.who.int/handle/10665/324930> (137)
- The benefits of investing in school-based mental health support. <https://www.unicef.org/reports/benefits-investing-school-based-mental-health-support> (160)
- Welsh framework on embedding a whole-school approach to emotional and mental well-being. <https://www.gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-wellbeing> (161)
- Youth Aware of Mental Health (YAM). <https://www.y-a-m.org/> (162)

# Mental health and the **employment** sector



## Overview

About 60% of the world's population spends one-third of their lives working (163). Work environments can bring both protective and risk factors for mental health. When workplaces are inclusive, promote mental health and well-being, and reduce psychosocial risks and work stress, they are associated with improved mental and physical health outcomes, increased performance and productivity, higher motivation, and reduced absenteeism and conflict between colleagues (2).

However, when the environment and associated occupational risks are not properly managed, they can have severe consequences for workers' mental health, leading to distress, mental health conditions, or psychosocial disabilities (2, 164). These challenges in turn lessen companies' productivity as well as national economic performance. Occupational risks include the nature of the work itself, workplace culture, and factors such as job control, workload, demands, and the level of social support. Poor, precarious, and insecure working conditions further exacerbate these risks. Long or irregular working hours, unsafe or unhealthy environments, unstable contracts, low and unpredictable pay, and limited social protection, as well as bullying, discrimination, and workplace exploitation, increase the likelihood of emotional distress and worsening mental health conditions (2, 164, 165). Evidence from low, middle and high income countries highlights the strong links between job loss, economic insecurity and poor mental health outcomes, particularly among young people, underscoring the urgent need for employment policies that reduce precariousness and promote stability as a means of protecting mental well-being (166, 167).

Mental health-related absence, including absenteeism and reduced productivity (presenteeism), imposes significant costs on companies and economies. At the same time, many people with mental health conditions or psychosocial disabilities remain excluded from the labour market, despite evidence that employment can improve mental health (35, 168, 169). Emerging trends such as artificial intelligence (AI) and automation introduce new risks of exclusion, as technological change may reduce work opportunities, especially for those already disadvantaged in the labour market. Inclusive employment policies that address both persistent and emerging risks of exclusion will therefore be essential to protect mental health and well-being.

While being employed can offer important protective factors for mental health, including income, social connection, and a sense of purpose, not everyone can access these benefits. For people with psychosocial disabilities, older adults, and other marginalized groups, employment opportunities may be limited or associated with narrower pathways and increased risks of discrimination. Employment-related measures, policies and laws should therefore balance business interests such as reducing absenteeism and improving productivity with social objectives to uphold the right to work, to promote inclusion, and to ensure that all people can benefit from meaningful employment.

Investing in mental health in the workplace benefits not only individual workers and employers but also contributes to national economic growth and is essential for achieving SDG 8 on Decent Work and Economic Growth (170).

This Guidance highlights the crucial links between mental health and the employment sector, recognizing that many core activities already protect and promote mental health. Additionally, it proposes a menu of policy directives and strategic actions that can be integrated into sectoral policies, supporting both improved mental health outcomes and the broader objectives of the employment sector. The numbering uses the prefix Em (employment) to help avoid confusion when discussing policy directives for specific sectors or from other guidance.

In particular, this Guidance suggests strategic actions focusing on fostering inclusive and non-discriminatory workplaces, ensuring decent and fair working conditions and social protection, and integrating mental health into occupational safety and health laws, regulations, and systems on an equal basis with physical health. It also outlines strategic actions for preventing and managing psychosocial risks through improvements in work organization, job design, and workplace practices; creating positive workplace environments and cultures; and building capacity among managers and workers to support mental health. Finally, it addresses how to promote early help-seeking, support recovery and returns to work, and ensure access to rights-based mental health and psychosocial support in the workplace and through community services.

It is important to note that the roles and responsibilities of sectors might vary from country to country and that therefore, some areas covered in this Guidance might fall under the responsibility of a different sector. For example, issues related to employment may fall under sectors such as justice or health, depending on the national context and structures. Conversely, issues considered as a legal matter might be discussed under employment within this Guidance. To support navigation and help the reader find all relevant information, Fig. 1 in the Introduction to this Guidance offers a [directory of key issues](#), indicating where each is covered throughout the Guidance.

The Guidance includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators let sectors track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## Policy directive Em1 Promote inclusion, prevent discrimination, and uphold respect for human rights

### Strategic actions

#### 1. Develop inclusive employment opportunities that support mental health and psychosocial well-being.

To achieve true inclusion in the workplace, national employment policies should reflect the CRPD and promote inclusive environments, including equitable recruitment practices, flexible working arrangements and supportive workplace cultures (171). Inclusive employment strategies should provide reasonable accommodations at all stages of employment, including recruitment and retention, to remove barriers and enable equal participation of people with mental health conditions and disabilities, including psychosocial disabilities (163).

Governments need a comprehensive strategy to put these commitments into practice. This should incorporate active labour market measures. These might include: Individual Placement and Support (IPS) schemes; other forms of assisted and supported employment; vocational training; job search assistance; job carving (modifying or customizing job tasks to match individual abilities); job matching (aligning job opportunities with individuals' skills and preferences); wage subsidies; and internships or apprenticeships tailored to the specific needs of people at risk of discrimination including people with mental health conditions or psychosocial disabilities (172). These measures help to ensure that employment opportunities align with individual abilities and needs and provide pathways to meaningful and sustainable employment.

Collaboration with the education sector can strengthen inclusive employment policy. Educational and vocational programmes can be designed to equip people with the skills required for competitive employment, and can provide coordinated support for the transition from school to work for students with mental health conditions or psychosocial disabilities. Companies should also be encouraged to partner with NGOs and OPDs to promote inclusive recruitment practices, raise awareness of mental health and disability issues, and foster positive workplace attitudes (173).

In addition to these initiatives, workplaces should ensure reasonable accommodations are available to support individuals both during recruitment and once in employment. This can include adjustments during hiring processes, as well as flexible working hours, supportive meetings with a mentor or supervisor, and designated rest areas. Programmes should also be available to support people returning to work, and sustaining employment after a mental health crisis. Reasonable accommodations and supportive measures should take into account people's caregiving responsibilities, to promote equal opportunities for all.

Such inclusive employment strategies are highly effective in helping people secure and sustain meaningful employment whether they have mental health conditions, psychosocial disabilities, or come from other populations at risk of discrimination, such as adolescents and young adults without formal education, people with chronic illnesses, and those with a history of substance use (174, 175).

In some countries and contexts, it may also be possible to promote inclusive work through social cooperatives, as seen in various locations in Brazil and in Trieste, Italy (176). Such cooperatives bring together people with psychosocial disabilities, other disabilities and people without disabilities, and are part of solidarity economy approaches. They offer real jobs that generate income while fostering collective responsibility, participation, and mutual support, including during times of mental health crises.

**Example indicator**

**Name** People with mental health conditions or psychosocial disabilities are accessing inclusive employment placements.

**Definition** Number of people with mental health conditions or psychosocial disabilities in employment arranged under inclusive support programmes (for example, assisted employment, wage-subsidized roles, vocational training leading to job placement).

**Data source(s)** National employment agency placement records; assisted employment programme reports; vocational training provider placement logs; records from organizations of people with lived experience.

**2. Establish regulations that address issues such as mobbing, bullying, sexual and other forms of harassment, violence, abuse, and discrimination in the workplace, along with mechanisms for reporting and redress.**

Mobbing and bullying, including cyber-mobbing and online bullying, as well as other forms of harassment, violence, abuse, and discrimination violate human rights. They can lead to severe and long-lasting consequences for workers' mental health, including the development of mental health conditions and even suicide (177). It is crucial that employment sector policies include strategies for managing and addressing these issues, and for facilitating help-seeking and redress for those affected.

Internal reporting procedures should be strengthened to ensure they are safe, confidential, and that they protect individuals throughout complaints processes. This includes safeguarding workers from retaliation or threats to their employment or professional status when reporting harassment, discrimination, or other forms of abuse.

Establishing safe spaces or informal mechanisms for conflict resolution can help ensure that emerging issues are addressed early in a supportive manner. They let workers, particularly those in less powerful positions, raise and address behaviours or conflicts that may not constitute criminal offences but could nevertheless cause harm.

**Example indicator**

**Name** Workplace policies regulating harassment, violence, abuse, and discrimination, and offer straightforward reporting and redress processes.

**Definition** Number of workplaces that have fully operationalized comprehensive regulations addressing mobbing, bullying, sexual and other forms of harassment, violence, abuse, and discrimination, and that have completed redress actions for 80% of substantiated cases.

**Data source(s)** Ministry of Labour incident-reporting logs; workplace misconduct and discipline reports; internal investigation and resolution records; complaints monitoring tracking systems.

### **3. Ensure workers have health insurance that covers mental health, a minimum wage, paid parental leave, paid sick leave, and reasonable working hours in line with international labour and human rights standards.**

Although already mandated by policy and legislation in some countries, health insurance providers often do not cover physical and mental health equally. People seeking mental health services, such as psychotherapy or counselling often are required to pay for sessions themselves. It is important that regulations in policy stipulate both (1) health insurance for all workers and (2) coverage of mental health services and support.

The employment sector should also establish clear regulations on the minimum wage, aligned with the cost of living. This is crucial for reducing suicide risk and improving mental health outcomes (178). Workers' rights to representation through trades unions or other forms of worker representation should also be guaranteed to help protect rights, ensure accountability, and promote fair pay and working conditions. Policies can also ensure paid parental leave (179, 180) and other flexible accommodations at the workplace to support better mental health for new parents and for those with other caregiving responsibilities. Similarly, regulations can require paid sick leave, including for mental health conditions and emotional distress. To protect mental health, policies should also limit consecutive working hours and ensure adequate rest periods, especially for shift workers.

#### **Example indicator**

**Name** Access to mental health inclusive social protections.

**Definition** Percentage of employees covered by health insurance that includes mental health services and who are entitled to essential labour protection, including minimum wage, paid parental leave, paid sick leave, and regulated working hours.

**Data source(s)** Social insurance enrollment records; payroll and leave administration systems; labour ministry compliance audits; social protection records.

### **4. Integrate mental health measures into national and regional occupational safety and health (OSH) laws on an equal basis with physical health.**

Governments should ensure this integration aligns with international labour and human rights standards, including the Occupational Safety and Health Convention, 1981 (No. 155) (181) and the Convention on the Rights of Persons with Disabilities (CRPD) (1).

Furthermore, OSH laws and regulations can include provisions for structured health monitoring systems, such stress audits, or well-being surveys. Voluntary assessments and anonymous data collection on mental health are important steps toward addressing mental health on an equal basis with physical health. All relevant stakeholders including experts in mental health, disability, human rights, and occupational safety and health, should be involved in the reviewing and revising legislation.

#### **Example indicator**

**Name** Jurisdictions integrate mental health into occupational safety and health (OSH) legislation.

**Definition** Number of national or regional jurisdictions that have amended occupational safety and health laws to include mental health provisions on an equal basis with physical health.

**Data source(s)** Official legal gazettes; OSH regulatory agency legislative update records.

## Policy directive Em2 Assess, prevent, and manage occupational risk factors in workplace environments across organizations, businesses, and enterprises

### Strategic actions

#### 1. Implement measures to improve job control, such as participatory approaches to job design.

Low job control, often characterized by a lack of autonomy, uncertainty about working hours, and unclear objectives, is linked to higher stress and anxiety, increasing the risk of developing mental health conditions (182). Participatory job design approaches that involve workers in decision-making, that provide clear objectives, and allow adequate control over workflow and pace can enhance job control (2, 183). Examples include giving workers more say over how tasks are completed or clarifying roles to reduce ambiguity. Job redesign can also help manage and reduce psychosocial risks. For example, tasks may be redistributed to balance workloads or job rotation can be introduced to reduce monotony and increase engagement. Work tasks and roles should be regularly reviewed and adapted to support mental health and well-being (184).

##### Example indicator

**Name** Workplaces implement participatory job design practices.

**Definition** Number of organizations that have introduced and implemented employee-inclusive job design measures such as joint task-mapping workshops, role clarification sessions, or regular staff input fora.

**Data source(s)** Human resources policy records; job design meeting minutes; employee engagement survey summaries.

#### 2. Implement flexible work policies that include regular workload assessments and options for remote or hybrid work.

Heavy workloads, rigid schedules, and inflexible work modes can cause levels of high stress and harm workers' mental health and well-being. In contrast, a balanced work and personal life with flexible schedules and options for hybrid or remote work leads to greater job satisfaction, well-being, and a more productive workforce (2). Workplaces should be encouraged to promote mental health and well-being by embracing flexibility and supporting a healthy work-life balance.

##### Example indicator

**Name** Access to workload assessments and flexible work arrangements.

**Definition** Percentage of employees who have received at least one formal workload assessment and hold an approved remote or hybrid work agreement.

**Data source(s)** Human resources department workload assessment logs; flexible work agreement registers; employee records of work-mode entitlements.

### **3. Clarify workplace roles and tasks to effectively use each worker's skills, while fostering skills variety, task significance, task identity, and autonomy.**

Clearly defined roles and tasks prevent ambiguity and conflict, which are common sources of workplace stress (163). When expectations and deadlines are clear, and workers' skills are used effectively, it enhances their sense of control and competence, which are both essential for mental well-being. Encouraging skills variety keeps work engaging and promotes personal growth, leading to higher job satisfaction. Emphasizing the significance and identity of tasks helps workers feel their contributions are meaningful, fostering a sense of purpose and reducing disconnection. By focusing on these areas, organizations can create a more supportive environment that protects mental health and boosts job satisfaction and productivity.

#### **Example indicator**

**Name** Enriched job designs.

**Definition** Percentage of organizational units that have implemented more than one enrichment element to job designs, such as skills variety, task significance, task identity, or autonomy.

**Data source(s)** HR job design review reports; departmental action plans.

### **4. Establish a career development framework offering opportunities for personal and professional growth, including promotions, regular performance reviews, and financial rewards.**

Career stagnation, uncertainty, under-promotion, over-promotion, poor pay, job insecurity, and low social value of work can all undermine mental health (163). To address these issues, employers should create clear pathways for career progression and offer opportunities for reviews and promotions. The criteria for promotion should be transparent. Regular performance and satisfaction reviews, and a pathway to better financial rewards like bonuses and pay raises are essential. These measures help reduce stress and improve mental well-being by providing a sense of security, value, and purpose in the workplace.

#### **Example indicator**

**Name** Career development frameworks in departments or other recognized units.

**Definition** Percentage of departments or units with a formal career development framework including defined promotion pathways, scheduled performance review cycles, and structured financial reward mechanisms.

**Data source(s)** HR framework adoption records; promotion and performance review logs; payroll and bonus disbursement data.

## 5. Ensure physical work environments are safe and healthy, with appropriate lighting, temperature and noise levels and no exposure of workers to harmful substances.

Poor physical working conditions or hazardous environments significantly harm both mental and physical health. Key factors to assess and improve include the availability, suitability, and maintenance of equipment; environmental conditions like adequate space, lighting, low noise levels, and comfortable temperatures. Workers should not be exposed to harmful substances. By creating a safe and healthy work environment, employers can protect the well-being of their workers, reducing stress and enhancing overall job satisfaction.

### Example indicator

**Name** Workplaces implement physical environment safety and health standards.

**Definition** Percentage of workplaces that have completed a formal environmental safety audit and implemented corrective actions to address issues related to lighting, temperature, noise levels, and exposure to hazardous substances.

**Data source(s)** Occupational safety and health inspection reports; workplace environment audit logs; compliance certification records.

## Policy directive Em3 Develop employee and workplace cultures that foster mental health and well-being

### Strategic actions

#### 1. Train employees on mental health literacy and raise awareness to combat stigma and discrimination.

Training should improve people's understanding of mental health and well-being at work, covering essential topics like self-care, active listening, and open communication. Managers and supervisors who receive targeted mental health training are better equipped to support their teams, and this benefits overall workplace mental health (165, 185). Evidence-based programmes like [WHO QualityRights e-training on mental health, recovery, and community inclusion \(152\)](#) are effective tools for changing attitudes and reducing stigma. Involving people with lived experience of mental health conditions in training development adds significant value by addressing the real needs of workers (2). All training should be culturally appropriate, delivered by experienced trainers during paid working hours (163) and should clearly define managers' and supervisors' roles in supporting mental health, while emphasizing that they are not mental health professionals.

### Example indicator

**Name** Workplaces deliver mental health literacy and anti-stigma training.

**Definition** Percentage of employees (across all levels) who have completed at least one mental health literacy and anti-stigma training session.

**Data source(s)** Training logs; Human resources department training completion records (disaggregated by employee level); attendance registers.

## 2. Implement individual interventions to promote mental health and well-being.

Interventions aimed at individuals should be part of a holistic organizational approach that includes interventions to prevent occupational risks, comprehensive training for both managers and workers, and supportive measures for individuals with mental health conditions. To ensure effective uptake, avoid stigmatization, and maximize impact, interventions should be made universally available to all workers in the target roles, regardless of their mental health status (111). These interventions can take various formats, including face-to-face, online, group-based, or one-on-one, and may offer stress management and self-care training, relaxation techniques, mindfulness-based or cognitive-behavioral approaches, and clear mental health education resources (2, 111, 186).

Special attention should be given to providing interventions for individuals in high-risk occupations or those exposed to distressing or traumatic events, such as first responders, military personnel, and others working in crisis situations. They may need tailored approaches. In addition to the interventions mentioned above, peer support schemes are particularly valuable for this group (165).

To enable people to access the support they need, workplaces should promote a culture that encourages safe and voluntary disclosure of mental health conditions. This requires protecting confidentiality, ensuring that disclosure does not lead to discrimination or disadvantage, and facilitating access to appropriate supports and accommodations.

It is important to consider that focusing solely on helping people manage their individual stresses may inadvertently lead to feelings of personal blame without addressing the broader work environment (2). Furthermore, all interventions should be evidence-based and adapted to be culturally-appropriate.

### Example indicator

**Name** Employee engagement in individual mental health interventions.

**Definition** Percentage of employees participating in at least one intervention offered at work, such as stress-management workshops, mindfulness sessions, or resilience training.

**Data source(s)** Workplace programme attendance logs; Human resources department engagement records; intervention evaluation reports.

## 3. Promote leadership training, coaching, and mentoring for managers and supervisors.

This should include leadership skills, training on managing change processes, organizational risks, supporting employees, and resolving conflicts within teams. Studies consistently show that a supportive and positive leadership style is linked to improved mental health outcomes for workers (187). Effective leadership is especially crucial during organizational change, a time often marked by uncertainty, job stress, and anxiety. Open and realistic communication from leaders can mitigate these challenges and help resolve team conflicts during change processes and beyond (188).

It can also be helpful to implement coaching and mentoring programmes for managers and supervisors. These programmes provide ongoing support, helping senior staff navigate challenging situations and offering opportunities for continuous learning and personal and professional growth. Managers and supervisors should be supported to foster a nurturing work environment where staff feel valued, appreciated and recognized for their contributions, through fair and transparent appraisal processes.

**Example indicator**

**Name** Managers and supervisors complete leadership training and mentoring.

**Definition** Percentage of managers and supervisors who have completed a formal leadership training, coaching, or mentoring programme covering positive and inclusive leadership skills, healthy work environments, supporting employees' mental health, and workplace conflict resolution.

**Data source(s)** Training attendance logs; coaching and mentoring programme completion records; training completion certificates; course evaluation reports.

#### **4. Establish training to prevent workplace mobbing, harassment, violence, and discrimination, and mechanisms for reporting and redress.**

Mobbing, bullying (including online bullying), harassment, violence, abuse, and discrimination have severe and long-lasting impacts on workers' mental health. To mitigate these issues, every workplace should be required to implement evidence-based, mandatory training to prevent such behaviours. Training should be regular, and should ensure that employees at all levels, including senior management, remain informed and vigilant. Training can be delivered face-to-face or online. Additionally, effective mechanisms for reporting and redress must be established to ensure that incidents are promptly and properly addressed. See also Strategic actions under Policy directive Em1.

**Example indicator**

**Name** Workplaces implement mobbing, harassment, violence, and discrimination prevention processes.

**Definition** Number of organizations that have trained staff to prevent workplace mobbing, harassment, violence, and discrimination, and that have formal reporting and redress processes.

**Data source(s)** Human resources department policy registers; training attendance records; incident-reporting system logs.

#### **5. Encourage social networks and connections through workplace social and recreational events.**

A sense of social connectedness and support has been linked to positive mental health outcomes and higher job satisfaction ([165](#), [189](#)). Workplaces should be encouraged to develop and implement initiatives that include regular cultural, recreational, and social events, inviting participation from all employees and, where appropriate, their family members, partners, and children. These opportunities for connection can strengthen relationships within the workplace, contributing to a more supportive and cohesive work environment.

**Example indicator**

**Name** Workplace social and recreational events for employee connection.

**Definition** Number of social or recreational events organized during the reporting period that foster employee social networks and connections.

**Data source(s)** Human resources event calendars; employee engagement reports; attendance registers.

## Policy directive Em4 Encourage and facilitate early help-seeking when workers experience emotional difficulties; and support their recovery

### Strategic actions

#### 1. Establish a mental health and well-being unit or focal point at the workplace.

Workplaces should designate a dedicated internal unit or focal point for mental health and well-being. This structure plays a coordination and facilitation role, ensuring that information, initial support, and referral pathways are easily accessible to all employees. Staffed by trained personnel, the unit can offer initial consultations, organize employee peer support groups, and coordinate rights-based interventions. It also serves as a central hub for distributing information about community-based or online services and referring workers to appropriate mental health and psychosocial support.

To be effective, it must maintain strict confidentiality and be well-publicized and accessible across the organization. When adequately resourced, this unit may also provide more direct and comprehensive services, such as on-site counselling or structured well-being programmes, depending on workplace needs and capacity.

##### Example indicator

**Name** Workplace mental-health and well-being unit established.

**Definition** Achieved if a formal mental health and well-being unit or designated focal point is operational within the workplace, staffed by trained personnel, and publicly advertised to all employees.

**Data source(s)** Organizational structure charts; unit appointment records; internal communications announcing the unit.

#### 2. Implement an Employee Assistance Programme (EAP) to provide comprehensive, person-centred and rights-based support.

Employee Assistance Programmes (EAPs) are external or contracted services designed to provide direct, individualized mental health and psychosocial support to workers. They are distinct from internal coordination mechanisms, as discussed in the previous strategic action. EAPs should be person-centered, rights-based, and tailored to the specific risks and needs of the workplace. In occupations with high exposure to distressing or traumatic events, timely access to specialized services is essential. EAPs can offer a range of interventions, including individual or group counselling, cognitive behavioural therapy (CBT), peer support, crisis services, and referrals to external providers ([190](#), [191](#)).

##### Example indicator

**Name** Mental health and well-being Employee Assistance Programmes (EAPs).

**Definition** Number of workplaces that have established EAPs.

**Data source(s)** Workplace human resources programme logs; EAP records of services provided; reports showing how workers use EAPs.

### 3. Implement flexible return-to-work programmes for workers recovering from mental health issues.

Creating tailored and supportive return-to-work programmes should involve coordination between various stakeholders, including the returning workers, their family, or carers, (mental) healthcare providers, employers, and social services. Programmes should not only support re-entry and skill development but also enable people to experience the broader benefits of employment, including earning an income, developing social connections, and participating fully as active members of society. Return-to-work programmes should be adaptable to individuals' specific needs and include strategies and reasonable accommodations. For example, flexible work arrangements, phased re-entry, ongoing mental health and psychosocial support, and a supportive environment that encourages communication and adjustments may be needed. Importantly, confidentiality of health information should be strictly maintained at all times (163). For return-to-work programmes to be successful, managers and supervisors will need training that ensures they have the skills to support workers during their leave and to enable a smooth, flexible and supportive return.

#### ••• **Example indicator**

••• **Name** Participation in flexible return to work programmes

••• **Definition** Percentage of employees recovering from mental health conditions who participate in a flexible return to work programme offering phased re-entry, adjusted duties, modified schedules, or ongoing support.

••• **Data source(s)** Human resources return-to-work participation logs; employee health and wellbeing records.

Box 8 offers further resources for addressing mental health from within the employment sector.

## Box 8. Resources for addressing mental health from within the employment sector

- A review of good workplace practices to support individuals experiencing mental health problems. <https://osha.europa.eu/en/publications/review-good-workplace-practices-support-individuals-experiencing-mental-health-problems> (192)
- From loneliness to social connection: charting a path to healthier societies: report of the WHO Commission on Social Connection. <https://iris.who.int/handle/10665/381746>
- Guidance for workplaces on how to support individuals experiencing mental health problems. <https://osha.europa.eu/en/publications/guidance-workplaces-how-support-individuals-experiencing-mental-health-problems> (193)
- How workplaces can support workers experiencing mental health problems. <https://osha.europa.eu/en/publications/how-workplaces-can-support-workers-experiencing-mental-health-problems> (194)
- Mental health at work: Policy brief. <https://www.ilo.org/publications/mental-health-work> (163)
- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)
- SOLVE training package. Integrating health promotion into workplace OSH policies. <https://www.ilo.org/resource/training-material/solve-training-package-integrating-health-promotion-workplace-osh-policies> (195)
- Stronger, fairer, greener Wales: a plan for employability and skills. <https://www.gov.wales/stronger-fairer-greener-wales-plan-employability-and-skills> (196)
- United Nations system workplace mental health and well-being strategy (2024 and beyond). [https://www.un.org/sites/un2.un.org/files/un\\_system\\_mental\\_health\\_and\\_well\\_being\\_strategy\\_for\\_2024.pdf](https://www.un.org/sites/un2.un.org/files/un_system_mental_health_and_well_being_strategy_for_2024.pdf) (197)
- WHO guidelines on mental health at work. <https://www.who.int/publications/i/item/9789240053052> (111)

# Mental health and the **environment, conservation, and climate protection** sector



## Overview

Climate change and environmental destruction are serious global threats that affect everyone and have both direct and indirect impacts on people's physical and mental health. Experiencing environmental disasters resulting from natural hazards such as hurricanes, floods, landslides, droughts, and wildfires; or witnessing environmental damage from human activities such as deforestation, industrial emissions, and the overexploitation of natural resources, can lead to increased emotional distress and heightened stress responses, as well as causing or exacerbating depression, anxiety, and other mental health conditions (198). These impacts are not experienced equally. Environmental damage and climate change disproportionately affect groups already at risk of discrimination, including low-income communities, Indigenous Peoples, minoritized racial and ethnic groups, and people with disabilities.

Other environmental factors also harm mental health. Air, noise, and light pollution are linked to higher risks of depression, more stress, sleeping problems, trouble concentrating, fatigue, and increased irritability (199, 200). Water insecurity and inadequate sanitation, including inadequate access to clean water, sanitary facilities, and proper waste disposal, have been widely proven to damage mental health, causing higher levels of stress, depression, and anxiety (201, 202). This issue affects millions worldwide, especially in low-income communities, informal settlements, and slums that have little or no access to water, sanitation, and hygiene (WASH) services (203).

The long-term effects of climate change, such as food and water shortages, economic instability, armed conflict, and climate-induced displacement and migration, further increase the risk of emotional distress and developing or worsening of mental health conditions (198).

The Guidance highlights the critical links between mental health and the environment, conservation, and climate protection sector, recognizing that many core activities of the sector already contribute to protecting and promoting mental health. Additionally, it proposes a menu of policy directives and strategic actions that can be integrated into sectoral policies, supporting both improved mental health outcomes and the broader objectives of the sector. The numbering uses the prefix ECC (environment, conservation, and climate protection) to help avoid confusion when discussing policy directives for specific sectors or from other guidance. In particular, this Guidance suggests strategic actions for national and regional environment, conservation, and climate protection sectors focusing on: integrating mental health into leadership and policy efforts, on measures that protect both the environment and promote mental health and well-being, and on collaboration between mental health professionals and local communities to address the mental health impacts of environmental damage and climate change.

Given the close connection between mental health and environmental conditions, collaboration between the environment, conservation, climate protection, and the mental health sector is crucial for effectively implementing strategies. Collaboration is also essential for: making cities and communities safer, more resilient, and sustainable (SDG 11); providing access to affordable and clean energy (SDG 7), and clean water and sanitation (SDG 6); and advancing efforts to combat climate change and its impacts (SDG 13) (15). Good mental health also contributes to broader sustainable development goals, that are linked to the environment, conservation, and climate protection sector, including supporting responsible consumption and production (SDG 12), helping to reduce poverty (SDG 1), and promoting progress toward reducing inequalities (SDG 10) (15).

It is important to note that the roles and responsibilities of sectors might vary from country to country and that areas covered here in this Guidance might sometimes fall under the responsibility of a different sector. For example, issues related to environment, conservation, and climate protection may fall under sectors such as natural resources, agriculture, infrastructure, energy, or urban development, depending on national context and structures. Conversely, issues considered an urban development planning matter in some countries might be discussed under environment, conservation and climate protection within this Guidance. To support navigation and help the reader find all relevant information, Fig. 1 in the Introduction section offers a [directory of key issues](#), indicating where each is covered throughout the Guidance.

The Guidance includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators let sectors track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## Policy directive ECC1 Enhance mental health considerations in leadership on protecting the environment and addressing climate change

### Strategic actions

#### 1. Collaborate to integrate mental health into environmental, conservation, and climate protection policies, laws, and adaptation strategies.

When developing environmental, conservation, and climate protection policies, laws, and adaptation strategies, it is crucial to consider their impact on mental health, including how they might address the anxiety that environmental issues cause in the general population. Groups that face discrimination, including people with mental health conditions or psychosocial disabilities, are especially vulnerable to climate change, natural hazards, and environmental damage from human activities. For instance, they may experience worsening mental health and disruptions in services following environmental disasters. In particular, the mental health and well-being of Indigenous Peoples are severely affected by environmental and climate impacts. These communities may suffer profound losses to their culture and identity because of environmental disasters and climate-induced events, in addition to threats to their livelihoods and increased risk of displacement, all of which can have grave consequences for mental health (204).

To address these issues effectively, it is important to include mental health measures in vulnerability and needs assessments (205), and to involve climate advocates as well as people with mental health conditions and psychosocial disabilities, Indigenous Peoples, and other groups that face discrimination in creating and implementing policies, laws, and strategies. This helps develop a comprehensive and holistic approach and ensures that policies consider what the most affected segments of the population need.

#### Example indicator

**Name** Formal integration of mental health actions into environmental, conservation, and climate policies, law, or adaptation strategies.

**Definition** Achieved if at least one environmental, conservation, or climate-protection policy, law, or adaptation strategy explicitly includes mental health objectives.

**Data source(s)** Official policy registry (environment, conservation, climate portfolios); government gazette or ministry publications recording policy/law/strategy texts; government/ministry website.

## 2. Integrate mental health considerations into monitoring and research for climate change and environmental disasters.

Monitoring the impacts of climate change and environmental disasters on mental health is crucial for deepening our understanding of how mental health is affected and how harms can be mitigated. Terms such as eco-anxiety, climate anxiety, ecological grief, and solastalgia have been coined to describe the psychological distress caused by environmental change and are increasingly recognized, used, and studied. Climate change and environmental disasters have been linked to a range of mental health issues, including anxiety, depression, post-traumatic stress, and suicidality (206, 207). As the climate continues to warm, the connection between rising temperatures and increased mental ill health, including suicidal ideation, and suicide rates, is expected to become an increasingly urgent public health concern (208, 209).

It is important to include mental health indicators in national and regional environmental monitoring systems so these track how environmental disasters and climate change affect mental health and well-being. Monitoring systems should also collect data on eco-anxiety, climate anxiety, and the number of individuals seeking support for mental health conditions related to environmental challenges. Such data will provide a clearer picture of how climate change is affecting mental health.

Additionally, incorporating health and mental health dimensions into all research on climate change and environmental disasters is essential. Although research on the mental health impacts of climate change and environmental disasters has grown over the past two decades, significant gaps remain (198). Embedding mental health considerations into climate and environmental studies, securing appropriate funding, and ensuring that groups facing discrimination (including people with mental health conditions or psychosocial disabilities) have their perspectives heard will enhance our ability to mitigate mental health harms. It is also critical to prioritize translating research findings into practical, tangible actions and prevention strategies that directly address the mental health consequences of climate change and environmental disasters.

### Example indicator

**Name** Mental health metrics integrated into climate change and disaster-monitoring and research protocols.

**Definition** Achieved if at least one officially adopted climate change or environmental disaster monitoring framework and research guideline explicitly includes one or more mental health-related indicators or assessment metrics.

**Data source(s)** Official documents from agencies or institutions responsible for climate change and environmental disasters monitoring and research (for example, monitoring frameworks/guidelines, research TORs, environmental impact assessments).

### **3. Implement risk monitoring and early warning systems that reach groups facing discrimination, including people with mental health conditions and disabilities.**

Environmental emergencies and disasters disproportionately impact groups that face discrimination, including persons with disabilities and mental health conditions, Indigenous Peoples, and people from lower socio-economic backgrounds. For example, people with disabilities are up to four times more likely to perish in disasters due to attitudinal, physical, and economic barriers to their survival (210). This risk is even higher for those living in institutions (211). The Sendai Framework for Disaster Risk Reduction 2015–2030 (212) emphasizes that it is essential to adopt a participatory and inclusive approach in developing and implementing early warning systems. These systems must be accessible to all affected populations, including people with mental health conditions and disabilities.

In parallel, the environment, conservation, and climate protection sector should collaborate with the interior sector to develop and implement a multi-sectoral preparedness and response plan for mental health and psychosocial support within emergency preparedness schemes. This is critical to ensure continuity of care and support. This approach benefits the safety and also the well-being and resilience of all communities (210). For more detail, refer to the section on Mental health and the interior sector in this Guidance.

#### **Example indicator**

**Name** Early warning systems reach and accommodate people with mental health conditions and disabilities.

**Definition** Achieved if the officially adopted early warning system guidelines or protocols explicitly require systems to identify and warn people with mental health conditions or disabilities, through measures such as accessible alert formats, targeted community engagement plans, referral pathways to psychosocial support, or dedicated communication strategies.

**Data source(s)** Official early warning system manuals and guidelines; national disaster risk reduction strategies, agency protocols for early warning systems.

## Policy directive ECC2 Implement measures to protect the environment, address climate change and foster mental health and well-being

### Strategic actions

#### 1. Incorporate nature into urban areas, including street trees, gardens, nature views, and walkable green spaces.

Access to urban nature is widely recognized for its positive impact on both general health and mental well-being (213). SDG 11 explicitly aims to “provide universal access to safe, inclusive, and accessible green and public spaces” in cities and human settlements by 2030 (15). Urban nature and green infrastructure in cities offer various environmental benefits that protect mental health, such as temperature regulation, improved water management, economic prosperity, and biodiversity conservation. Moreover, they reduce stress levels, help people relax (214), and foster stronger social connections within communities (215). In collaboration with the urban and rural development sectors, green infrastructure and access to nature should be integrated into all neighbourhoods, (also see Mental health and the urban and rural development sector in this Guidance).

#### Example indicator

**Name** Natural spaces incorporated into urban planning guidelines.

**Definition** Achieved if municipal planning documents (master plans, zoning codes or urban design guidelines) explicitly require new or redeveloped urban areas to include one or more of the following: street trees, community gardens or pocket parks, accessible nature views, walkable green corridors, or water-related infrastructure (for example, ponds, or canals).

**Data source(s)** Municipal planning codes; urban development guidelines; zoning ordinances; or related land-use regulations.

## 2. Protect natural habitats and ecosystems, and Indigenous lands.

The widespread degradation of natural environments is a pressing global crisis, with far-reaching consequences for ecosystems, livelihoods, and human health. Environmental destruction, including deforestation, overfishing, and allowing industrial development and other human activities (including sometimes conservation efforts) to dispossess Indigenous People of their lands, can have severe consequences on mental health, general health, and well-being (198). Countries should place greater emphasis on prioritizing protection of natural spaces and ecosystems. This can be achieved for instance with national and marine-protected areas, stricter deforestation controls, and regulations on industrial fishing. The Global Biodiversity Framework has adopted the so-called 30 x 30 target of protecting at least 30% of terrestrial, inland water, and coastal and marine areas by 2030 (216). It is equally important to recognize and protect Indigenous rights related to land ownership and use, which are essential for sustaining both environmental integrity and human health.

### Example indicator

**Name** Ecosystem and indigenous land protection measures enacted.

**Definition** Number of formal legal or policy measures enacted to protect natural ecosystems or Indigenous lands, including protected area designations, ecological buffer zones, habitat restoration mandates, and legal recognition of Indigenous land rights.

**Data source(s)** Environmental agency reports; official legal gazette entries; Ministries Environment, of Indigenous Affairs or Land Management publications.

## 3. Reduce air, noise, and light pollution and expand access to clean energy.

Reducing air, noise, and light pollution is crucial for improving physical and mental health. Air pollution is a major risk factor for non-communicable diseases, poor health outcomes, and premature deaths. It also harms mental health, increasing the risk of depression, stress, and dementia (217, 218). Air, noise and light pollution also disproportionately affect low-income communities and groups that face discrimination, because of where they live and work, and their limited ability to pay for a better environment. Since transport contributes very substantially to urban air pollution, collaborations between the environment and the urban and rural development sectors can bring benefits for mental health, and also help address inequalities.

Established air quality actions include enforcing emission regulations, creating low emission zones to restrict heavy traffic in densely populated areas, relocating industrial zones away from residential areas, and increasing access to e-powered public transport and car-sharing programmes. Promoting active commuting by creating safe walking and biking paths also plays a key role.

Noise pollution, common in urban areas due to traffic, industry, and construction, leads to sleep disturbances, stress, and irritability (199, 219). Similarly, light pollution in cities affects mental health, contributing to depression and sleep disturbances (200). The urban and rural development sector has long-recognized the importance of effective pollution reduction strategies. For noise pollution, this includes setting maximum sound levels, limiting construction hours in residential areas, using effective building insulation, and incorporating street trees and walls to protect residential areas. In addressing light pollution, approaches such as directing streetlights downward, restricting illuminated advertisements in residential zones, and using window blinds to block out street lights have been effective. These efforts play a crucial role in supporting better sleep, lowering stress, and improving mental health.

Expanding access to clean and affordable energy sources such as solar, wind, and other renewable technologies is also critical in reducing air, noise and light pollution and thus in supporting better physical and mental health outcomes. For example, replacing diesel generators with solar-powered systems in homes, schools, and health facilities can significantly reduce background noise and improve air quality, helping to lower stress and anxiety levels. Clean energy technologies also enable better lighting design, such as dimmable LED streetlights, which reduce sleep disturbances caused by excessive brightness and light spillover. Together, these improvements contribute to healthier, quieter, and more restful environments that promote mental well-being. For associated discussions, refer to [Mental health and the urban and rural development sector](#) in this Guidance.

⋮ **Example indicator**

⋮ **Name** Policy and programmes for pollution reduction and clean energy seek mental health co-benefits.

⋮ **Definition** Achieved if the officially adopted programme or strategy to reduce air, noise, or light pollution, or to expand access to clean energy, explicitly includes objectives, targets, or activities aimed at measuring and improving mental health and well-being.

⋮ **Data source(s)** Government programme documents and strategy publications (for example, Environment, Energy or Health Ministry dossiers); official project charters or implementation plans.

#### **4. Improve access to sustainable clean water, sanitation, waste disposal, and recycling systems.**

Millions of people worldwide, particularly in low-income communities and in informal settlements, and slums, have limited or no access to water, sanitation and hygiene (WASH) services (203). Experiencing water insecurity and inadequate sanitation raises risks for infectious diseases but has also been associated with poor mental health outcomes, including higher levels of stress, depression and anxiety (201, 202). Hence, programmes to improve sanitation and hygiene standards, as well as programmes to provide effective and environmentally-friendly water and waste disposal management, can improve health and mental health outcomes while helping create sustainable cities and settlements. Programmes should recognize this potential, plan for mental health benefits, and incorporate monitoring and evaluation that records the outcomes. For associated discussions, refer to [Mental health and the urban and rural development sector](#) in this Guidance.

⋮ **Example indicator**

⋮ **Name** Mental health considerations integrated into sustainable WASH project guidelines.

⋮ **Definition** Achieved if the officially adopted guideline, manual, or protocol for water, sanitation, or waste-management explicitly requires the evaluation of mental health outcomes, such as community stress reduction targets, psychosocial support referrals, or other well-being impact indicators.

⋮ **Data source(s)** WASH programme manuals and guidelines; Ministry of Water and Sanitation project documents; government environmental health or public health strategy publications.

## Policy directive ECC3 Collaborate with the mental health sector to create sustainable services and address climate and environmental challenges

### Strategic actions

#### 1. Collaborate with the mental health sector to create low-carbon mental health services.

Healthcare systems globally account for over 4% of greenhouse gas emissions, with healthcare in industrialized countries contributing up to 10% of national emissions (220, 221). These figures underscore the urgent need for health systems, including mental health services, to reduce their carbon footprint.

Close collaboration between the climate and environment sectors and the health and mental health sectors is essential to develop and implement more sustainable strategies. Mental health services should focus on reducing emissions through better design, construction, and daily operations. Key strategies include improving energy efficiency, transitioning to renewable energy sources, using eco-friendly materials, implementing effective waste management systems (including recycling), and integrating effective digital mental health interventions into routine practice where they save on resource use, including users' transport needs (222). Incorporating natural spaces within services can help achieve sustainable services, for example by helping to regulate building temperatures, while also offering service users mental health benefits from contact with nature, as discussed in Policy directive ECC2 above.

Collaboration between the environment, conservation, and climate protection sector and the urban and rural development sector is crucial for achieving low carbon mental health services. Services must be accessible via sustainable transportation and they need robust digital infrastructure if they are to expand tele-mental health services and support. Low carbon mental health services will contribute to climate goals and also create healthier, more restorative care environments for service users and staff alike.

#### Example indicator

Name Sustainable mental health service facilities.

**Definition** Number of mental health service facilities that have obtained an official sustainability certification.

**Data source(s)** National or regional certification registries, Ministry of Health service accreditation records.

## **2. Build people's capacity to address the mental health impacts of environmental destruction and climate change.**

Environmental degradation and climate-related disasters have both direct and indirect impacts on mental health, contributing to increased stress, anxiety, and worsening of existing conditions. Factors such as food insecurity, rising living costs, climate-induced migration, job loss, and social disruption can all undermine well-being. It is essential to strengthen people's capacity to understand and respond to these mental health impacts ([223](#), [224](#)). The environment, conservation and climate protection sector can collaborate with mental and broader health services to provide environmental education on the most pressing environmental challenges. The mental health sector can provide reciprocal input on how to mitigate mental health impacts, including by supporting people experiencing climate related distress such as climate anxiety and eco-anxiety. Training can emphasize the importance of providing support without pathologizing normal stress reactions to the climate crisis ([225](#)).

### **Example indicator**

**Name** Professionals trained in the mental health impact of environmental destruction and climate change.

**Definition** Percentage of targeted personnel (environmental protection staff, mental health professionals or primary care workers), who have completed at least one accredited training session on the mental health impact of environmental destruction and climate change during the reporting period.

**Data source(s)** Training attendance and completion records from human resources or training departments; accredited training programme databases; professional registration databases.

## Policy directive ECC4 Collaborate with local communities to address mental health issues related to the environment and climate change

### Strategic actions

#### 1. Engage local communities to identify mental health, environmental and climate change issues, assess vulnerabilities and capacities, and develop bottom-up solutions.

The environment, conservation and climate protection sector can collaborate with the health and mental health sectors and communities to identify and discuss and identify pressing issues related to mental health, the environment, and climate change. Communities should include local leaders, climate advocates, Indigenous Peoples, and other groups that face discrimination. Discussions can cover vulnerabilities, capacity, and adaptation options.

A collaborative approach will encourage solutions and interventions to be developed and delivered from the bottom up. Discussions could lead to information and awareness campaigns, as well as other actions on climate change, its impacts on mental health, and on mental health services and support.

Campaigns can inform the public about climate change science, problems, and policies, highlighting how these affect mental and also physical health and where to get support (226). Campaigns can change attitudes and behaviours, mobilize advocacy for effective climate and environmental governance, and benefit people's mental health by fostering a sense of purpose and efficacy (226), enhancing overall community resilience.

#### Example indicator

**Name** Communities engaged through facilitated forums.

**Definition** Percentage of predefined target communities that held at least one facilitated forum or similar participation sessions during the reporting period. Additionally, the forum has aimed to identify local mental health, environmental, and climate change vulnerabilities, assess community capacities, and co-design locally relevant interventions or solutions.

**Data source(s)** Community engagement reports; local government meeting logs; forum attendance registers; documentation from civil society organizations.

## 2. Support community programmes that increase nature and outdoor activities for all.

Regular exposure to nature is linked to various mental health benefits, such as reduced anxiety and depressive symptoms (227). To ensure that everyone, including people with mental health conditions or psychosocial disabilities and other groups that face discrimination, can share the benefits, it is essential to support wide-ranging access programmes and actively remove barriers to participation. The environment, conservation and climate protection sector can work collaboratively with communities (and with the leisure, health, and development sectors, see next Strategic action) to increase access to parks, trails, and organized outdoor activities, including culturally meaningful activities led by Indigenous Peoples. Community programmes should provide tailored support, to widen accessibility, such as language interpretation for migrants, refugees and asylum seekers, and personal assistance for individuals with disabilities.

### Example indicator

**Name** Inclusive community nature and outdoor programmes delivered.

**Definition** Number of distinct community-based programmes implemented that offer structured nature or outdoor activities and include documented outreach, accessibility accommodations, or enhanced participation of people with mental health conditions, psychosocial disabilities, or other groups at risk of discrimination.

**Data source(s)** Programme monitoring databases; attendance and outreach reports disaggregated by participant group.

## 3. Collaborate with the health and other sectors to promote nature and outdoor activities.

Nature-based activities can be integrated into universal health coverage (UHC) packages to improve their availability across various levels of the health and social care systems. Health and mental health professionals can be encouraged to prescribe activities such as gardening, green exercise, and nature-based therapies, given their proven benefits, including reduced anxiety and depressive symptoms (227). Collaborating with the health sector and other relevant sectors to provide financial coverage for these interventions and to advocate for their inclusion in health systems can enhance access and support overall mental well-being. Additionally, joint research efforts based on this collaboration can help strengthen the evidence base and build the economic case for investing in nature-based interventions to promote mental health.

### Example indicator

**Name** Cross-sector nature-based initiatives delivered to promote mental health.

**Definition** Number of distinct initiatives jointly implemented with other sectors that explicitly aim to promote mental well-being through organized nature-based or outdoor activities.

**Data source(s)** Intersectoral action plans or agreements; programme implementation reports; official registers of joint initiatives; Ministry or agency documentation.

Box 9 offers further resources for addressing mental health from within the environment, conservation, and climate protection sector.

## Box 9. Resources for addressing mental health from within the environment, conservation, and climate protection sector

- A threat to progress: confronting the effects of climate change on child health and well-being. [https://www.unicef.org/media/159341/file/A\\_Threat\\_to\\_Progress\\_190824%20EN.pdf](https://www.unicef.org/media/159341/file/A_Threat_to_Progress_190824%20EN.pdf) (228)
- Blog: signed, sealed and 212 steps towards delivering the world's first net zero health service. <https://www.england.nhs.uk/greenernhs/2022/06/blog-signed-sealed-and-212-steps-towards-delivering-the-worlds-first-net-zero-health-service/> (229)
- Communicating on climate change and health: toolkit for health professionals. <https://iris.who.int/handle/10665/376283> (230)
- Climate change, mental health and wellbeing: Examples of practical inclusive practices. [https://cbm-global.org/wp-content/uploads/2021/12/Climate-change-and-Mental-Health\\_CBMGlobal.pdf](https://cbm-global.org/wp-content/uploads/2021/12/Climate-change-and-Mental-Health_CBMGlobal.pdf) (231)
- Creating healthy cities. <https://www.who.int/activities/creating-healthy-cities> (232)
- IASC Guidelines on mental health and psychosocial support in emergency settings. <https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007> (233)
- Mental health and climate change: policy brief. <https://iris.who.int/handle/10665/354104> (198)
- Nature-based solutions and health. <https://iris.who.int/handle/10665/381437> (213)
- Operational framework for building climate resilient and low carbon health systems. <https://iris.who.int/handle/10665/373837> (222)
- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)
- Promoting walking and cycling: a toolkit of policy options. <https://iris.who.int/handle/10665/381335> (234)
- State of the world's indigenous peoples: Volume VI – climate crisis. <https://social.desa.un.org/publications/state-of-the-worlds-indigenous-peoples-volume-vi-climate-crisis> (204)
- Sustainability solutions for health care. <https://practicegreenhealth.org> (235)
- Technical note. Linking Disaster Risk Reduction (DRR) and Mental Health and Psychosocial Support (MHPSS): practical tools, approaches and case studies. <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/technical-note-linking-disaster-risk-reduction-drr-and-mental-health-and-psychosocial-support-mhpss> (211)
- WHO European healthy cities network. <https://www.who.int/europe/groups/who-european-healthy-cities-network> (236)
- WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments. <https://iris.who.int/handle/10665/331959> (237)

# Mental health and the **health** sector



## Overview

The health sector in each country typically leads policies and actions related to mental health. Mental and physical health are closely connected, and health policies offer numerous opportunities to address both simultaneously. For example, people with mental health conditions or psychosocial disabilities are at higher risk of developing physical health conditions, such as diabetes, cardiovascular disease, cancer and HIV/AIDS, due to factors like the effects of psychotropic drugs, lifestyle factors (for example, high rates of smoking), living conditions, and discrimination. They have an excess all-cause mortality rate two- to three-fold higher than the general population (238). Conversely, many people diagnosed with physical health conditions, whether chronic or serious acute conditions, are likely to experience mental distress and are at higher risk of developing a mental health condition, highlighting the bidirectional relationship between physical and mental well-being (239). Hence, mental health workers should recognize and assess physical health problems, and primary care and general health workers should be adept at identifying distress and mental health conditions and distinguishing them from symptoms of underlying physical illnesses or their treatments.

Policy should require that the health ministry has a strong team dedicated to mental health and that coordination mechanisms with other sectors are in place. The mental health team needs secure and sufficient funding for mental health services and support. It also needs finance to establish multisectoral collaborations to address key social and structural determinants of mental health, recognizing that these affect physical health too.

Integrating mental health into general and specialized health services is as important as having a dedicated mental health unit. For example, mental health needs to be integrated into: accident and emergency services; child and maternal health care; older adult care; noncommunicable disease care (such as for cancer, cardiovascular, respiratory, and autoimmune diseases); communicable diseases care (such as for HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases); palliative care; sexual and reproductive health-care; and services addressing alcohol and other psychoactive substance use. For people with mental health conditions or psychosocial disabilities, facilitating access to general and specialized health services is critical.

Making mental health expertise available across the spectrum of health services requires training all health workers in basic mental health and well-being knowledge and skills. It is also crucial that they adopt a rights-based and person-centred approach, and address the social and structural factors that impact health. If specialist mental health staff are not directly employed in any particular service, a mechanism or liaison service should be established to draw on their expertise.

Comprehensive information on all aspects of mental health policy and strategic actions is available in Modules 1–5 of [Guidance on mental health policy and strategic action plans \(25\)](#) and guidance for integrating mental health provisions into law can be found in [Mental health, human rights and legislation: guidance and practice \(36\)](#).

This Guidance recognizes that mental health policy typically falls under the responsibility of the health sector and that many core activities of the sector already contribute or are directly dedicated to protecting and promoting mental health. Nevertheless, to ensure that mental health is adequately addressed in all areas of general health planning, financing, service development, and provision this Guidance proposes a menu of policy directives and key strategic actions on mental health that can be incorporated into broader health sector policy.

The numbering uses the prefix H (health) to help avoid confusion when discussing policy directives for specific sectors or from other guidance. Strategic actions emphasize that mental health should be integrated as a core component of Universal Health Coverage (UHC) and that everyone should have equitable access to comprehensive, quality mental health services and support, regardless of their socioeconomic status or location.

It is important to note that many issues covered in other sections of this Guidance, for example in the social protection sector, the education sector and the urban and rural development sector, are directly or indirectly relevant for the health sector. To support navigation and help the reader find all relevant information, Fig. 1 in the Introduction to the Guidance offers a [directory of key issues](#), indicating where each is discussed.

This Guidance includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators enable sectors to track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## Policy directive H1 Strengthening governance on mental health

### Strategic actions

#### **1. Create a team within the Ministry of Health to integrate mental health into all health policies and initiatives.**

Such a team, unit, or department could co-develop and inform policies and lead the development, management, and coordination of mental health strategies, services, and actions across all health areas, from national to regional and district levels.

Comprehensive integration requires an organized coordination mechanism and regular meetings with representatives from different health areas within the Ministry of Health. In this way, mental health can become a central consideration in every aspect of healthcare for all age groups and demographics.

To support this integration, the mental health team should consult with key stakeholders from both general and mental health fields as well as service users, families, and providers. These stakeholders should be actively engaged in discussions and decision-making processes, enabling them to offer advice and direction on issues that affect them directly.

Close multisectoral collaboration will help to comprehensively address the structural and social determinants that impact mental health. To achieve this, a formal mechanism can be established to engage other sectors, hold regular discussions, and coordinate actions in a unified and sustained manner.

It is essential to train policy-makers and stakeholders within the health sector on person-centred, rights-based, and recovery-oriented approaches to mental health. This helps align all health policies and actions and ensure they meet international human rights standards, including those set by the Convention on the Rights of Persons with Disabilities (CRPD) (1). The WHO QualityRights face-to-face training (151) and e-training (152) are examples of rights- and evidence-based training that can be used.

••• **Example indicator**

••• **Name** A mental health team is established and operational in the Ministry of Health.

••• **Definition** Achieved if a formal mental health team or unit has been officially established within the Ministry of Health, is staffed with dedicated personnel, and has organized at least one meeting that convenes multiple departments to integrate mental health into broader health policies and initiatives.

••• **Data source(s)** Ministry of Health organizational charts; official gazette, decree, or formal directive establishing the team; HR staffing records; cross-departmental meeting minutes.

## **2. Allocate sufficient funds to develop community mental health services and integrate mental health into general health-care.**

In most countries, mental health funding comes from the Ministry of Health. Based on a thorough cost analysis, the health sector should allocate adequate resources for national mental health policies and action plans, prioritizing community-based services that meet rights-based criteria. Financing should support the development of person-centred, rights-based, and recovery-oriented community mental health services. These might include mental health crisis services, hospital-based services, peer support services, community mental health centres, community outreach services, and supported living services (176).

Finance allocations should also be based on population needs. For example, specific funds should be allocated for creating sufficient high-quality services for children and adolescents, and for older adults.

It is also essential to finance the integration of mental health into primary care and other general health services. Such integration is cost-effective and can dramatically improve outcomes for service users.

At the same time, ongoing funding for psychiatric institutions should be phased out. Institutional care too often delivers poor-quality services, breaches human rights, and is associated with high mortality. Instead, a robust network of integrated community mental health services needs to be developed. This will yield the best outcomes and lay the groundwork for true deinstitutionalization. Importantly, deinstitutionalization must proceed in an orderly, coordinated way and “double funding” is needed to ensure that comprehensive community mental health, housing, and other support services are fully in place before individuals transition out of institutions. For more detailed guidance on financing and budget see [Guidance on mental health policy and strategic action plans \(25\)](#).

••• **Example indicator**

••• **Name** Health budget is allocated to community mental health services and to integrating mental health into general health-care.

••• **Definition** Percentage of the Ministry of Health’s annual budget that is allocated specifically to developing community mental health services and integrating mental health into general health care.

••• **Data source(s)** National budget law; Ministry of Health budget execution reports.

### 3. Update health insurance schemes to eliminate discriminatory practices and improve access to mental health care.

Health insurance schemes need to be updated to eliminate discriminatory practices that deny access to mental health treatments and support, or that restrict people with mental health conditions from accessing general health treatments available to others. It is essential to address financial incentives or disincentives within health insurance schemes that create barriers to providing, accessing, and using rights-based community mental health services and interventions. Health insurance should also cover mental health care and support over the long term, not just for acute admissions.

Discriminatory practices in health insurance can take many forms. For example, insurance schemes that offer coverage for drug treatments might fail to cover a range of evidence-based and rights-based services and interventions such as psychological therapies or psychosocial interventions. Additionally, people with mental health conditions or psychosocial disabilities may be sidelined or excluded from treatments that others receive, such as when they are not given priority for vaccines or treatments. In some cases, individuals with psychosocial disabilities may be denied health insurance entirely, based on their disability status. These discriminatory practices should be prohibited by law, and regulations must be adopted to ensure insurance plans and premiums are set fairly and reasonably (240). Protections should extend to people with complex or costly needs, such as those with disabilities, older people, migrants, refugees and asylum seekers who may require additional support, including translation services or culturally-adapted care.

Beyond discriminatory practices, there are often financial disincentives within health insurance schemes that act as barriers to rights-based community care and support, and these should be addressed in health sector policy. For example, schemes may refuse to reimburse services delivered in community-based settings while covering equivalent, and often more expensive, hospital-based services. This creates incentives to maintain hospital-based care rather than shifting to community-based services, which have been shown to be more beneficial for people and their mental health (241). Additionally, health insurance schemes should be reformed so they no longer favour convenient and discrete interventions, like medications that may not always be the best or most evidence-based choice, over more complex but potentially more beneficial interventions, such as lifestyle, psychological, social, and economic interventions (242). For more details, see Policy directive 1.2 Financing and Budget in Module 2 in the [Guidance on mental health policy and strategic action plans \(25\)](#).

#### Example indicator

**Name** Reformed health insurance schemes for mental health inclusion.

**Definition** Achieved if law has prohibited the national health insurance scheme from discriminatory exclusions of mental health services (or exclusion of specific population groups from accessing these services) and if the schemes ensure coverage for psychological interventions.

**Data source(s)** National health insurance legislation; regulatory authority scheme guidelines; insurance enrolment and claims records.

#### **4. Integrate mental health indicators into the national health information system for better planning and evaluation.**

Collecting, analyzing, and interpreting mental health data is crucial for understanding the mental health landscape and people's most urgent service provision and support needs (34, 243). Such data enables effective monitoring of health and other sector policies, helping to identify gaps and areas for improvements, and directing policy and strategic action plan creation or revision.

To be useful, data must be collected, processed, analyzed, and communicated in a transparent and timely manner that makes its information accessible to all stakeholders, including policy-makers, healthcare providers, and service users (243). Indicators should incorporate broad recovery and quality measures as opposed to having a narrow focus on diagnosis and symptoms. Data to collect should cover: the availability, coverage, and continuity of services and interventions; the prevalence of mental health conditions, and risk factors; the rates of involuntary hospitalization and treatment; how often seclusion and restraints are used (and why); and suicide rates.

Data should be suitable for disaggregation by age, sex, gender, disability and other sociodemographic variables to better inform decision-making and policy formulation.

For a full list of examples of mental health-related items to include in the health information system at the population, service, and individual levels, see Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans in [Guidance on mental health policy and strategic action plans \(25\)](#).

##### **Example indicator**

**Name** Mental health indicators are integrated into the national health information system.

**Definition** Number of distinct mental health indicators (for example, service coverage, morbidity, expenditure, outcome metrics) that have been formally incorporated into the national health information system's core data modules.

**Data source(s)** Health information system metadata registry; Ministry of Health annual health information reports; system configuration and module documentation.

## Policy directive H2 Make comprehensive mental health services and support an integral part of the health system

### Strategic actions

#### 1. Integrate mental health into primary care and other general health services, including specialized services.

Mental health service integration should include (but not be limited to): accident and emergency services; child and maternal health care; older adult care; noncommunicable disease care (such as for cancer, cardiovascular, respiratory, and autoimmune diseases); communicable diseases care (such as for HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases); palliative care; sexual and reproductive health care; and services addressing alcohol and other psychoactive substance use (34).

Primary care and general health services should play a vital role in providing physical health and lifestyle interventions that benefit mental health, and also enable access to psychological, social, and economic support, either through direct service provision or by referring individuals to other community-based services. To support this, strong referral networks should be established between primary care, general health services, mental health services, and community services and support.

Primary care and general health services are often the first point of contact for people whose physical health issues or treatment side effects have caused or worsened emotional distress or mental health conditions (34). Given the close connection between mental and physical health, integrated primary and general health care that addresses both can provide more holistic treatment and support. Numerous studies show such integration contributes to improved affordability, accessibility, acceptability, and to better health outcomes (239).

Integrating mental health into primary care and general health services requires careful planning and consideration, and sometimes legislative changes to allow tasks to be allocated to different professions. The responsibilities and mental health-related tasks of primary care and other general health workers should be clearly defined according to local circumstances, and these workers must receive adequate training, ongoing support, and supervision from mental health professionals. Importantly, mental health support at the primary care level and in general health should be complemented by more specialized care at secondary and, when needed, tertiary levels. This includes a range of dedicated mental health services to provide ongoing care and support.

Services must be delivered without the over-medicalization that can result from short appointments, overburdened or poorly trained professionals, and limited access to psychological, social and economic interventions. Psychotropic drugs, especially when prescribed routinely and inappropriately, can themselves harm health. This risk is compounded by poor recognition of withdrawal effects, such as those seen with antidepressants (25).

Strong collaboration between health and other government sectors is crucial for successful integration. For instance, the education, social, and employment sectors can work with primary care and other general health services to help people with mental health conditions access opportunities that support recovery and community inclusion. Services will achieve better outcomes when people with lived experience and their families are consulted from the beginning.

**Example indicator**

**Name** Services integrate mental health within general health provision.

**Definition** Percentage of primary care and other general health services (including specialized ones) that have implemented staff training in mental health and that have integrated lifestyle, psychological, social, and economic interventions into health service delivery through direct service provision or referral pathways.

**Data source(s)** Ministry of Health service delivery records; service assessment and accreditation reports; staff training completion databases; insurance claim records.

## **2. Make general health services more accessible for people with mental health conditions or disabilities, and those facing discrimination.**

People with mental health conditions or psychosocial disabilities are at higher risk of developing physical health conditions, such as diabetes, cardiovascular disease, cancer, and HIV/AIDS (238, 244, 245) as well as issues related to alcohol and other psychoactive substance use (2, 246). However, these physical-health and substance-use concerns are often overlooked within mental health contexts (247, 248). Conversely, people with dual diagnosis related to mental health conditions and alcohol and other psychoactive substance use, face multiple barriers to accessing physical health care. Service staff often attribute their physical health concerns to their mental health condition, and they are frequently assigned a low priority for certain treatments. Poor coordination between mental and physical healthcare, along with fragmented services, further contributes to poor physical health outcomes (249, 250) and an excess mortality risk up to three times higher than the general population (238, 251). Actions to improve accessibility must involve changing culture, mindsets, and attitudes, as well as addressing stigma and discrimination (see below).

Other barriers affect people from groups that face discrimination. For example, general and mental health services may be offered in inaccessible buildings without ramps or elevators. They may lack adaptive equipment, and information in accessible formats (for example, Easy Read, Braille, sign language, video relay or TTY services, AI-based tools). There may be insufficient translation and interpretation for migrants, refugees, and asylum seekers. It is crucial that health-sector policy proactively addresses these obstacles through targeted infrastructure upgrades, communication strategies, and staff training.

**Example indicator**

**Name** Accessibility measures in general health facilities.

**Definition** Percentage of general health facilities that have implemented at least one accessibility measure for people with mental-health conditions, disabilities, or other at-risk groups. Measures might include ramp access, accessible restrooms, adaptive equipment, information in accessible formats, or staff training on disability-inclusive care.

**Data source(s)** Health service accessibility audit reports; Ministry of Health accreditation and inspection records; national health information system service profiles.

### 3. Implement a rights-based and recovery-oriented approach in health services.

All general and mental health services should implement a rights-based and recovery-oriented approach. They should include holistic, person-centred assessments of needs and should provide interventions and support to achieve mental health and well-being for all, aligned with international human rights standards. The WHO QualityRights in person training tools (151) and QualityRights e-training (152) can help build capacity in these areas.

Assessments of care and support needs should consider all domains of a person's life, including physical health, lifestyle, mental health, emotional well-being, coping mechanisms, relationships, social networks, community inclusion, and support mechanisms (252–254). For instance, assessments in general health settings should consider mental health dimensions. Conversely, mental health services should assess physical health dimensions and address them through referrals and collaborations. Assessments and interventions should address the social and structural determinants of mental health (see Strategic action below) as well as the person's symptoms and challenges. For more detailed information see Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans in [Guidance on mental health policy and strategic action plans \(25\)](#).

Services should be able to offer, or refer to, a wide range of interventions, including lifestyle and physical health, lifestyle, psychological, social, and economic interventions (see Box 10 below) and drug interventions.

While medical approaches, including psychotropic drugs, can play an important role in recovery and crisis management, there are significant concerns about over-reliance on these drugs. Issues such as incomplete information on adverse effects (255–258), polypharmacy (259, 260), lack of safe monitoring, prescription without informed consent (9, 23), and high prescription rates (261–263) should be addressed. Mental health and general health services need to be cautious in prescribing psychotropic drugs. Staff should be skilled in supporting people who wish to taper off their use, should know about the adverse effects of these medications on general health, and should be capable of supporting people experiencing these effects. Box 11 gives more information on prescription, tapering and discontinuation of psychotropic drugs.

Many drugs for treating general health conditions, such as corticosteroids, interferons, and mefloquine, can cause symptoms of mental health conditions during use or withdrawal (264). It is important to inform patients about this possibility, provide close monitoring, and, after evaluating the risks and benefits, consider non-pharmacological or pharmacological measures to optimize safety and treatment tolerability. All interventions should be thoroughly explained and discussed, including their advantages, limitations, and potential risks or negative effects, and must always be based on the individual's free and informed consent.

#### Example indicator

**Name** Rights-based and recovery-oriented approach implementation in health services

**Definition** Percentage of general and mental health facilities that have adopted formal rights-based policies that cover legal capacity, informed consent, and zero-coercion goals and conducted rights and recovery-oriented mental health training for staff.

**Data source(s)** Ministry of Health service policy registers; training completion logs; service user rights documentation and compliance records.

## Box 10. Flexible and non-exhaustive menu of physical health and lifestyle, psychological, social, and economic interventions for treatment and well-being

This box is an excerpt from *Guidance on mental health policy and strategic action plans: module 2: key reform areas, directives, strategies, and actions for mental health policy and strategic action plans* (25) where it was numbered Box 11.

There are many interventions that promote and support mental health, and that provide effective treatment without the use of psychotropic drugs.

### Physical health and lifestyle interventions:

- physical activity and sport (53, 265);
- nutrition and healthy diet (266, 267);
- sleep (268, 269);
- sexual and reproductive health (270, 271);
- stress management and relaxation techniques (for example, mindfulness-based interventions, yoga) (2, 272, 273);
- art and culture-based therapy (51, 65, 274);
- nature-based green and blue interventions (2, 275, 276);
- harm reduction interventions (for example, needle and syringe programmes) (277, 278);
- screening, brief interventions, and referral to treatment for hazardous substance use and substance use disorders (277);
- tobacco cessation (279, 280); and
- collaboration/referral for screening and treatment of physical health conditions as appropriate (for example, diabetes, cardiovascular disease, cancer, HIV/AIDS) (281–283).

### Psychological interventions:

- cognitive behavioural therapy, interpersonal therapy, behavioural activation therapy, brief psychodynamic therapy, third-wave therapies, trauma-informed approaches (for example, psychotherapy with a trauma focus, eye movement desensitization and reprocessing), and – mainly in relation to alcohol and other psychoactive substance use – contingency management therapy, motivational interviewing and enhancement therapy, positive affect therapy, supportive expressive therapy (284–285);
- eye movement desensitization and reprocessing (EMDR) (286);
- family therapy (for example, parenting programmes including home visits for pregnant or postpartum mothers, their partner, and their children, couples therapy, family-focused interventions) (2, 287–289);
- family and other care giver interventions (for example support interventions, education, and guidance) (284, 290, 291);
- problem-solving therapy and skills training (284, 292, 293);
- psychoeducation (2, 294);
- interpersonal and social skills, cognitive and organizational skills and self-regulation-based interventions (284, 285);
- cognitive stimulation therapy and cognitive training (284, 285), mainly in relation to dementia;
- beginning-to-read interventions, early communication interventions and specialized instructional techniques (284, 285), mainly for children and adolescents; and
- recovery, advance, and crisis response plans (295–298).

**Social interventions:**

- social prescribing ([274](#), [299](#), [300](#));
- housing assistance (for example, Housing First, other supported social housing programmes) ([2](#), [301](#));
- personal assistance (for example, supported decision-making, assistance for daily activities) ([302–304](#));
- peer support and mutual help groups (1:1, group and online) ([305–307](#));
- social support and community reinforcement approaches (including to build meaningful social connection and combat isolation and loneliness) ([2](#), [308](#), [309](#));
- occupational therapy ([2](#), [310](#), [311](#)); and
- community-led interventions and bottom-up interventions ([58](#), [312–314](#)).

**Economic interventions:**

- access to income generation and employment (for example, individual placement and support, supported employment and other employment schemes) ([2](#), [176](#), [315](#), [316](#));
- housing assistance (for example, rental assistance programmes) ([317](#), [318](#));
- cash transfer ([2](#), [319](#), [320](#));
- personal budget ([2](#), [321](#), [322](#)); and
- disability allowances and concessions, (for example, disability pensions, living allowances, tax exemptions, discounts) ([304](#), [323](#), [324](#)).

**Note on electroconvulsive therapy (ECT)**

- In countries where electroconvulsive therapy (ECT) is used, this intervention must only be administered with the written or documented, free and informed consent of the person concerned. ECT should only be administered in modified form: with anesthesia and muscle relaxants. Using ECT for children is not recommended and should be prohibited through legislation ([36](#)).

## Box 11. Topics for psychotropic drug prescribing and usage guidelines

This box is an excerpt from [Guidance on mental health policy and strategic action plans: module 2: key reform areas, directives, strategies, and actions for mental health policy and strategic action plans \(25\)](#) where it was numbered Box 12.

### Guidelines for prescribing psychotropic drugs should cover these topics

- Assessing indications and contraindications: how to evaluate individuals' need for psychotropic drugs, identifying contraindications, and assessing likely interactions before prescribing.
- Alternatives and combined interventions: consideration of alternatives to psychotropic drugs and their use in combination with other interventions, such as lifestyle changes, psychological support, social interventions, and economic assistance as part of a comprehensive recovery plan.
- Informed consent: ensuring free and informed consent before prescribing, with clear explanations of potential adverse effects, side effects, and possible complications discussed in advance.
- Avoiding polypharmacy: strategies to avoid using multiple interacting medications, and guidelines for reducing or discontinuing unnecessary psychotropic medications, while ensuring safe withdrawal management and preventing health complications.
- Monitoring and maintenance: how to monitor the effects of drugs, ensure safe maintenance, and provide follow-up for individuals taking psychotropic drugs, including access to adequate laboratory equipment for monitoring medication levels and organ functions, along with regular follow-ups and specialist reviews.
- Communication and coordinated care: ensuring effective communication and coordinated care between the individual's primary and specialist health care teams when psychotropic drugs are prescribed or adjusted.
- Supported decision-making: providing supported decision-making processes for individuals considering psychotropic drug use.

### Guidelines for safely tapering or discontinuing psychotropic drugs should cover these topics

- Routine discussions: providing regular opportunities for service users to discuss the possibility of discontinuing psychotropic drugs.
- Comprehensive information: offering detailed information to all service users about what to expect during the tapering and discontinuation process.
- Safe tapering and discontinuation practices: ensuring that tapering is done slowly over months rather than weeks to maximize safety and efficacy (325). Withdrawal symptoms from psychotropic drugs can be more severe than previously thought (326–328) and may be mistaken for relapse (329).
- Specialist support: guaranteeing access to specialist medical support (for example, psychiatrists or doctors with expertise in psychopharmacology) to facilitate safe withdrawal.
- Recovery plan review: revising each person's recovery plan to anticipate the need for additional support, adjustments to crisis plans, or more intensive support during withdrawal.
- Follow-up care: providing access to follow-up and ongoing review after individuals discontinue using psychotropic drugs.

#### 4. Address social and structural determinants of mental health from within services.

Social and structural determinants significantly influence health outcomes (16). Important determinants include sex- or gender-based inequalities, low income, poor education, insecure housing, and discrimination, amongst others. To improve health and mental health outcomes and reduce inequities, health services must integrate appropriate responses into their assessments, interventions, and supports. This involves creating comprehensive service-level policies and protocols that address the root causes of mental health challenges, and improve long-term health, social, and economic outcomes. For example, service protocols might refer users to services such as women's support groups, legal aid, income generation opportunities, housing, education, disability benefits, community engagement opportunities, and other social protection measures. Since health services rarely provide these directly, collaboration between the health and other sectors is essential. For more detail see Module 2 of [Guidance on mental health policy and strategic action plans \(25\)](#).

##### Example indicator

**Name** Health and mental health services screen for social and structural determinants of mental health, and have protocols for providing and referring to appropriate interventions.

**Definition** Percentage of health and mental health services that have implemented formal screening processes for social and structural determinants of health (such as poor housing, low income levels, low levels of education, legal needs) and maintain active referral pathways to appropriate support services.

**Data source(s)** Service protocol documents; social service referral logs; service integration and implementation reports; link worker reports.

#### 5. Enhance social connection and prevent isolation.

Many people with physical and mental health conditions are at high risk of experiencing social isolation and loneliness, which can contribute to poor health outcomes (330-332). Studies show that socially isolated or lonely people are less healthy, have longer hospital stays, higher readmission rates, and are more likely to die earlier than those with supportive social connections (333). Health services can help protect and restore mental health through measures to improve social connection and community inclusion. It is important to support socially-isolated people but also people who feel lonely despite being socially engaged, because social isolation and loneliness are not necessarily connected.

Measures that help people with physical and mental health conditions participate in the community are crucial. They can include close links and referral networks between health services and volunteering, cultural and sports opportunities, clubs, special interest groups, and various face-to-face and online support groups and peer support schemes (334). Community volunteers and multi-disciplinary mobile teams, including general and mental health professionals, peer support workers, and social workers, can provide home support to people with limited mobility.

Responding to social isolation (as with other social and structural determinants) is a systemic challenge that cuts across government sectors and requires a unified response. The response should be facilitated, rather than led, by mental health services. For more detail see Policy Directive 2.3 in Module 2 of [Guidance on mental health policies and strategic action plans \(25\)](#).

**Example indicator**

**Name** Health services facilitate social connection interventions.

**Definition** Percentage of health facilities that have implemented or have established referral pathways to at least one structured social connection intervention, such as peer support groups, community activities, or mobile in-home support teams.

**Data source(s)** Service delivery records; peer support group attendance logs; community referral databases.

## Policy directive H3 Introduce and focus on mental health training for the general health service workforce

### Strategic actions

#### 1. Collaborate with the education sector to integrate high-quality mental health training into curricula for the health workforce.

Everyone working in health needs to understand the basics of mental health. This includes:

(i) core mental healthcare workers, including psychiatrists; nurses; medical doctors; psychologists; peer supporters and workers; social workers; community health workers; occupational therapists; counsellors; clinical staff; community volunteers; and

(ii) other health professionals, including ambulance officers, nutritionists, physiotherapists, and dentists; neurologists; pharmacists; employment and education specialists; physical activity trainers and sports coaches; art and music therapists; speech therapists; legal advisers; traditional and faith-based leaders or healers.

While not all these professionals specialize in mental health, they frequently interact with people experiencing emotional distress, mental health conditions and psychosocial disabilities. They should have the skills to recognize common signs of mental health concerns, provide basic support, and refer individuals to appropriate services and supports in the community. It is essential for Ministries of Health to work with the education sector, and universities, colleges, and other training institutions to embed comprehensive mental health education into health profession curricula.

Curricula should cover the social and structural determinants of mental health; public mental health approaches including prevention (for example suicide prevention), promotion and early intervention; as well how emotional distress, mental health conditions and psychosocial disabilities may present. Health professionals should know about evidence and rights-based physical health and lifestyle, psychological, social, and economic interventions so they can respond effectively to people experiencing emotional distress as well as to those with mental health conditions or psychosocial disabilities. For more information on interventions see Box 10 and also Module 2 of [Guidance on mental health policy and strategic action plans \(25\)](#).

It is also crucial that health professionals can impart evidence-based knowledge of drug treatment, including safe prescribing, and de-prescribing, covering adverse effects of psychotropic drug use and managing withdrawal associated with discontinuing drug use. For professionals specializing in paediatric care and care for older adults, education and training should specifically address the mental health needs of these age groups.

All health professionals should receive training on the national mental health system, available services and referral pathways so they can help coordinate effective service use. Training should follow a person-centred, rights-based, and recovery-oriented approach, aligned with international human rights standards, including the CRPD. For more detailed information on education and training for the health workforce, see Module 2 of [Guidance on mental health policy and strategic action plans \(25\)](#).

**Example indicator**

**Name** Mental health content is integrated into health workforce curricula.

**Definition** Percentage of accredited health training institutions that have incorporated comprehensive mental health content into their core curricula, including content on social and structural determinants of mental health, rights-based approaches to care, and psychosocial interventions.

**Data source(s)** Accreditation body curriculum review reports; training institution programme documentation; Ministry of Health and Education joint initiative records.

**2. Employ mental health staff and/or facilitate task-sharing in general and specialized health services.**

General and specialized health services often encounter people facing personal crises or emotional distress related to their health, including chronic pain, treatment side effects, loss, grief, or other hardships. It is essential that these services provide adequate mental health and psychosocial support, especially in settings such as palliative care, care for older adults, oncology, HIV/AIDS care, child and maternal care, and alcohol and other psychoactive substance use treatment.

General and specialized health services should consider employing mental health professionals, including psychologists, psychiatrists, psychiatric nurses, community mental health workers, peer support workers, and social workers. If mental health resources are limited, task-sharing among existing general health staff trained in mental health and psychosocial support can be an effective alternative.

The approach should follow rights-based, recovery-oriented, and person-centred principles and ensure the quality of care is maintained. For more discussion of task-sharing, see Policy Directive 3.1 in Module 2 of [Guidance on mental health policy and strategic action plans \(25\)](#).

**Example indicator**

**Name** Facilities employ mental health staff or have task-sharing protocols.

**Definition** Percentage of general health service facilities with professional mental health staff or that have formal task-sharing protocols for mental health care.

**Data source(s)** Service staffing records; task-sharing protocol documents; Ministry of Health service delivery reports.

### 3. Provide ongoing training, support, and supervision to general health services' staff.

All staff in general health services should receive training to develop a basic understanding of mental health and psychosocial support needs. (See also Strategic action 1 on collaborations for curricula development.)

Training should address the need to change discriminatory attitudes and mindsets, and this should be emphasized continuously and seamlessly throughout ongoing training and supervision. One-off sessions are not sufficient. Ongoing training is essential to overcome reluctance to provide treatment, care, and support to people with mental health conditions or psychosocial disabilities, and to help staff learn effective ways to interact, communicate, and support these individuals.

Furthermore, those actively and regularly providing mental health and psychosocial services should receive regular, ongoing training, supervision, and support from experienced supervisors with clinical mental health expertise. Training should reinforce clinical skills and human rights practice as well as addressing stigma and discrimination and unconscious biases. It should also address challenges specific to mental health support in general health settings. Supervision should offer a safe supportive space for exploring clinical and human rights dilemmas encountered in practice. Additionally, supervision models should be flexible and responsive to feedback from both staff and service users. For more detail on ongoing training and supervision in services see Policy Directive 3.1. in Module 2 of [Guidance on mental health policy and strategic action plans \(25\)](#).

#### Example indicator

**Name** General nursing staff of health services receiving ongoing mental health related training, support, and supervision.

**Definition** Percentage of nursing staff in general health services who have received regular mental health-related training, support sessions, and clinical supervision.

**Data source(s)** Ministry of Health training programme records; service training and supervision logs; staff development and professional support databases.

#### 4. Train and collaborate with people in the community to improve their understanding of mental health and human rights, so they can better-support people in distress.

Collaborating with and training families, schools, traditional and faith-based leaders and healers, organizations of people with disabilities, other NGOs and police personnel can support people in distress and improve health and social outcomes. They can be trained to identify people at risk, support people in distress or crisis, connect people to services, and help prevent suicides. Training trusted community members enhances understanding, protects rights, and dispels myths. Since stigma and resource gaps can lead to harmful practices (such as seclusion or restraint), respectful dialogue should be established to promote culturally appropriate alternatives.

##### **Example indicator**

**Name** Trusted people in the community are trained in mental health awareness and rights-based support.

**Definition** Number of people from key community groups, including families, traditional and faith-based leaders, healers, schools, and local organizations, who have completed certified training programmes on mental health and on human rights-based approaches to supporting people in distress.

**Data source(s)** Training attendance registers; certification records; training programme database; civil society organizations documentation.

Box 12 offers further resources for addressing mental health from within the wider health sector.

#### **Box 12. Resources for addressing mental health from within the wider health sector**

- Comprehensive mental health action plan 2013–2030. <https://iris.who.int/handle/10665/345301> (34)
- Doing what matters in times of stress: an illustrated guide. <https://iris.who.int/handle/10665/331901> (335)
- Educating medical and nursing students to provide mental health, neurological and substance use care: a practical guide for pre-service education. <https://iris.who.int/handle/10665/380914> (336)
- From loneliness to social connection: charting a path to healthier societies: report of the WHO Commission on Social Connection. <https://iris.who.int/handle/10665/381746>.
- Guidance on community mental health services: promoting person-centred and rights-based approaches. <https://apps.who.int/iris/handle/10665/341648> (176)
- Guidance on mental health policy and strategic action plans. Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans. <https://iris.who.int/handle/10665/380466> (25)
- IASC Handbook, mental health and psychosocial support coordination. <https://reliefweb.int/report/world/iasc-handbook-mental-health-and-psychosocial-support-coordination> (337)
- Integration of mental health and HIV interventions: key considerations. <https://iris.who.int/handle/10665/353571> (338)

- Integrating mental health into primary care: a global perspective. <https://iris.who.int/handle/10665/43935> (239)
- Mental health and psychosocial support: minimum service package. <https://www.mhpssmsp.org/en/downloads> (339)
- mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) forthcoming 2025. (340)
- mhGAP training manuals for the Intervention Guide forthcoming 2025. (341)
- mhGAP e-training on integrating mental health into primary care, WHO Academy <https://whoacademy.org/> (342)
- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)
- Preventing suicide: a resource for primary health care workers. <https://iris.who.int/handle/10665/67603> (343)
- Problem Management Plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity, WHO generic field-trial version 1.1. <https://iris.who.int/handle/10665/375604> (292)
- Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. <https://iris.who.int/handle/10665/376208> (284)
- The alcohol, smoking and substance involvement screening test (ASSIST): manual for use in primary care. <https://iris.who.int/handle/10665/44320> (344)
- WHO global report on health equity for persons with disabilities. <https://iris.who.int/handle/10665/364834> (304)
- WHO operational handbook on tuberculosis: module 6: tuberculosis and comorbidities: mental health conditions. <https://iris.who.int/handle/10665/373829> (345)
- World mental health report: transforming mental health for all. <https://iris.who.int/handle/10665/356119> (2)
- WHO QualityRights e-training on mental health. <https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training> (152)
- WHO QualityRights materials for training, guidance and transformation. QualityRights face-to-face training. <https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools> (151)

# Mental health and the **interior** sector



## Overview

The interior sector, responsible for internal affairs, policing, emergencies, and public security, has a significant impact on the mental health of the population. This sector responds to a wide range of emergencies, whether caused by natural hazards such as floods, earthquakes, or health emergencies, or human actions such as mass shootings, terrorist attacks, and people's individual crises. All of these emergencies can profoundly affect mental health and well-being. As a key partner alongside health, protection, and other sectors, as well as humanitarian agencies, the interior sector plays a vital role in integrating mental health and psychosocial support into preparedness, coordination, and response efforts, ensuring frontline responders are equipped to act appropriately. Because of the sector's role, police and emergency responders are often the first to assist when someone is experiencing a mental health crisis. However, these situations are not always resolved smoothly. Many result in involuntary treatment, violence, abuse, and even fatalities (346), underscoring an urgent need for change.

Within its wide-ranging roles, the interior sector plays a vital part in supporting refugees, asylum seekers, and migrants. It often leads multisectoral responses to large influxes, arrivals at sea, and addresses the needs of people in particularly vulnerable situations, such as unaccompanied and separated children, victims of trafficking, or those with irregular status. The interior sector also engages with migrants for more routine administrative and registration processes.

Many migrants enjoy decent living conditions, fair working environments, and access to rights. However, as global numbers of migrants continue to rise, certain groups, such as those in precarious, low-skilled, irregular, or semi-regular employment, face heightened risks of exploitation, discrimination, and limited access to services. Many face language barriers, social isolation, and poor living conditions. All these factors can severely impact mental health, increasing the likelihood of emotional distress and mental health conditions (347, 348). Investing in mental health initiatives for migrants, refugees, and asylum seekers is therefore essential for effective migration governance and for reducing inequalities, as required for SDG 10 (15). Indeed, across its many roles, the interior sector's efforts are crucial in promoting peace, fostering sustainable development, and building effective, accountable, and inclusive institutions, as outlined in SDG 16 (15).

The Guidance highlights the critical links between mental health and the interior sector, recognizing that many core activities of the sector already contribute to protecting and promoting mental health. Additionally, it proposes a menu of policy directives and strategic actions that can be integrated into sectoral policies, supporting both improved mental health outcomes and the interior sector's broader objectives. The numbering uses the prefix Int (interior) to help avoid confusion when discussing policy directives for specific sectors or from other guidance. This menu includes strategic actions emphasizing new roles and enhanced training for law enforcement and emergency responders to manage mental health crises safely; strategic actions to improve the mental health and well-being of migrants, refugees and asylum seekers; and actions to strengthen psychological preparedness for emergencies, offer psychosocial support, and provide specialized care and training for frontline workers. Key measures to support other groups that face discrimination are also included.

It is important to note that the roles and responsibilities of sectors might vary from country to country and that therefore, some areas covered here in this Guidance might sometimes fall under the responsibility of a different sector. For example, in some countries, internal affairs, policing, emergencies, and public security might fall under the responsibility of the justice sector or are the shared responsibility of the justice and interior sectors. Conversely, topics relevant to the interior sector are likely to be included under different sectors within this

Guidance. To support navigation and help the reader find all relevant information, Fig. 1 in the Introduction to this Guidance offers a [directory of key issues](#), indicating where each is discussed.

The Guidance includes adaptable examples of indicators for the strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators enable sectors to track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## **Policy directive Int1 Reform the roles of law enforcement and emergency responders who intervene in mental health crises**

### **Strategic actions**

#### **1. Expand options for responding to mental health crises beyond policing, for via example 24/7 crisis lines, peer navigator programmes and multidisciplinary mobile crisis teams.**

Police officers are often first responders to a wide range of social issues, including mental health crises, substance use, and homelessness or housing insecurity. While many officers are trained in de-escalation, they may not have the specialized skills needed to handle mental health emergencies safely and effectively. In some cases, the mere presence of police can escalate the situation, particularly in communities where there is a history of mistrust and tension, such as in some ethnic minority communities and others at risk of discrimination (349). This can lead to disproportionately high rates of arrests, incarcerations, and tragically even deaths among people with mental health conditions or psychosocial disabilities (346, 350).

To address these challenges, it is crucial to expand mental health crisis response options beyond police intervention. Developing such alternatives requires collaboration among stakeholders, including law enforcement, emergency responders, health and social service providers, peer support networks, and community advocates. Additionally, sufficient funding is necessary to create and sustain programmes, which should be tailored to the needs and resources of each community (351).

Several innovative models have been developed. Each helps communities address mental health crises more effectively. They prioritize the mental health and safety of people in crisis, complying with a person-centred, rights-based approach. They reduce the risk of harm, and ensure that people in need receive proper care and support, avoiding inadvertent channeling into the criminal justice system.

- **Police-based co-response teams.** In this model, mental health professionals or peer supporters accompany police officers responding to a mental health crisis. This allows for immediate appropriate support and de-escalation, while still ensuring safety ([351](#), [352](#)).
- **Multidisciplinary mobile crisis teams (MCTs).** These teams, composed of mental health professionals, healthcare providers, and peer supporters, can be directly dispatched to respond to mental health emergencies instead of the police. MCTs offer on-site support, de-escalate the situation, and connect individuals to ongoing mental health services and support within the community ([351](#), [352](#)).
- **Crisis call diversion programmes.** These programmes reroute calls related to mental health crises away from police and emergency services to trained mental health professionals. The professionals provide support over the phone and, if necessary, dispatch a mobile crisis team to the scene ([353](#)).
- **Around the clock free-of-cost crisis telephone lines.** These phone lines, often referred to as warmlines, are staffed by trained mental health professionals and peer supporters who can provide immediate counselling and support over the phone. They offer people facing crisis an alternative to calling the police and can coordinate further remote and on-site support where required ([354](#), [355](#)).
- **Peer navigator programmes.** These programmes connect people with peer navigators who help them access support services. By providing ongoing assistance, these programmes aim to prevent crises and reduce the likelihood of encounters with police ([356](#)).

⋮ **Example indicator**

⋮ **Name** People in mental health crisis access a non-police response.

⋮ **Definition** Number of individuals who have received at least one non-police mental health crisis response, such as a 24/7 crisis hotline, peer navigator programme, or a multidisciplinary mobile crisis team response.

⋮ **Data source(s)** Crisis hotline call logs; peer navigator programme records; mobile crisis team dispatch and service delivery reports.

## 2. Comprehensively train emergency responders on managing mental health crises.

It is essential that all police officers, fire department officers, and other emergency responders who are involved in crisis situations receive comprehensive mental health training. These professionals are often the first to arrive when someone is experiencing a mental health crisis or severe emotional distress. Without proper training, emergency responders may feel overwhelmed and resort to using force, coercion, or involuntary admission to psychiatric care – responses that can exacerbate the person’s mental health crisis. Responders need specialized training to effectively recognize and respond to these situations in a way that de-escalates tension and ensures the person feels safe and supported. Mandatory training should cover the following key areas:

- **Human rights and stigma.** It is crucial that training covers human rights in the context of mental health and responding to people in crisis. Training should address the stigma and discrimination often associated with mental health conditions. This includes challenging common stereotypes, such as the misconception that people with mental health conditions are unreliable, cannot make decisions for themselves, are violent or dangerous, or that they need treatment and should be sent to mental health services. Training should cover the broader consequences of stigma and discrimination, including responders’ common failure to take seriously reports of violence or abuse made by people with mental health conditions, whether in mental health facilities, domestic settings, or elsewhere. Too often, such concerns are ignored, dismissed, or misrepresented. Useful tools are the WHO QualityRights e-training on mental health, recovery and community inclusion ([152](#)) and the QualityRights face-to-face training tools ([151](#)).
- **Understanding mental health crises.** Training should include education on how mental health crises can present, helping responders to identify and understand their signs.
- **De-escalation techniques.** Responders should be trained in communication skills and non-coercive methods to defuse tense situations, reducing the likelihood of harm and the need for force.

Training should be co-developed and co-delivered with people who have lived experience of mental health conditions or psychosocial disabilities. This ensures that the training is grounded in real-world experiences and fosters empathy and understanding among emergency responders.

By mandating and regularly refreshing this training, the interior sector can equip emergency responders with the tools they need to handle mental health crises more effectively and humanely. This approach improves outcomes for individuals in crisis and also contributes to a broader culture of respect and understanding for mental health within emergency services.

### Example indicator

**Name** Emergency responders complete comprehensive mental-health crisis training.

**Definition** Percentage of emergency response personnel who have completed certified training on managing mental-health crises, including identification, de-escalation, and referral protocols.

**Data source(s)** Training attendance registers; certification records; emergency services personnel databases.

### 3. Create independent mechanisms for reporting abuse during mental health crisis responses.

Encounters between emergency responders and people in mental health crises or severe emotional distress can sometimes lead to harmful practices, including violence, coercion, restraint, or involuntary hospitalization (351). These practices can severely harm mental health, hinder recovery and foster distrust and fear towards emergency responders. As part of a culture change, it is crucial to define and implement independent mechanisms that allow people to report violence, harassment, abuse, or coercion. Mechanisms should ensure safety and anonymity, making it easy for people to come forward without fear of retaliation. The process should be free from complicated bureaucratic procedures and accessible, including offering suitable formats for people with disabilities.

Equally important, these mechanisms should include clear procedures for investigating and resolving complaints in a timely and transparent manner, with accountability measures in place to prevent future violations.

Information about reporting mechanisms should be widely disseminated to ensure that everyone is aware of their availability. For more detailed information on reporting mechanisms refer to [Mental health and the justice sector](#) in this Guidance.

#### **Example indicator**

**Name** Independent reporting mechanisms record abuse in crisis response services.

**Definition** Number of crisis response services that have established and activated an independent mechanism for people to report abuse during crisis interventions.

**Data source(s)** Crisis service protocol and policy documents; agency implementation and compliance reports; independent oversight body or complaint registry records.

## Policy directive Int2 Promote mental health and well-being among police forces, fire services and other first responders

### Strategic actions

#### 1. Implement mental health promotion interventions among first responder workforces.

It is crucial to implement regular mental health promotion measures for police officers, fire service personnel, and other first responders who face elevated occupational risks due to frequent exposure to high-stress and critical incidents. Interventions to support their well-being can be provided at the workplace. These could include ways to address stress, promote self-care, encourage a healthy lifestyle, and build personal resilience. For example, activities like yoga, walking, and strength training, along with psychoeducation, mindfulness-based approaches, cognitive-behavioral techniques, and peer support, can reduce stress and rates of depression and anxiety (2, 111, 186). In providing these interventions, it is important to recognize the unique pressures first responders face. For more discussion on workplace interventions for mental health and well-being, see Mental health and the employment sector in this Guidance.

##### Example indicator

**Name** First responders have access to mental health promotion and interventions.

**Definition** Percentage of first responder personnel who have participated in at least one mental health promotion programme.

**Data source(s)** Training attendance logs; programme participation records; first responder health promotion databases; programme evaluation reports.

#### 2. Enhance access to quality mental health and psychosocial support for first responders.

Improving access to high-quality, rights-based mental health and psychosocial support is essential for police officers, fire service personnel, and other first responders, given their ongoing exposure to challenging and emotionally demanding situations. Employee Assistance Programmes (EAPs) are an effective way to connect first responders with person-centred, rights-based services, whether in their community or online (190). Support should include a range of lifestyle, social and psychological interventions in individual or group settings such as peer support, psychoeducation and cognitive behavioral therapy, amongst others. First responders may themselves need crisis support services during times of acute stress. All support should be personalized to meet the specific needs of each worker, ensuring they receive the appropriate help at the right time. For more discussion, refer to Mental health and the employment sector in this Guidance.

##### Example indicator

**Name** First responders' access to mental health support

**Definition** Percentage of first responders who have been identified as needing mental health support and who have accessed at least one accredited mental health or psychosocial service.

**Data source(s)** Support service utilization logs; EAP programme records; employee health and well-being records.

## Policy directive Int3 Protect and promote the mental health of migrants, refugees and asylum seekers

### Strategic actions

#### **1. Provide migrants, refugees and asylum seekers with affordable and non-discriminatory access to mental health services and support.**

Affordable and non-discriminatory access to mental health services and supports (particularly to state-funded mental health and psychosocial services) should be guaranteed at every stage of asylum seeking and migration, irrespective of people's status. In collaboration with mental health and other relevant sectors, the interior sector should map all available services and supports that can help meet these people's needs, support their inclusion, and promote their mental health and well-being.

Active outreach efforts should be strengthened. Information about services should be provided in accessible formats and multiple languages that reach migrant, refugee and asylum seeker populations, who may be unaware of their entitlements or reluctant to seek support due to stigma ([357-360](#)).

Service providers should receive appropriate training and resources to understand the rights and entitlements of migrants, refugees, and asylum seekers, and to work effectively with people from diverse cultural, linguistic, and social backgrounds. Improving access to interpreters and offering services in different languages is crucial to reducing communication barriers. This makes mental health and psychosocial support more accessible and helps to lower the risk of involuntary admission to psychiatric hospitals and other coercive measures ([361](#)).

Policies can guarantee easily accessible, state-funded interpretation services across all mental health and psychosocial support settings, including outpatient psychotherapy, crisis services, hospital-based care, and community-based supports.

It is important to provide choice and flexibility in how care is provided including care location, service providers, referral pathways, and treatment approaches. Flexibility should also incorporate culturally appropriate communication, ensure voluntary participation, and respect people's right to decline certain aspects of mental health services, such as unwanted interventions or diagnostic labelling. This approach improves access and acceptability, supports autonomy, and helps ensure that services are person-centred and are optimized outcomes ([360](#)).

Groups at particular risk of discrimination within the migrant, refugee, and asylum seeker population need special consideration. These groups include women, children and adolescents, older adults, people belonging to the LGBTIQ+ community, survivors of gender-based violence, people with mental health conditions, and people with disabilities (including psychosocial disabilities) ([359](#)). These groups often face additional barriers to accessing mental health and psychosocial support. Policy measures should address their specific needs and ensure equitable access to services.

**Example indicator**

**Name** Refugees, asylum seekers and migrants have access to affordable and non-discriminatory mental health and support services.

**Definition** Percentage of refugees, asylum seekers, and migrants who have been identified as needing mental health support and who have accessed at least one mental health or psychosocial support service.

**Data source(s)** Service provider client registries; refugee and migrant health programme logs; NGO mental health support records.

## **2. Build workers' capacity to provide health and mental health interventions to migrants, refugees and asylum seekers.**

Social workers, migration officers, educators, peer workers and others who support migrants, refugees and asylum seekers often feel unequipped to address the specific mental health and psychosocial needs of the people they support. These populations frequently experience psychological distress linked to past and ongoing exposure to violence, persecution, torture, racism, and other intersecting forms of discrimination. Some are particularly vulnerable, such as victims of trafficking and unaccompanied children.

Supporters may also lack training in recognizing cultural expressions of distress, addressing racism and minority-related stress, and avoiding clinical biases linked to Western-centric approaches ([359](#)).

It is essential that all health and mental health staff working with these populations receive specialized rights-based training on these topics, as well as ongoing supervision and support.

Furthermore, all professions working closely with migrants, refugees, and asylum seekers need training in holistic, person-centred approaches to mental health that encompass active listening, open communication, respect for diversity, cross-cultural understanding, and the most prevalent mental health needs. Such training will better equip them to assess and support people, and refer them to mental health services when required.

In addition, peer support networks and community-based support mechanisms involving people from these groups should be established or strengthened to provide culturally relevant care. This includes recognition and support for civil society organizations led by migrants, refugees, and asylum seekers, which play a vital role in delivering social, financial, translation, and psychosocial support within their communities.

**Example indicator**

**Name** Capacity building on mental health for professionals supporting migrants, refugees and asylum seekers.

**Definition** Number of health, mental health, and related professionals who have completed at least one tailored training intervention on mental health needs and psychosocial support for migrants, refugees, and asylum seekers.

**Data source(s)** Training attendance registers; capacity-building programme reports; professional development logs.

### **3. Enhance social integration and participation of migrants, refugees and asylum seekers in the host country, and reduce anti-migrant sentiment and discrimination.**

Experiencing social exclusion and lack of social integration in the host country exacerbates emotional distress among migrants, refugees, and asylum seekers, often leading to feelings of hopelessness, anxiety, anger, or sadness, as well as social and behavioural difficulties such as sleeping problems and social withdrawal ([347](#), [359](#)).

Social integration involves developing a sense of belonging to the host society and a sense that the society accepts and includes you as part of their community ([362](#)). It is a complex and multi-dimensional process influenced by factors such as access to employment, participation in social activities, overcoming language barriers, addressing discrimination, and promoting active citizenship ([362](#)). Collaboration between sectors is crucial to enhance integration. For instance, offering educational opportunities, vocational training, and employment support, along with intercultural events and mentorship that foster social connections can greatly improve social integration and contribute to overall well-being. In addition, engaging with the media and social media platforms to promote responsible reporting and counter misinformation and stereotyping can reduce discrimination and violence.

#### **Example indicator**

**Name** Migrants, refugees, and asylum seekers participate in social integration initiatives.

**Definition** Number of asylum seekers, refugees, or migrants who have participated in at least one officially recognized social integration activity, such as language courses, community volunteering, cultural orientation session. Number of anti-discrimination workshops organized for host communities.

**Data source(s)** Integration programme attendance registers; municipal community event logs; NGO participation databases.

### **4. Advocate for and protect migrant workers' rights through cross-sector collaboration.**

Many migrant workers, particularly those in precarious, low-skilled, irregular, or semi-regular employment, face discrimination, abuse, and violations of their human and labour rights in host countries. Common violations include unfair recruitment practices, unsafe work environments, unequal access to employment rights, remuneration, social security, and legal remedies, workplace discrimination, and limited access to health, mental health, social, legal, and other essential services and supports. In some cases, migrant workers are trafficked into forced labour ([363](#)).

Additionally, they may be forced to live in poor, unsafe, and overcrowded conditions. The interior sector can advocate for stronger legal protections, fair treatment, and for including migrant workers' rights in national policies and frameworks. The sector can also coordinate with employment, justice, health, and social protection to develop and implement measures such as: strengthened labour inspections to ensure safe working conditions and standards; and accessible complaint and reporting mechanisms and legal support. Facilitating access to, health, mental health, psychosocial, and social supports is also crucial, and may require action to remove specific barriers. All these actions help safeguard the well-being and dignity of migrant workers. Given the potential for harm to mental health, detaining migrant workers who don't appear to have their paperwork in order should be avoided wherever possible. Alternatives should be actively prioritized. When detention occurs, access to psychosocial support must be ensured.

**Example indicator**

**Name** Migrant workers access cross-sector services that protect their rights.

**Definition** Number of migrant workers who have received at least one support service delivered through cross-sector collaborative measures that protect rights. Services might include legal aid, labour dispute resolution, or social protection enrolment.

**Data source(s)** Ministry of Labour and Social Protection programme records; inter-ministerial collaboration logs; NGO service delivery databases.

## 5. Improve living conditions for asylum seekers and refugees.

Asylum seekers and refugees often endure poor living conditions in refugee camps, settlements, or other inadequate accommodation during transit or in their final host country (364). These may be characterized by overcrowding, unsanitary environments, limited privacy, restricted autonomy, and isolation from the local community (365). Such living situations have detrimental effects on mental health, leading to increased emotional distress, anxiety, and decreased overall life satisfaction (365). Separating children from their parents during migration processes is another major stressor and is consistently associated with harm to children's mental health, well-being, and development (366). In collaboration with other sectors and stakeholders, the interior sector should implement measures to improve refugee and asylum seekers' living conditions and to protect their well-being and mental health. Measures might encompass minimum standards for space, sanitation, safety and privacy in publicly provided accommodation. In addition, policies can promote family unity throughout the asylum process, ensure access to community-based housing options where possible, and create opportunities for social participation and integration with host communities. Providing access to mental health and psychosocial support services within living facilities, as well as facilitating safe spaces for recreation and cultural or religious practices, can further support mental health and promote dignity and resilience.

**Example indicator**

**Name** Asylum seekers and refugees receive adequate living conditions.

**Definition** Percentage of asylum seekers and refugees provided with accommodation that meet defined minimum standards for living conditions, including space, sanitation, safety, and privacy.

**Data source(s)** Shelter and housing programme registries; accommodation inspection and compliance reports; beneficiary intake and assessment records; NGO documentation.

## Policy directive Int4 Take a multi-sectoral approach to mental health and psychosocial support in humanitarian crises and disasters

### Strategic actions

#### 1. Integrate mental health and psychosocial support into emergency preparedness and response planning.

The interior sector can ensure that mental health and psychosocial support (MHPSS) is integrated across the preparedness, prevention, response, and recovery phases of emergency management, alongside basic services (233–367). This requires working in close collaboration with other key sectors such as health, protection, social services, disaster risk management, and with humanitarian agencies. Representatives from the interior sector should actively participate in MHPSS coordination mechanisms to support a unified, cross-sectoral response that reduces mental health harm, fosters resilience, and promotes recovery.

Identifying at-risk groups can help incorporate mental health and well-being risks into emergency risk assessments. These groups may include people with mental health conditions or psychosocial disabilities who face disrupted care or discrimination; displaced people exposed to distressing or crisis events and instability; first responders experiencing chronic stress; and people in institutions who face isolation and lack of support.

The interior sector can contribute to contingency planning to deploy mobile psychosocial teams or other outreach support services; ensure safe delivery of treatment and care; and maintain continuity of mental health support through systems such as registries (to track individuals receiving care), tele-support, and referral pathways (339).

It can also support training for first responders in basic psychosocial support, ensuring these skills are integrated into emergency procedures and simulation exercises. The interior sector can promote emergency protocols that uphold the rights of people with mental health conditions or psychosocial disabilities, including by ensuring trained mental health professionals are available in shelters, reception centres, and detention settings.

In addition, the interior sector can lead or support public communication efforts that promote coping strategies and provide information about services in accessible formats and multiple languages. Finally, it can help establish monitoring and evaluation systems to track MHPSS implementation, identify service gaps, and guide improvements for future preparedness and response efforts.

#### Example indicator

**Name** Mental health and psychosocial support integrated into emergency plans

**Definition** Percentage of national and subnational emergency preparedness and response plans that explicitly include mental health and psychosocial support protocols, including defined roles, interventions, and resource allocations.

**Data source(s)** Official emergency preparedness and response planning documents; Ministry of Health and Disaster Management Agency plan registries.

## 2. Strengthen community and individual mental health and psychosocial preparedness.

The interior sector can foster psychological resilience, mental health and psychosocial well-being for individuals and communities as an integral part of emergency preparedness initiatives. Initiatives should be undertaken collaboratively with local authorities, civil society organizations, community leaders, and sectors such as health, education, and communication ([233](#), [368](#), [369](#)), and might include:

- Facilitating locally driven psychosocial services and supports, such as peer support groups, safe spaces for children, and other interventions that strengthen community networks and collective coping capacities ([233](#), [339](#));
- Promoting public awareness and education initiatives to help people understand common psychological reactions to crises;
- Promoting stress management and self-care strategies, and providing clear guidance on when and how to seek support ([368](#), [369](#));
- Ensuring inclusivity, solidarity and collective resilience by coordinating efforts to make information on mental health and psychosocial support services culturally appropriate, accessible, and available in multiple languages and formats, particularly for people with disabilities, for minorities, and for other marginalized groups ([233](#));
- Supporting mapping of available community resources and support;
- Strengthening referral pathways by establishing clear, coordinated procedures that connect people to appropriate services across health, protection, and social support systems without delay or unnecessary complexity; and
- Promoting inclusive participation in preparedness planning by engaging with affected communities and groups to identify needs and shape local responses.

### ••• **Example indicator**

••• **Name** Community psychosocial preparedness activities implemented.

••• **Definition** Number of psychosocial preparedness initiatives initiated (for example, peer support groups, child-friendly safe spaces, or public awareness sessions).

••• **Data source(s)** Community engagement reports; civil society partner activity logs.

### **3. Build primary care workers' and first responders' capacity to deliver evidence-based mental health and psychosocial interventions.**

The interior sector plays a key role in supporting capacity building for mental health and psychosocial support, in close coordination with the health, protection, social and other sectors. Integrating mental health care with general health care is a crucial strategy to scale up the availability of mental health services in emergencies. It is essential that primary care providers, including non-specialized staff, receive capacity building and training on delivering evidence-based, culturally appropriate mental health and psychosocial support interventions (such as psychological first aid) and basic mental health care (233).

First contact workers (for example, police officers, fire department officers, ambulance officers, first responders, search and rescue teams, humanitarian assistance staff, and volunteers) play a crucial role in providing initial support (370). They also need capacity building and training in crisis intervention and mental health support. Such training will equip them to effectively support populations affected by emergencies, while also safeguarding their own mental health.

#### **Example indicator**

**Name** Primary care workers and first responders trained in evidence-based mental health and psychosocial interventions.

**Definition** Percentage of primary care workers and first responders (including health, social service, and community workers) who have completed certified training in evidence-based mental health and psychosocial support interventions (for example, psychological first aid, cognitive-behavioral techniques).

**Data source(s)** Training attendance logs; certification records; programme completion reports; Ministry of Health and Interior training programme records; staff development databases.

### **4. Strengthen specialized care and support for community members needing a more complex ongoing response.**

After a disaster or emergency, some people experience high emotional or psychological distress, and may require ongoing care. This care might include psychological, physical health and lifestyle, social and economic interventions, and access to safely prescribed psychotropic drugs (233). See also Module 2 of [Guidance on mental health policy and strategic action plans](#), Policy directives 4.2 and 4.3 (25).

It is important to focus on groups within the community that face discrimination, including children and youth, women, older adults, people with disabilities (including psychosocial disabilities), and individuals with mental health conditions. These groups are often disproportionately affected by disaster or emergency situations. The interior sector should coordinate with health, social protection and other relevant actors from the outset to facilitate timely referral and access to specialized services. These groups' elevated risks can arise from lost education, the death of parents or other caregivers, or disruption to social support networks and services. Specialized services can be delivered in various ways depending on the circumstances, and might include collaborating with mental health units in primary health care centres, community mental health centres, mobile teams, and NGOs.

**Example indicator**

**Name** Communities with specialized mental health care services.

**Definition** Number of communities that are receiving specialized and ongoing mental health and psychosocial support services (for example, multidisciplinary mobile teams, specialized clinics, or sustained outreach programmes).

**Data source(s)** Service mapping database; programme deployment records; outreach and service delivery logs.

## **5. Improve access to mental health services and support for frontline workers in disasters and emergencies.**

Frontline workers such as primary health care workers, volunteers, humanitarian workers, reporters, and search and rescue personnel are at heightened risk of distressing and potentially traumatic events during disasters and emergencies. They may also experience depression, anxiety, post-traumatic stress, or other mental health conditions that affect them long after the initial event ([371](#)).

Policies should include provisions that improve access to a wide range of high-quality, rights-based mental health services and support for these workers. This support can encompass individual and group psychotherapy, counselling, peer support networks, and specialized services such as trauma-focused therapy.

It is crucial that these services are both available and accessible, not only during the disaster or emergency but also in the aftermath, ensuring that continued and follow-up support is provided for those affected.

**Example indicator**

**Name** Access to mental health services and support among frontline responders identified as needing support.

**Definition** Percentage of frontline disaster and emergency responders who have been screened and identified as needing mental health or psychosocial support and who have then received at least one support service.

**Data source(s)** Screening assessment records; service usage logs; emergency response health records.

## 6. Continuity planning for routine mental health services and support during disasters and emergencies.

During disasters and emergencies, routine mental health services and support, such as hospital-based services, psychological interventions, peer support, or psychotropic drug supplies, are often disrupted or discontinued. This can occur due to the destruction of facilities, outbreaks of contagious physical illness, supply shortages, or other logistical disruptions.

Mechanisms to mitigate these disruptions should be included as part of preparedness planning. For example, investing in digital infrastructure can allow services to move online when face-to-face delivery is not possible.

Any evacuation, disaster response, and emergency preparedness plan must also prepare to support people living in facilities or institutions, ensuring that they are kept safe and that their support needs are adequately addressed.

This comprehensive planning is crucial to maintaining access to mental health services and support for the general population, even in times of crisis.

### **Example indicator**

**Name** Mental health service continuity during disasters.

**Definition** Number of mental health facilities that have activated formal service continuity mechanisms to maintain routine mental health service delivery without interruption during periods of declared disasters or emergencies.

**Data source(s)** Service continuity protocol documents; service delivery monitoring logs; emergency operations reports.

Box 13 offers further resources for addressing mental health from within the interior sector.

### Box 13. Resources for addressing mental health from within the interior sector

- From loneliness to social connection: charting a path to healthier societies: report of the WHO Commission on Social Connection. <https://iris.who.int/handle/10665/381746>
- IASC guidelines on mental health and psychosocial support in emergency settings, 2007. <https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007> (233)
- IASC Information note on disability and inclusion in MHPSS. <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-information-note-disability-and-inclusion-mhpss> (372)
- Refugee and migrant mental health. <https://www.who.int/news-room/fact-sheets/detail/mental-health-and-forced-displacement> (364)
- Mental health and psychosocial support for migrants at border crossing points/points of entry: A toolkit <https://migrantprotection.iom.int/en/resources/guideline/mental-health-and-psychosocial-support-migrants-crossing-pointsports-entry> (373)
- Mental Health and Psychosocial Support Minimum Service Package (MHPSS MSP). <https://www.mhpssmsp.org/en/all-activities> (367)
- Mental health in emergencies. <https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies> (374)
- Mental health of refugees and migrants: risk and protective factors and access to care. <https://iris.who.int/handle/10665/373279> (360)
- Mental health promotion and mental health care in refugees and migrants: technical guidance. <https://iris.who.int/handle/10665/342277> (375)
- mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP) forthcoming 2025. (340)
- mhGAP training manuals for the Intervention Guide forthcoming 2025. (341)
- mhGAP e-training on integrating mental health into primary care, WHO Academy. <https://whoacademy.org/> (342)
- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)
- WHO QualityRights e-training on mental health. <https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training> (152)
- WHO QualityRights materials for training, guidance and transformation. <https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools> (151)



# Mental health and the **justice** sector



## Overview

The justice sector, responsible for lawmaking, legal reform, the courts (judiciary), and the wider criminal justice system, has a direct and indirect impact on mental health for everyone: the general public, crime victims, witnesses, alleged offenders, convicted offenders etc.

Justice sector policy and legislation have influence at various levels. For instance, broad human rights-based legal and policy reforms for non-discrimination, access to justice, recognition of legal capacity, decriminalization of suicide, and provision of appropriate services and support can all promote mental health across the board as well as protect the rights of people with mental health conditions or psychosocial disabilities.

Additionally, mental health legislation that addresses critical issues, such as recognizing and supporting substitute decision-making, and eliminating coercive practices, is pivotal in aligning a country's mental health and social care systems with international human rights instruments, including the CRPD, and for reducing inequalities (SDG 10) and fostering just and peaceful societies (SDG 16) (15).

The criminal justice system has a significant impact on mental health and creates a significant social and economic burden for many countries. It also worsens mental health outcomes not just for the people detained, but also for their families and particularly their children.

In most countries, people with mental health conditions or psychosocial disabilities are disproportionately represented in custody facilities pre-trial, in jails (used for short term detentions often in local facilities), in prisons (used for longer term detention post-sentencing) and in juvenile detention facilities. For example, a recent study examining data from 43 countries found that the pooled prevalence of depression in prison populations was 12.8% and that of psychosis was 4.1% (376). Being detained is itself a significant risk factor for experiencing mental health crises and developing mental health conditions (350). Justice sector reforms that promote voluntary diversion programmes before trial as well as alternatives to custody and post-trial incarceration (such as attendance at education or support programmes for low-level offences) can help mitigate the overall mental health toll of the criminal justice system.

People who are in custody or incarcerated often lack access to high-quality mental health and psychosocial services that meet their needs and support their recovery. Most of these individuals will eventually return to the community, and if they are released with untreated or worsened mental health conditions, it not only undermines their well-being but also negatively impacts society as a whole. Through collaboration with the mental health sector, justice sector policies and actions can develop and implement interventions that provide treatment for detainees with existing mental health conditions and protect and promote mental health for both detainees and detention centre staff. This includes ensuring jails, prisons and other custodial facilities provide good-quality, rights-based mental health and psychosocial services.

In some countries, people with mental health conditions are detained indefinitely without a conviction or time-bound sentence in forensic psychiatric facilities. Poor physical conditions, limited social interaction, and lack of recreational activities further undermine mental well-being for both those incarcerated and the staff who work in these environments.

The justice sector also has responsibility for ensuring equal access to justice for people with mental health conditions or psychosocial disabilities who are victims of crime or witnesses in legal proceedings. In many jurisdictions, they face discrimination and procedural barriers that limit their ability to participate fully. For example, they may be excluded from testifying, considered unreliable, or denied necessary accommodations and support.

Justice sector responsibility extends to ensuring that people who experience violence or abuse in mental health settings have the same rights to recognition and support, and equal access to justice and legal recourse, as anyone else. All too often, complaints go uninvestigated, are dismissed solely on staff testimony, and are not formally recognized. This effectively denies people with mental health conditions access to redress, reparations, and the support services that are available to others.

Justice sector action is equally essential in meeting the specific needs of children and adolescents in contact with the system, whether as victims, witnesses, or alleged offenders. This includes ensuring procedures are understandable and appropriate for young people, prioritizing non-custodial sentences, and guaranteeing age-appropriate protections and support where detention cannot be avoided.

This Guidance highlights the critical links between mental health and the justice sector and proposes a menu of policy directives and strategic actions that can be integrated into sectoral policies, supporting both improved mental health outcomes and the sector's broader objectives. The numbering uses the prefix J (justice) to help avoid confusion when discussing policy directives for specific sectors or from other guidance. In particular, this Guidance suggests strategic actions that focus on implementing legal and policy reforms. These promote access to justice and human rights; establish mechanisms to monitor and address rights violations; protect the mental health of staff and people in prisons; ensure rights-based, high-quality mental health services throughout the justice process; and help people leaving custody, prisons, and forensic facilities reintegrate into the community.

It is important to note that sectors' roles and responsibilities vary from country to country and that some areas covered here in this Guidance might sometimes fall under the responsibility of a different sector. For example, in some countries prisons are the interior sector's responsibility, or are a shared responsibility. Conversely, topics some countries consider to fall within the justice sector may be discussed elsewhere in this Guidance. To support navigation and help the reader find all relevant information, Fig. 1 in the Introduction to this Guidance offers a [directory of key issues](#), indicating where each is discussed.

This Guidance includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators let sectors track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## **Policy directive J1 Implement comprehensive legal and policy reforms to promote access to justice and protect human rights**

### **Strategic actions**

#### **1. Reform law to enhance access to justice for people with mental health conditions and disabilities, including participation in court proceedings and procedural and other accommodations.**

In many jurisdictions, discriminatory legal provisions and a lack of procedural accommodations restricts access to justice for people with mental health conditions or psychosocial disabilities, whether they are victims, witnesses, alleged offenders, or convicted offenders.

Reforms are needed to ensure that people with mental health conditions or disabilities can participate effectively and equally in legal proceedings. This includes revising laws and policies to provide free and accessible legal aid services, and to require individualized procedural accommodations. Reforms should enshrine the right to necessary and appropriate modifications and adjustments that let people with disabilities (including psychosocial or developmental disabilities) access justice on an equal basis with others. This is important, because these groups are often disproportionately in contact with the criminal justice system. Legislation could require: access to information and communication in accessible formats perhaps including sign-language interpretation or augmentative communication devices; additional time for comprehension and breaks during testimony; assistance from supporters (staff or personal support people); alternative testimony formats such as video links or private rooms; courtroom environments that accommodate sensory difficulties; and flexible scheduling that accommodates treatment needs.

Legal reforms are essential to ensure age-appropriate accommodations for children and adolescents in contact with the justice system, including victims or witnesses of gender-based violence or child abuse. These may include protective measures such as separate entrances and waiting areas, protective screens, video or pre-recorded testimony, same-sex staff and staff trained in trauma-informed approaches. Legal frameworks should also minimize repeated testimony, the number of interviews, and repeat hearings. This reduces the risk of revictimization and retraumatization, particularly for children and adolescents. Legal standards should also guarantee that children and adolescents who are detained have age-appropriate accommodations, including separation from adults, uninterrupted access to education, child-appropriate judicial processes, and robust safeguarding measures.

Legal frameworks should also revise designations such as Unfit to stand trial, Not guilty by reason of insanity, or Incapacity for criminal responsibility. Without sufficient safeguards, these classifications can result in people with mental health conditions or psychosocial disabilities being denied the opportunity to defend themselves. In some contexts, where no sentence has been issued, this can lead to indefinite incarceration in forensic facilities or other institutional settings, effectively denying access to justice.

The WHO OHCHR publication [Mental health, human rights, and legislation: guidance and practice \(36\)](#) provides detailed recommendations on legal reforms in this area.

**Example indicator**

**Name** Legal reforms enhance access to justice for people with mental health conditions and disabilities.

**Definition** Number of legal reform measures initiated that establish or expand procedural accommodations such as supported decision-making, accessible court materials, and in-court assistance so as to ensure people with mental health conditions and disabilities can participate meaningfully in legal proceedings.

**Data source(s)** Official legal gazette; Ministry of Justice reform and legislative logs; parliamentary bill tracking records.

**2. Lead and also collaborate on reviews and revisions of law related to legal capacity, mental health, forensic facilities, non-discrimination and decriminalization of suicide.**

The justice sector plays a lead role in legal reforms but will often need to work closely with other sectors. For example, in some contexts the social sector may take the lead on legal capacity reforms, while the health sector may lead reforms to mental health laws. In all cases, the justice sector can actively support reviews and legal revisions, ensuring alignment with international human rights standards and facilitating legislative change. Key areas include:

- **Legal capacity.** Legal capacity allows individuals to hold rights and act under the law. However, national laws often restrict the legal capacity of people with mental health conditions or psychosocial disabilities through provisions like substitute decision-making, where a legal guardian makes decisions on behalf of the person. This violates CRPD standards, which advocate for supported decision-making that respects the individual's own will and preferences (36, 377). Justice sector policy can therefore include provisions to collaborate with all relevant sectors, including the mental health and social sectors, to review and revise legislation related to the right to legal capacity and to replace any provisions on substitute decision-making with supported decision-making.
- **Mental health laws.** Many countries' mental health laws authorize involuntary psychiatric treatment and coercive practices such as involuntary medication, electroconvulsive therapy, and physical, chemical, and mechanical restraint (36, 378). These practices do severe harm to mental and physical health and violate CRPD requirements (379). The justice sector policy can specify the need to work with relevant sectors to review and revise mental health laws to fully align with international human rights standards, eliminating coercion, promoting rights-based care and removing discriminatory provisions. Removing discriminatory provisions includes revising the designations Unfit to stand trial, or Not guilty by reason of insanity/ incapacity for criminal responsibility since these can deny people their rights (see also the discussion under Strategic action 1).

- **Phasing out forensic facilities.** This requires strong participation and even leadership from the justice sector, particularly when it oversees or manages forensic hospitals. Policy can specify the need to closely collaborate with the health and social sectors and other actors to ensure that people can transition safely into community-based mental health settings wherever possible. This includes developing individualized care plans, identifying appropriate community services and support and establishing systems for judicial oversight and follow-up after release. The goal is to ensure that even people considered high-risk receive care and support in line with CRPD, and that no one is subject to indefinite detention in institutional settings under the guise of treatment. Not all people in forensic facilities will transition to community-based care. Some may be transferred to regular prisons. For these people, mental health care should be provided within the general prison health system. In practice, however, this often does not happen, leading to unmet needs, worsening mental health, and lack of continuity of care. Justice, health and social sectors must work together to ensure access to rights-based mental health care for all people deprived of liberty.
- **Decriminalizing suicide.** In some countries, suicide is still considered a criminal act, punishable by fines or imprisonment (48). This discourages people from seeking help when they experience suicidal thoughts and contributes to the stigma surrounding mental health issues. It also affects the families of those who have attempted suicide. Criminalizing suicide not only violates basic human rights, such as such as freedom from discrimination, the right to liberty and security of person, and the right to seek health care and support, but it also creates barriers to effective suicide prevention strategies (48). Justice sector policies can prioritize reviewing and revising any legislation that criminalizes suicide or suicide attempts, in collaboration with the mental health sector.
- **Non-discrimination.** All forms of discrimination can harm mental health and well-being (380). Legislation plays a crucial role in upholding the principle of non-discrimination across all sectors and areas of life. Justice sector policy can include collaboration with key sectors (for example with employment, health, education, housing and social protection sectors) to propose and strengthen non-discrimination laws. These should address direct, indirect, and structural discrimination based on age, race, sex, gender, disability, and other characteristics. This comprehensive approach is essential to protect mental health and promote overall well-being.

For detailed guidance see [Mental health, human rights, and legislation: guidance and practice \(36\)](#) and [WHO policy brief on the health aspects of decriminalization of suicide and suicide attempts \(48\)](#).

••• **Example indicator**

••• **Name** Laws reviewed and revised for legal capacity rights.

••• **Definition** Number of legislative instruments officially reviewed and revised to align with the right to legal capacity for people with mental health conditions and disabilities.

••• **Data source(s)** Ministry of Justice legislative review reports; government gazette amendment notices; parliamentary revision committee records.

### **3. Train the judiciary, lawyers, legal practitioners and other justice sector professionals on human rights and mental health, including rights-based legal reforms.**

Policy should promote training on human rights, especially those required under the CRPD (1), so justice sector stakeholders fully understand their role in underpinning the rights of people with mental health conditions or psychosocial disabilities. Training should cover what these rights are, including rights related to legal capacity, eliminating coercion, and addressing discrimination. Training should also cover all rights-based legal revisions and reforms implemented or in process in the country, such as those related to mental health law, decriminalizing suicide, and non-discrimination. Training should include special considerations for children and adolescents interacting with the justice system. Importantly, training should be co-developed and co-delivered with people who have lived experience of mental health conditions and psychosocial disabilities, and preferably those with experience of the justice sector.

[WHO QualityRights e-training on mental health, recovery and community inclusion \(152\)](#) as well as WHO QualityRights face-to-face training modules (151) are useful evidence-based training tools.

#### **Example indicator**

**Name** Justice-sector professionals trained in mental health and human rights law.

**Definition** Proportion of judges, lawyers, and other justice-sector professionals who have completed certified training on rights-based legal reforms and mental health law.

**Data source(s)** Judicial training institute records; bar association continuing education logs; Ministry of Justice training completion databases.

### **4. Explore pre-trial diversion programmes and also alternatives to incarceration after conviction, such as restorative justice initiatives.**

Programmes designed to divert people away from illegal activity and from contact with the court system, rather than convicting them and imprisoning them as punishment, should not be limited to juveniles and first-time offenders. They should also be considered for people with multiple convictions, people with mental health conditions or psychosocial disabilities, and other groups that face discrimination.

Diversion programmes can be broadly categorized into pre-booking diversions and post-booking diversion. Pre-booking diversion programmes aim to link individuals to appropriate support services, including mental health or social services, rather than formally charging them with a criminal offence. Participation should always be voluntary and based on informed consent. Post-booking diversion programmes occur after a person has been charged and can offer a pathway that avoids prosecution. Some may be similar to alternatives to custodial sentences, for example restorative justice processes.

Alternatives to custodial sentences can be used after conviction and instead of imprisonment. They can serve as redress mechanisms while significantly reducing the prison population. They can be particularly useful for keeping people with mental health conditions away from the damaging consequences of imprisonment. They can include probation, house arrest with electronic monitoring, community service, fines, restitution, and restorative justice programmes (381, 382).

Restorative justice brings together victim and perpetrator to address a crime. It focuses on understanding the harm caused, on looking for ways to repair the harm, and in particular on ensuring the offender takes responsibility for their actions. This provides an opportunity for accountability, healing, and resolution through dialogue, while avoiding the often-damaging effects of detention. Studies have shown that restorative justice can lead to reduced reoffending rates and improved mental health outcomes for both victims and offenders ([383](#), [384](#)).

Diversion schemes tailored for children and adolescents in contact with the justice system are particularly important, especially for those with mental health conditions or psychosocial disabilities. Diversion programmes should prioritize rehabilitation, education, and social reintegration. They should be child-sensitive, trauma-informed, and grounded in the principles of dignity, development, and participation, in accordance with the Convention on the Rights of the Child and the CRPD.

When implementing such programmes, it is essential to address concerns that diversion initiatives often fail to tackle the underlying structural inequalities that lead to criminalization, such as stigma, ableism, racism, poverty, and lack of community support and instead often rely on medicalized approaches and coercive practices that conflict with human rights. Therefore, it is crucial that all diversion programmes are tailored to local needs and are fully aligned with the CRPD. Post-booking diversions should only be used when there is sufficient evidence that the person committed the alleged offence. They should be offered as a voluntary alternative to the normal judicial process, and people should have good information about the programme's nature, content, and duration. Programmes should focus on delivering person-centred, rights-based community support and restorative justice. Diversions from the normal court-based justice procedure should never involve coercive mental health care, indefinite detention in forensic facilities or social control ([36](#), [385](#)).

⋮ **Example indicator**

⋮ **Name** Diversion and restorative justice programmes implemented.

⋮ **Definition** Percentage of eligible people, including people with mental health conditions or psychosocial disabilities, who have accessed voluntary diversion or restorative justice initiatives established as alternatives to custody.

⋮ **Data source(s)** Ministry of Justice programme registry; Ministry of Justice case management records; justice sector annual reports; NGO pilot project documentation; diversion and restorative justice programme enrolment logs.

## Policy directive J2 Establish mechanisms to monitor rights violations and discrimination and provide pathways for redress and reparations

### Strategic actions

#### 1. Mandate and oversee independent monitoring and complaint mechanisms for mental health and social services, including forensic facilities.

Independent monitoring is crucial for ensuring accountability. Requiring and overseeing such monitoring, alongside establishing effective complaint mechanisms, are essential steps in protecting these people's rights. The justice sector can implement mechanisms such as mental health review bodies, national human rights institutions, ombudspersons, mental health commissions, quality commissions, and independent bodies established under international human rights law (including national CRPD monitoring mechanisms and national preventive mechanisms under the Optional Protocol to the Convention Against Torture) ([36](#), [386](#), [387](#)).

Legislation can guarantee the institutional, financial, and political independence of these monitoring bodies, clearly defining their functions and responsibilities. These functions should include regular and unannounced inspections of public and private mental health and social services, with unrestricted access to facilities and medical records. Monitoring bodies can also review unusual incident and death reports, collect data on hospitalization lengths and treatments, and maintain registers of accredited outpatient and inpatient services. Additionally, they can establish and enforce quality and human rights standards for accreditation.

Establishing accessible, efficient, and transparent complaint mechanisms is equally vital. These mechanisms should enable current and former users of mental health and social services to report issues and pursue legal action, including against human rights violations. Given the prevalence of coercion, violence, abuse, and neglect in mental health services, it is necessary for people to have the right to report complaints and to initiate legal proceedings, with support as needed. Legislation should ensure that complaint mechanisms are robust, with clear procedures for submission, investigation, and resolution, and should be developed in collaboration with all relevant sectors, particularly the mental health sector.

For detailed guidance on both independent monitoring and complaint mechanisms refer to [Mental health, human rights and legislation: guidance and practice \(36\)](#).

#### Example indicator

**Name** Independent monitoring and complaint mechanisms for mental health and social services.

**Definition** Percentage of mental health and social service facilities, including forensic units, that have established independent monitoring bodies, with accessible and rights-based complaints channels, and have processed 100% of complaints within the reporting period.

**Data source(s)** Regulatory agency service accreditation records; independent monitoring body annual reports; complaint registry logs.

## **2. Support and advocate for independent reporting and monitoring for all discrimination and human rights violations.**

Discrimination remains pervasive across all areas of life, impacting sectors such as employment, education, health, and social protection, and should be a critical issue for all sectors. The justice sector can collaborate with sectors and bodies, including national human rights institutions, human rights commissions, ombuds offices, and other relevant entities, to create independent reporting and monitoring mechanisms for all forms of discrimination. Establishing robust national mechanisms is essential for giving a voice to people who have experienced discrimination, including those affected by mental health-related stigma, and for holding offenders accountable. These mechanisms can also help inform future policies by identifying the most urgent issues and areas for action to eliminate discrimination.

### **Example indicator**

**Name** Independent discrimination and human rights monitoring mechanisms implemented.

**Definition** Number of independent reporting and monitoring bodies for discrimination and human rights violations that have been formally established and are operational.

**Data source(s)** Oversight agency records; independent body establishment documents; complaint registry logs.

## **3. Establish comprehensive redress and reparations for victims and survivors of crime, discrimination, and abuse, including in institutional and mental health settings.**

Victims and survivors of crime, abuse, or sustained discrimination often face serious legal, financial, and psychological burdens. Many are reluctant to file complaints, struggle to navigate complex legal systems, and experience financial hardship from loss of income, medical expenses, and other related costs. Emotional distress is common, and many are at risk of developing mental health conditions such as depression, anxiety, or post-traumatic stress ([388](#), [389](#)).

Redress and reparations efforts should encompass a range of coordinated measures that address harm and support recovery. These may include facilitating access to trauma-informed mental health services and support, such as peer programmes, individual and group counselling, and specialized trauma services tailored to the needs of victims and survivors and their families. They may also involve legal assistance to help people understand their rights and navigate justice systems, along with appropriate financial compensation to address the costs of harm.

These mechanisms can explicitly cover victims and survivors who have experienced violence, abuse, or neglect within mental health services and institutional settings. Such people are frequently excluded from legal protections. Mechanisms should also cover people who have experienced systemic discrimination on the basis of disability, race, ethnicity, gender, or other factors ([380](#), [390](#)). Where appropriate, restorative justice initiatives may be offered. These can provide a complementary process that supports healing, accountability, and reparation through structured dialogue between victims, offenders, and communities. However, restorative justice must always uphold the rights and wishes of victims.

**Example indicator**

**Name** Victims and survivors receive redress and reparations.

**Definition** Number of victims or survivors of crime, discrimination, or abuse, including in institutional or mental health settings, who have received redress or reparations through formally established mechanisms.

**Data source(s)** Official redress and reparations programme registers; institutional complaint resolution logs; reparations disbursement records.

## Policy directive J3 Protect and promote mental health for people in custody and incarceration, as well as for staff

### Strategic actions

#### 1. Train staff in mental health, including crisis intervention, self-care, communication, de-escalation techniques, human rights, and addressing stigma and discrimination.

Working in jail or prison environments can severely undermine staff mental health, often leading to emotional distress, depression, burnout, and symptoms of post-traumatic stress. Additionally, correctional officers sometimes contribute to or perpetuate violence and abuse within these settings (391). To address these issues, it is crucial to require comprehensive training programmes for all correctional officers, prison staff, and parole officers. These programmes should include strategies for self-care and maintaining mental well-being, and education on human rights, including standards related to the CRPD. Training should focus on reducing stigma and discrimination related to mental health, and should provide staff with skills to recognize and support people experiencing a mental health crisis. Staff need training in de-escalation, open communication, and other techniques to manage tense situations without resorting to violence or abuse.

Training should also prepare staff to engage effectively with people who face specific barriers or have specific mental health support needs within the justice system. This includes learning child- and adolescent-appropriate approaches; understanding the rights and mental health needs of people with disabilities (including those with intellectual disabilities and autism); and equipping staff to provide respectful, rights-based, and trauma-informed care to women, men, and gender-diverse people.

**Example indicator**

**Name** Staff and parole officers complete mental health training.

**Definition** Percentage of correctional service staff and parole officers who have completed training covering key mental-health related topics, including crisis intervention, self-care, effective communication, de-escalation techniques, human rights, and stigma reduction.

**Data source(s)** Training attendance logs; certification records; human resources training databases.

## 2. Establish evidence-based suicide prevention programmes in prisons and custodial settings.

The risk of suicide is significantly higher among people in jail and prison compared with the wider community (392). Key risk factors in these settings include, having a mental health condition, a history of suicidal ideation, single-cell occupancy, and lack of social visits and calls (392). To address this, dedicated evidence-based suicide prevention programmes can be implemented in all jails and prisons. Programmes should focus on reducing the risks, and can be a component of a wider national suicide prevention strategy (393). Prevention interventions should extend beyond detention, and should include processes to connect people with community-based programmes, because the risk of suicide remains high after release (394). Programmes should always be tailored to the age and demographics of the target population and should be culturally-appropriate.

### Example indicator

**Name** Correctional facilities have implemented evidence-based suicide prevention programmes.

**Definition** Number of correctional and detention facilities that have established and are delivering dedicated evidence-based suicide prevention programmes.

**Data source(s)** Correctional service programme implementation logs; service session and participation records; correctional health service reports.

## 3. Create independent mechanisms to anonymously report harassment, violence, and abuse during arrest, custody, and incarceration, and ensure conflict resolution and redress.

Violence, harassment, and abuse, including physical attacks, coercion, and threats, can be common in jails and prisons, among inmates, instigated by staff against inmates, and by inmates against staff (391). Such incidents create an unpredictable and dangerous environment that can severely harm people's mental health and well-being. To effectively prevent and address these issues, it is essential to establish independent mechanisms that allow inmates and staff to anonymously report any form of violence, harassment, or abuse. Redress can include structured, non-violent conflict resolution options, such as restorative justice panels or reconciliation circles (395). Effective mechanisms should also include clear consequences and disciplinary actions for perpetrators, whether staff or inmates, to serve as a deterrent and maintain a safe environment. Guaranteeing safety and anonymity is crucial to encourage individuals to come forward without fear of retaliation. These mechanisms should be widely available and easily accessible, free from complicated bureaucratic procedures, with information provided in accessible formats. All incarcerated people and staff should be fully informed about the availability of these mechanisms and how to use them. Additionally, prison and facility leadership have a responsibility to actively prevent violence and ensure accountability within their institutions. Similar risks of violence, harassment, and abuse also occur during arrest and in pre-trial detention facilities, where independent reporting mechanisms are equally crucial.

### Example indicator

**Name** Correctional facilities with anonymous reporting and redress mechanisms.

**Definition** Number of correctional or detention facilities that have established independent and anonymous reporting mechanisms for incidents of harassment, violence, or abuse during arrest, custody, or incarceration and have processed at least 50% of cases through these mechanisms with appropriate follow-up or redress action for at least 80% substantiated cases.

**Data source(s)** Correctional service audit reports; service complaint and incident logs; independent oversight body records.

#### **4. Create opportunities for education, work, and income generation during custody and incarceration, including occupational training.**

Education and income generation opportunities in detention centres, jails and prisons are linked to lower reoffending rates and reduced violence. They are also associated with improved social and economic prospects after people are released and better health and mental health (396). Despite these benefits, education is not systematically offered or encouraged in jails and prisons.

Prisons could offer incarcerated individuals the chance to complete a high school diploma, enroll in college-level courses, and even earn a degree. Essential resources, such as books, computers, and writing materials, can be provided.

Additionally, voluntary participation in occupational or vocational training should be encouraged, and opportunities for work and income generation created to support inmates.

##### **Example indicator**

**Name** People in detention participate in education, work, and income-generation programmes.

**Definition** Percentage of people in detention who have participated in at least one certified programme during custody, including formal education courses, vocational or occupational training, or structured income-generation activity.

**Data source(s)** Correctional service programme participation logs; vocational training and education provider records; service activity reports.

#### **5. Enhance communication, recreation, living conditions and accommodations for people in detention.**

A supportive environment that prioritizes communication, recreation, and living conditions is essential for improving people's mental health and well-being in detention centres, jails and prisons. Regular contact with family and support networks significantly improves people's mental health and well-being, and helps the families too. Contact strengthens parent-child relationships, and reduces reconviction rates. Despite these benefits, many prisons lack mechanisms to support this communication. People serving sentences are often placed far from home, have visiting or phone privileges revoked as punishment, and their mail can be delayed or censored. Video calls, while increasingly used, cannot fully replicate the psychological benefits of in-person visits. Policies should guarantee regular contact through visits, calls, and mail, and ensure incarceration close to home to facilitate these connections.

Recreational and leisure activities, including physical exercise like yoga, sports, and games, have lasting mental health benefits for people in detention. The resulting social connection, teamwork, self-esteem, health and fitness, and stress relief, all contribute to a better environment for both inmates and staff (397, 398). It is important that jails and prisons offer regular and structured recreational opportunities to all inmates.

A safe physical environment in jails and prisons is crucial for mental health. Poor conditions, such as overcrowding, unsanitary facilities, inadequate nutrition, lack of nature, poor lighting, and excessive noise, can exacerbate violence, emotional distress, and mental health issues (399). Implementing regular assessments and addressing these risk factors can help to improve the mental well-being of both inmates and staff, and may lower reoffending rates.

All people deprived of liberty should receive reasonable accommodations to ensure equal access to rights, services, and participation. This includes accessible facilities, assistive technologies, communication support (such as sign language or easy-to-read materials), and other adjustments based on individual needs. People with intellectual disabilities and neurodevelopmental conditions such as autism may require tailored communication methods, sensory-friendly environments, or accommodations to daily routines. Staff should be trained to understand and respond to diverse needs in a respectful, rights-based way.

Where children and adolescents are deprived of their liberty, it is essential that they receive age-appropriate accommodations, including separation from adults, uninterrupted access to education, child-appropriate judicial processes, and robust safeguarding measures. Ensuring child- and adolescent-specific support and protections is critical to upholding their rights, promoting healthy development, and protecting their mental health.

**Example indicator**

**Name** Enhanced conditions in correctional facilities.

**Definition** Number of detention facilities that have implemented at least two documented improvements related to communication access (for example, regular phone or video calls), structured recreational activities, or living accommodations. There should be evidence that inmates are using these during the reporting period.

**Data source(s)** Correctional service upgrade records; recreation and communication programme participation logs; beneficiary registers; service reports referencing uptake or use.

**6. Review and revise regulations on solitary confinement and punitive segregation, and implement alternatives including, for the most challenging situations, separation but not isolation.**

People with mental health conditions or psychosocial disabilities in jails and prisons are disproportionately subjected to disciplinary measures and solitary confinement (400). Isolation causes significant harm to their mental health, often exacerbating existing conditions or creating new ones, and it fails to improve safety (401). Regulations and monitoring systems that introduce alternatives to punitive segregation can improve this situation. Alternatives should include full days out-of-cell, in which people spend most or all of the day outside their individual cells engaging on education, work or other activities, peer-led programmes and activities, and, in the most challenging situations, separation without complete isolation from the rest of the detained population. Evidence shows that these approaches are effective in reducing challenging behaviours and acts of violence (402, 403).

**Example indicator**

**Name** Detention facilities implement alternatives to solitary confinement.

**Definition** Number of detention facilities that have officially revised policies to replace punitive segregation with structured alternatives such as full-day out-of-cell programmes, peer-led activities, and non-isolating separation practices.

**Data source(s)** Detention service policy implementation records; service daily activity and housing logs; independent oversight or monitoring reports.

## Policy directive J4 Provide good-quality and rights-based mental health services and support for people imprisoned and in custody, and for staff in these detention facilities

### Strategic actions

#### 1. Provide mental health services and support for people incarcerated or in custody.

Despite the alarmingly high prevalence of mental health conditions and psychosocial disabilities among prison populations (350, 404), mental health and other support services are often inadequate or unavailable in jails, prisons and custody facilities, leaving many individuals without the care or support they need (405).

The justice sector can work in close collaboration with the health, mental health, and social sectors to provide accessible, good-quality, rights-based mental health services and support in all custody and incarceration settings. These services can offer a variety of care options, including peer support, individual and group counselling, and the safe prescription of psychotropic medications when necessary. Tele-mental health interventions can also be integrated as a cost-effective component of mental health care, particularly in remote areas where in-person professional services may be limited. However, tele-mental health should complement, not entirely replace, in-person contact and should only be used when direct interaction is not feasible.

Mental health services and support in jails and prisons should be delivered by a diverse workforce, including psychologists, psychiatrists, social workers, peer support workers, and specialized therapists. This workforce should be specifically trained to provide effective and compassionate care within the specific environment of jails and prisons.

Mental health services and support should be tailored to address the distinct mental health needs of sub-populations in detention. This includes trauma-informed approaches for women who have experienced gender-based violence; inclusive and respectful support for people belonging to the LGBTIQ+ community, who often face discrimination; responses that take into account interpersonal violence among men in custody; and actions that address issues such as stigma around help-seeking. Care and support should also be adapted to suit people with disabilities, including those with intellectual disabilities and autism, and should be appropriate for children and adolescents where relevant.

#### Example indicator

**Name** Mental health services and support delivered to people incarcerated or in custody.

**Definition** Number of individuals in detention who have been identified as needing mental health support and have received at least one mental health intervention.

**Data source(s)** Correctional service health records; mental health service programme logs; counselling and support session registers.

## 2. Establish mental health units in prisons for people with mental health conditions and complex needs.

People with significant mental health needs often lack adequate care while serving sentences in prisons, which can lead to mental health crises and an increased risk of solitary confinement, further exacerbating their mental well-being (406).

Therapeutic units in prisons can provide more intensive, individualized treatment plans and support for those with mental health conditions or high levels of mental health needs. These units may be general or specialized, such as those designed for individuals convicted of sexual or violent offences. They have demonstrated promising results, including improved mental health outcomes and reduced self-harm (406). Policies can support the creation of such units, tailored to specific contexts, ensuring that treatment is always voluntary and based on the individual's full and informed consent.

### Example indicator

**Name** Mental health units established in prisons.

**Definition** Number of prisons that have operational mental health units staffed by multidisciplinary teams to serve people with mental health conditions and complex needs.

**Data source(s)** Prison service records; Ministry of Justice infrastructure and staffing reports.

## 3. Improve access to mental health services and support for detention facility staff.

Staff working in jails, prisons, and other detention facilities often face high levels of emotional distress and elevated rates of mental health conditions like depression, anxiety, and post traumatic stress disorder (391).

Policies should enhance access to a broad range of quality mental health services and support. This can include peer support schemes, individual and group therapy, counselling, and the safe prescribing of psychotropic drugs where needed. These services should ideally be offered through employee assistance programmes tailored to the specific needs of jail and prison staff.

Ensuring that such support is readily available, either at the workplace or within the local community, is crucial for supporting the mental well-being of this workforce. For further discussion on employee assistance programmes, refer to the Mental health and the employment sector in this Guidance.

### Example indicator

**Name** Access to mental health support for detention facility staff.

**Definition** Percentage of detention facility staff who have accessed at least one mental health or psychosocial support service.

**Data source(s)** Staff health records; employee assistance programme usage logs; programme attendance registers.

## Policy directive J5 Facilitate community integration for people leaving jails, prisons and forensic facilities

### Strategic actions

#### 1. Facilitate inter-sectoral collaboration on rehabilitation and reintegration programmes in the community for people leaving custody, prisons or forensic institutions.

Establishing strong inter-sectoral collaboration is crucial when developing effective rehabilitation and reintegration programmes for people leaving detention, and requires clear policy from the justice sector. These programmes, including restorative justice initiatives that involve victims of crime, their families, and other community stakeholders (see Spotlight on restorative justice), can significantly reduce reoffending by helping people reintegrate into society and access education, employment, general health, and mental health services and support.

Programmes should be designed to support not only people leaving detention, but also their families and communities, with an emphasis on strengthening social and support networks (407) and on addressing concerns and fears, particularly where convictions were for violent or sexual crimes.

Pre-release programmes can include work or study releases and temporary home visits to family or community settings. These can smooth the reintegration process.

On release, it is essential to ensure that people's basic needs, such as for safe housing, food, and income, are met. Meeting these needs is critical not only for successful reintegration, but also for reducing suicide risk, relapse, and reoffending. Support should also include assistance with employment, mentorship, and access to physical and mental health services and support, including specialized services such as substance use treatment (407-409).

Reintegration programmes should be gender-appropriate and trauma-informed, addressing individuals' specific needs, including the high rates of trauma experienced by imprisoned women, particularly related to male violence. While women-only spaces are important, they must be complemented by services that promote safety, dignity, and empowerment for everyone during reintegration.

#### Example indicator

**Name** Inter-sectoral community reintegration programmes.

**Definition** Number of released people, including those from forensic units or institutions, who have participated in at least one rehabilitation and reintegration programme delivered collaboratively, for example by the health, social, justice, and community sectors.

**Data source(s)** Programme participation logs; inter-agency collaboration agreements; community service provider records.

## 2. Enhance continuity of care and support after release.

Transitioning from mental health care in detention to community-based mental health services and support is often disjointed, leading to gaps. Justice sector policies should, in collaboration with the mental health sector, include clear guidelines for ensuring continuity of care. This should include training parole officers to help people connect with community services and support, ensuring that the care initiated during detention is sustained on release. This approach reduces the risk of relapse and promotes long-term mental health stability.

### Example indicator

**Name** Continuity of care and support on release.

**Definition** Number of people released, including those from forensic units or institutions, who have a pre-release coordinated care plan and who received at least one follow-up mental health or psychosocial service within 30 days of release.

**Data source(s)** Release-planning records; community mental health service logs; reintegration programme attendance registers.

## 3. Facilitate peer networks and community engagement for people leaving detention (including from forensic settings) to support recovery, prevent isolation, and reduce reoffending.

Peer support is highly effective in supporting people's community reintegration, recovery and rehabilitation when leaving detention. It has multiple benefits including reduced relapse and reoffending, an improved sense of hope and self-empowerment, improved social functioning and overall quality of life, and decreasing hospitalizations ([410](#), [411](#)).

Through peer support, people can be helped with treatment planning and navigating essential systems such as housing, employment, and social services. Initiating peer support before release can be particularly beneficial, helping people develop transition plans and identify resources for reintegration into the community.

Justice sector policies can go beyond regulations by actively partnering with community organizations to establish and support peer support networks for people who have been incarcerated. The justice sector can facilitate this by providing funding, creating referral pathways, and ensuring coordination with probation services and other community-based supports.

### Example indicator

**Name** Participation in peer networks and community engagement after release from detention.

**Definition** Number of people released from detention (including from forensic settings) who have participated in at least one peer support network or community engagement activity within three months of release.

**Data source(s)** Reintegration programme participation logs; peer network membership records; community organization activity registers.

#### **4. Educate, train and support reluctant community providers to serve people with a criminal/ forensic record and ensure strong collaboration between parole officers and community services.**

Some community mental health and support service providers may be reluctant or unwilling to serve people released from prison or forensic settings. This reluctance often stems from stigmatizing and discriminatory attitudes, particularly towards those with convictions for violent or sexual offences, or from concerns about whether they can adequately meet these individuals' needs.

It is essential to educate, train and support community providers so they have the confidence and skills to serve this population effectively, including training in mental health, human rights, and strategies to address stigma and discrimination.

For example, close collaboration between parole officers and community-based services can result in seamless referrals and address provider and community concerns. Such supportive partnerships enable people released from detention to access the services and support they need quickly and effectively.

##### **Example indicator**

**Name** Community providers receive training and have collaborations for reintegration support.

**Definition** Number of community service providers who have completed certified training on supporting people with criminal or forensic records and have formalized collaboration agreements with parole officers or correctional services.

**Data source(s)** Training attendance registers; signed memorandum of understanding logs; collaboration meeting records.

### **SPOTLIGHT on restorative justice**

Restorative justice is an inclusive, flexible, and participatory approach that aims to repair the harm caused by a crime and address its root causes, ultimately creating healthier and safer futures for all those involved. It engages all affected parties, including the offender(s) and their families, victim(s) and their families, and other community members. Restorative justice can take various forms but generally involves processes or programmes where victim(s) and offender(s) come together, supported by others such as family members, community members, or restorative justice facilitators, to address the harm caused and collaboratively find ways to repair it for the victim(s) and the broader community (412, 413). This approach can serve as an alternative to incarceration and as a means of reintegration and rehabilitation after a sentence is served.

For more guidance on restorative justice and how to incorporate these programmes into legislation and policy, see the comprehensive resources provided by the United Nations Office on Drugs and Crime available at <https://www.unodc.org/unodc/en/justice-and-prison-reform/cpcj-restorative-justice.html> (412).

Box 14 offers further resources for addressing mental health from within the justice sector.

### **Box 14. Resources for addressing mental health from within the justice sector**

- Criminal justice assessment toolkit: social reintegration.  
[https://www.unodc.org/documents/justice-and-prison-reform/cjat\\_eng/4\\_Social\\_Reintegration.pdf](https://www.unodc.org/documents/justice-and-prison-reform/cjat_eng/4_Social_Reintegration.pdf) (414)
- Introductory handbook on the prevention of recidivism and the social reintegration of offenders.  
[https://www.unodc.org/documents/justice-and-prison-reform/18-02303\\_ebook.pdf](https://www.unodc.org/documents/justice-and-prison-reform/18-02303_ebook.pdf)
- LIVE LIFE: an implementation guide for suicide prevention in countries.  
<https://iris.who.int/handle/10665/341726> (46)
- Mental health, human rights and legislation: guidance and practice.  
<https://iris.who.int/handle/10665/373126> (36)
- Mental health in prison: a short guide for prison staff.  
<https://www.penalreform.org/resource/mental-health-in-prison-a-short-guide-for/> (415)
- National suicide prevention strategies: progress, examples and indicators.  
<https://iris.who.int/handle/10665/279765> (393)
- Operational framework for monitoring social determinants of health equity.  
<https://iris.who.int/handle/10665/375732> (23)
- Preventing suicide: a community engagement toolkit.  
<https://iris.who.int/handle/10665/272860> (394)
- Prisons and health. <https://www.who.int/europe/publications/i/item/9789289050593> (396)
- Promoting the health of young people in custody.  
<https://iris.who.int/handle/10665/107532> (416)
- Technical Brief on Mental Health and Psychosocial Support for Children in the Justice System.  
<https://www.unicef.org/documents/reimagine-justice-children-technical-briefs>
- Handbook on prisoners with special needs.  
[https://www.unodc.org/pdf/criminal\\_justice/Handbook\\_on\\_Prisoners\\_with\\_Special\\_Needs.pdf](https://www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf) (417)
- WHO policy brief on the decriminalization of suicide and suicide attempts.  
<https://iris.who.int/handle/10665/372848> (48)
- WHO QualityRights e-training on mental health.  
<https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training> (152)
- WHO QualityRights materials for training, guidance and transformation.  
<https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools> (151)

# Mental health and the **social protection** sector



## Overview

Universal social protection and the right to social security are codified in the Sustainable Development Goals, to be achieved by 2030, and are integral elements of many national agendas to promote human development, economic growth, and social cohesion (15). These elements are central to development policies, playing a significant role in ending poverty and hunger (SDG 1 and SDG 2), promoting healthy lives and well-being for all (SDG 3), achieving gender equality (SDG 5), reducing inequalities (SDG 10), and fostering just and peaceful societies (SDG 16).

Despite significant progress, much of the global population still lacks adequate social protection, with this gap particularly pronounced in low-income countries and among groups that face discrimination, including people with mental health conditions or psychosocial disabilities. For example, while over half of unemployed workers in high-income countries receive unemployment benefits, only 1% do so in low-income countries (418). Similarly, 63% of those considered disadvantaged or at risk of discrimination in high-income countries receive cash benefits, compared with just 7.8% in low-income countries (418).

Limited or nonexistent social protection leaves people, particularly groups that face discrimination, vulnerable to poverty, inequality, ill health, and social exclusion. All of these hardships are closely linked to poor mental health and well-being (419, 420). For example, living in poverty and facing challenges such as housing insecurity, insufficient nutrition, and limited access to resources increases the risk of developing mental health conditions (21, 421, 422). Income insecurity due to unemployment also contributes to heightened psychological distress and poor mental health (423, 424). Moreover, inequalities based on characteristics such as age, sex, gender, sexual orientation, disability status, immigration or refugee status, race or ethnicity, indigeneity, or houselessness can lead to mental health issues and social exclusion, and can exacerbate mental health conditions (425, 426).

Investing in social protection throughout the life course and ensuring people are supported during vulnerable times of life, including in periods of financial constraints, is crucial for mental health (427). It not only improves living standards but also has a profound impact on mental health by reducing the stress and anxiety associated with poverty, social exclusion, economic instability, unemployment, and social inequality. Effective social protection enhances overall well-being from early childhood through to old age by providing stability and support, which are essential for mental resilience (428). Moreover, social protection contributes to economic progress by increasing productivity and employability, raising household incomes, and fostering greater consumption and spending (429). These economic benefits, in turn, can further improve mental health outcomes by alleviating the financial pressures that often exacerbate mental health conditions.

This Guidance highlights the critical links between mental health and social protection, recognizing that many core activities of the sector already contribute to protecting and promoting mental health. Additionally, it proposes a menu of policy directives and strategic actions that can be integrated into sectoral policies, supporting both improved mental health outcomes and the sector's broader objectives. The numbering uses the prefix SP (social protection) to help avoid confusion when discussing policy directives for specific sectors or from other guidance. In particular, this Guidance outlines strategic actions for the social protection sector that benefit mental health, including for groups that face discrimination. These strategic actions focus on promoting equal opportunities, social inclusion and cohesion, reducing poverty, addressing unemployment, guaranteeing minimum income and pension benefits, and ensuring access to high-quality social care and support.

It is important to note that the roles and responsibilities of sectors might vary from country to country and that therefore, some areas covered here in this Guidance might fall under the responsibility of a different sector. For example, policy on women's empowerment, diversity and inclusion, children and youth, or families may be addressed by other sectors. Conversely, topics addressed elsewhere in this Guidance may be relevant to the social protection sector. To support navigation and help the reader find all relevant information, Fig. 1 in the Introduction to this Guidance offers a [directory of key issues](#), indicating where each is covered.

The Guidance includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators let sectors track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## Policy directive SP1 Promote equal opportunities and social inclusion in order to protect and promote mental health

### Strategic actions

#### 1. Enhance mental health through improved guidelines and monitoring mechanisms for social equity and equal opportunities.

Addressing key issues such as the gender pay gap, disability employment gap, early school leaving rates among students from groups that face discrimination, child and old-age poverty, and racism in various contexts is already a fundamental part of the social protection sector's mandate. These efforts are not only essential for promoting equality and social justice but also have significant positive impacts on mental health. To make guidelines and mechanisms more effective, it is crucial to develop and implement them with involvement of people with mental health conditions and psychosocial disabilities, along with representatives from other groups that face discrimination. Their perspectives are vital for identifying barriers, crafting inclusive policies, and ensuring that measures address the specific needs of those at risk of discrimination.

#### Example indicator

**Name** Social protection programmes where stakeholders are involved in equity monitoring.

**Definition** Percentage of social protection programmes that involve people with mental health conditions and representatives from other at-risk groups in monitoring and evaluating equity-focused guidelines addressing systemic disparities such as gender pay gaps, disability employment gaps, school dropout rates, poverty, and racism.

**Data source(s)** Programme monitoring reports; stakeholder meeting minutes and participation records; membership rosters of advisory or oversight committees; government website or official records.

## **2. Implement awareness and communication strategies on mental health to transform mindsets and combat stigma and discrimination.**

The strategies, including targeted campaigns, should aim to raise awareness and motivate individuals to take action and drive change within their communities. Using various forms of social and traditional media can enhance the impact. Engaging people with lived experience, such as people with mental health conditions or psychosocial disabilities and other groups that face discrimination is crucial for developing and implementing these strategies. Collaboration with communication experts, community organizations, and influential local figures will further amplify campaign effectiveness.

### **Example indicator**

**Name** Stakeholder-inclusive mental health awareness strategies.

**Definition** Number of mental health awareness and communication strategies implemented during the reporting period that involve people with lived mental health experience and representatives of at-risk groups in their design and evaluation.

**Data source(s)** Programme strategy and campaign design documents; stakeholder consultation reports and meeting minutes; campaign evaluation reports.

## **3. Provide education and support initiatives in local communities to promote social inclusion and address key societal issues affecting mental health and well-being.**

Initiatives can be tailored to the specific needs and contexts of either whole communities or targeted groups. For example, recovery centers can offer mental health education and promote recovery-oriented attitudes, while intergenerational communities engage all age groups to prevent social isolation. Community education centers can focus on addressing racism, sexism, ableism, and other forms of discrimination. They can also offer different types of violence prevention programmes tailored to the specific risk factors in the communities (for example programmes engaging men and educating them on gender-based violence, programmes training community members to prevent violence and support survivors, programmes to economically empower women, and mentoring and after-school programmes for adolescents with a history of criminal activity).

Early childhood and parenting programmes can provide essential information on child development while youth development programmes can enhance social and emotional well-being and leadership skills.

Education and career outreach programmes can support migrants, refugees and asylum seekers with culturally sensitive workshops and counselling to help them integrate. Additionally, empowerment initiatives such as targeted employment and housing programmes can promote economic independence for people with mental health conditions, psychosocial disabilities, and for other groups that face discrimination.

When developing and tailoring such initiatives it is crucial to engage all stakeholders in local communities to explore and understand key societal issues. Strategies for engagement include creating local working groups, holding public meetings and community dialogues, organizing discussion forums, and implementing community-level solutions. These activities can be conducted in hard-to-reach and under-resourced areas to ensure the involvement of community residents from diverse demographics and backgrounds, including people with mental health conditions and psychosocial disabilities.

**Example indicator**

**Name** Communities offer education and support initiatives for social inclusion.

**Definition** Percentage of target communities that have implemented at least one education or support initiative, co-designed with local stakeholders, to address societal issues affecting mental health and well-being.

**Data source(s)** Community programme registers; records from stakeholder co-design workshops or focus groups; programme implementation and monitoring reports.

#### **4. Combat social isolation and loneliness and strengthen community cohesion.**

Social isolation and loneliness harm mental and physical health, presenting risks comparable to physical inactivity or obesity (330–332). Conversely, strong social connections are protective factors for mental health (430, 431). People at risk of discrimination are particularly vulnerable to social isolation and loneliness. It is important to support not only people who are socially isolated, but also people who feel lonely despite being socially active, as social isolation and loneliness are distinct experiences. To address these issues, it is crucial to raise awareness in local communities about how isolation and loneliness affect mental health and the importance of fostering social connections.

Some initiatives that have proven successful in combating loneliness, reducing social isolation, and improving social cohesion in the social protection sector, in collaboration with communities, include creating opportunities for volunteering (432), cultural activities (433) and sports (434); forming clubs centred around different hobbies (435); investing in intergenerational and special interest groups to enhance social connectedness (436); and offering language and culture courses for migrants and refugees (437). Such efforts are essential for promoting overall well-being.

**Example indicator**

**Name** Communities implement anti-isolation and cohesion measures.

**Definition** Percentage of target communities that have adopted and are actively implementing at least one multicomponent initiative to reduce social isolation, combat loneliness, and strengthen community cohesion. Initiatives might include volunteering programmes, cultural or sports activities, hobby clubs, intergenerational groups, or language and integration courses.

**Data source(s)** Community programme registers; NGO reports; municipal social cohesion reports; event and programme participation logs; feedback surveys from participants.

## Policy directive SP2 Implement measures to tackle poverty

### Strategic actions

#### 1. Provide financial and social support services for stable housing to improve mental health and quality of life.

Houselessness and housing insecurity significantly undermine mental health (438), especially for vulnerable groups like children and adolescents (439), and many individuals experiencing houselessness or housing insecurity live with mental health conditions or psychosocial disabilities (440).

Houselessness and housing insecurity often stem from gentrification, when better-off people start buying and raising the costs of previously affordable housing, and unaffordable rent resulting from income disparities. Providing financial assistance such as public housing, directly subsidized rent, and rental or cash vouchers is crucial for improving mental health for large populations where housing is a common challenge. Prioritizing people with mental health conditions or psychosocial disabilities for housing financial assistance programmes, alongside comprehensive mental health support, is essential.

Temporary housing and emergency shelters play a critical role in protecting individuals from danger, violence, and exploitation during crisis situations. Examples include providing temporary housing for children and adolescents fleeing domestic violence and abuse; ensuring migrants, refugees and asylum seekers have access to culturally appropriate living spaces upon arrival; and guaranteeing houseless people have access to night shelters and services that cover their basic needs until they achieve stable housing. Such interventions also offer opportunities to provide mental health services and support to people in crisis.

Multidisciplinary teams can engage directly with people affected by housing issues, whether on the street, in shelters, or through collaboration with peer advocates and local organizations. These teams can help improve access to housing assistance and support people to maintain housing security, for example, by providing case management, linking individuals to mental health and social services, helping resolve conflicts with landlords or neighbours, and offering ongoing practical and emotional support to prevent eviction or homelessness.

When assessing support needs, it is essential to evaluate people's housing status (for example, are they facing chronic or temporary lack of housing) and their ability to meet basic needs like food, clothing, hygiene, and physical health. Tailored interventions can address issues effectively. Collaboration with the mental health sector is crucial for developing new service models, such as Housing First (441–443), which specifically meets the needs of people struggling with housing. For more information, see [Guidance on community mental health services: promoting person-centred and rights-based approaches \(176\)](#).

#### Example indicator

**Name** Stable housing support services

**Definition** Percentage of eligible individuals or households who have received financial or social support aimed at securing or maintaining stable housing, such as subsidized rent, rental vouchers, housing allowances, transitional housing, or emergency shelter.

**Data source(s)** Housing assistance programme registries; social protection benefit payment logs; shelter intake records; case management and housing support service records.

## **2. Provide financial and social support to alleviate poverty, financial strain and improve mental health.**

Financial support ensures families and low-income households can cover basic needs. It can prevent child, old-age, and disability-related poverty; and assist young people transition to financial independence.

Social risks have shifted to younger generations, with many families struggling to meet basic needs. Child poverty is prevalent, and the associated challenges, such as inadequate nutrition and housing insecurity, significantly increase the risk of mental health issues like anxiety and depression (444).

Young people often experience delayed and unstable independence, for example they postpone milestones like moving out or achieving financial self-sufficiency, which can contribute to mental health struggles.

Older adults facing poverty are often unable to afford essential care, housing, or medications, which increases their vulnerability to both physical and mental health decline (445).

People with disabilities are at heightened risk of poverty due to additional daily living costs (for example, out-of-pocket expenditure for healthcare, assistive devices, or personal support) and barriers to employment, education, and social protection systems. All this has a damaging effect on their mental health (304).

Providing financial support to families and low-income households can lessen the risk of child labour, early marriage, and early school drop-out, while also supporting older adults in accessing essential services and enabling people with disabilities to meet disability-related costs and participate more fully in society.

Collaboration with other sectors to provide programmes that prevent poverty and support families and low-income households is crucial for mental health protection. Examples of support include cash transfers, family tax benefits, food stamps, energy assistance grants, paid parental leave, childcare grants, free school meals, parenting capacity building and support, home support for older adults, personal assistance, and disability-specific benefits (2, 320). Many of these measures can only be effectively achieved through cross-sectoral collaboration.

For example, supporting young adults in entering the job market and achieving independence also improves mental health outcomes (446). Educational partnerships to increase graduation rates, and employment programmes offering tailored support and apprenticeships, are essential. Ensuring access for groups that face discrimination (including people with mental health conditions or psychosocial disabilities) through mainstream or targeted initiatives remains important.

Additionally, financial and related emotional support are vital for people experiencing financial strain, whether temporary or acute. Poor mental health is common among people facing financial difficulties (419, 420, 447), and people in debt are at higher risk of depression and suicide (448). Financial literacy programmes, including workshops, hotlines, and information on loan cancellation and financial entitlements, provide assistance in managing money and planning for the future. Collaboration with the mental health sector addresses emotional support needs during financial difficulties, and engagement with the legal sector improves access to protections like debt respite periods.

**Example indicator**

**Name** Social services that alleviate poverty and provide financial support.

**Definition** Percentage of eligible individuals or households who have accessed at least one financial or social support service, such as cash transfers, food or energy vouchers, childcare grants, or financial literacy and budgeting counselling, aimed at alleviating poverty and financial strain.

**Data source(s)** Social protection programme registries; benefit payment records and voucher distribution logs; programme enrolment and eligibility assessment databases; case management and referral records from community-based organizations.

## Policy directive SP3 Develop employment schemes and benefits to protect individuals throughout their lives including during crises

### Strategic actions

#### 1. Ensure workers, including part-time, temporary, and self-employed people, are eligible for unemployment benefits, income-replacement, and job retention schemes during economic crises.

Financial problems and worries about job loss can severely affect workers' mental health (424). It is essential to implement comprehensive financial assistance programmes, including unemployment benefits or guaranteed minimum income, for people who lose their jobs involuntarily. These programmes are crucial for maintaining mental health. Mainstream programmes should cover people with mental health conditions, psychosocial disabilities, and other groups that face discrimination, with tailored initiatives and support from trained social care staff to help disadvantaged groups maintain employment and navigate the system.

Examples of such measures include contribution-related benefits, non-contribution benefits, sickness benefits, injury allowances, and social insurance benefits. Job retention schemes, such as short-time work programmes, wage subsidies, and short-time relief compensation, are especially vital during crises (like COVID-19) or economic downturns. They help preserve jobs, protect incomes, and mitigate the harm unemployment does to mental health.

**Example indicator**

**Name** Comprehensive eligibility for unemployment and job-retention benefits.

**Definition** Percentage of part-time, temporary, and self-employed workers who are eligible for at least one form of social protection support during economic crises, including unemployment benefits, income-replacement measures, or job-retention schemes.

**Data source(s)** Social insurance and benefit programme enrolment records; Labour Ministry eligibility and coverage databases; employment and income support programme administration logs; surveys of workers' awareness and uptake of benefits.

## **2. Introduce minimum incomes, support labour market participation, and strengthen job seekers' skills within groups that face discrimination.**

Unemployment and job insecurity, which are associated with increased psychological distress and poor mental health (423, 424, 449, 450), can be mitigated by initiatives such as cash payments, relief allowances, or disability benefits that help people cover basic needs while they are temporarily unable to work. Such interventions protect and promote mental health.

Minimum income schemes should be linked to tailored assistance for finding and maintaining employment, including support for skill development, job searches, and access to enabling services such as childcare and transportation. So-called all-or-nothing approaches should be avoided. People who can work part-time should be supported in doing so, with flexible pathways to return to full-time employment when possible.

It is also crucial to strengthen job seekers' skills within groups that face discrimination, including those with mental health conditions or psychosocial disabilities, who face significant barriers to employment. Enhancing their skills and supporting their inclusion in the labour market can involve funding education and training; adopting remote work options for those with disabilities or caregiving responsibilities; providing reasonable accommodations for workers experiencing mental health crises, and collaborating with NGOs and Organizations of Persons with Disabilities to ensure job opportunities are accessible.

Additionally, providing accessible information on mainstream schemes and related supports, including targeted initiatives like Individual Placement and Support programmes (451), is vital. Social care staff and link workers can be trained to help people access these resources, further supporting their integration into the workforce and improving their mental health outcomes.

### **Example indicator**

**Name** Access to minimum income and skills support schemes for at-risk job seekers.

**Definition** Percentage of job seekers from at-risk groups (including people with mental health conditions or disabilities) who have accessed minimum income support and participated in at least one labour market integration programme, such as skills development, vocational training, or supported employment.

**Data source(s)** Social protection and minimum income scheme enrolment records; vocational training and job programme participation logs; beneficiary eligibility and needs assessment databases; case management system used by employment or social protection services.

### **3. Facilitate access to adequate pensions and financial resources to prevent poverty in old age and protect mental health and well-being.**

Many older people live in poverty, facing disadvantages that harm their mental health and overall well-being (445). To address this, it is crucial to guarantee access to adequate pensions (whether public, private, pay-as-you-go, or funded) and decent minimum benefits in old age. Providing financial education and retirement planning support is essential for preventing the stress and anxiety associated with financial insecurity in later life.

This approach includes ensuring sustained employment to build pension entitlements, educating workers on pension rules and employment opportunities, and introducing flexible retirement transitions that promote active aging. Such transitions could involve flexible working arrangements, differential retirement ages based on job demands, gradual retirement schemes, and allowing pensioners to engage in voluntary part-time roles for additional income when pensions fall short. These measures are vital for protecting mental health by reducing the financial strain that can lead to depression, anxiety, and other mental health issues among older adults.

#### **Example indicator**

**Name** Adequate pension access for older adults.

**Definition** Percentage of eligible older adults receiving a pension at or above the nationally defined minimum income or benefit level necessary to meet basic living standards and avoid poverty.

**Data source(s)** National pension registry; social protection payment records; income support eligibility and coverage databases; household income surveys.

## **Policy directive SP4 Build schemes to provide social care and mental health support**

### **Strategic actions**

#### **1. Provide social workers with capacity-building and training on mental health and support options.**

It is crucial that all social workers receive ongoing training in mental health. They also need mental health topics incorporated into their university and training institution curricula, (see Policy directive H3 in Mental health and the health sector within this Guidance for related discussions).

Training should encompass common stress reactions in people of different ages, mental health crisis management, assessment of mental health needs, support for families and caregivers, and knowledge of appropriate referral pathways to specialized mental health services or protective services, such as for child abuse or intimate partner violence.

Standardized case management tools should include sections addressing mental health concerns and their assessment, following a rights-based, recovery-oriented, and person-centred approach.

Social workers should also have regular access to supervision and support, including mental health resources, to ensure their well-being and effectiveness in supporting others.

**Example indicator**

**Name** Social workers receive mental health capacity-building and training.

**Definition** Percentage of active social workers who have completed at least one certified training session on mental health during the reporting period.

**Data source(s)** Social worker training attendance logs; HR professional development records; certification or continuing education registers.

**2. Develop or link with home-based and community services for people with long-term needs, including those with mental health conditions or psychosocial disabilities.**

Some people with long term and complex needs cannot be fully accommodated through existing community service programmes related to housing, employment, education, and other essential areas. They include many older adults, people with disabilities, and with mental health conditions. The lack of tailored support can lead to increased stress, anxiety, and a decline in mental health. To address this, specialized home-based and community services can be developed and made available to ensure these individuals receive the necessary support to maintain their mental well-being and quality of life.

Home-based services can include individualized housing solutions with varying levels of support, reuniting or reconnecting individuals with their families or social networks if they wish, and medium-to long-term family-like group housing to provide support according to need. Individual home assistance programmes can help people live actively and autonomously, but must always ensure full consent from the individuals receiving care (176). Collaboration with sectors such as mental health, urban planning, and social services will be essential to create these tailored housing options and personal assistance programmes.

In the community, specialized services can include supported education programmes, such as individual assistance to navigate the education system, and supported employment programmes that offer retraining, vocational training, and transitional employment opportunities. These programmes help people acquire new skills, transition into new careers, or maintain and return to previous employment. Establishing community-based peer support programmes can also foster positive outcomes (307). Collaborating with sectors like mental health, education, and employment is crucial for developing these services, which play a vital role in reducing the stress and mental health challenges associated with long-term support needs.

Ensuring that both home-based and community services are tailored to individuals' unique needs supports mental health and overall well-being, fostering greater autonomy and integration into society.

**Example indicator**

**Name** Access to home-based and community services for individuals with long-term support needs.

**Definition** Percentage of people with long-term support needs, including people with mental health conditions or psychosocial disabilities, who receive ongoing support through home-based or community-based services.

**Data source(s)** Home-based care programme registries; community service provider records; case management or care coordination databases.

### 3. Collaborate with the mental health sector to deinstitutionalize psychiatric and social care facilities

Many people, particularly people with mental health conditions and disabilities, continue to live in large, segregated psychiatric and social care facilities (institutions) that are often associated with poor quality care and human rights violations (38, 452). Contrary to common misconceptions, these institutions operate at a higher cost per service user than community-based services (and serve only a small portion of the population) (453).

To address this, the social care sector can partner with the health and mental health sectors to identify and assess institutions across the country, develop deinstitutionalization plans for each facility, and create individualized support plans for residents transitioning to the community. These plans should include referrals to specialized home-based and community services, including family-based care for children formerly based in institutions, ensuring a smooth and supportive transition. Additionally, efforts should be made to build public support for deinstitutionalization through community discussions and media campaigns (for more detailed guidance on deinstitutionalization see Policy directive 1.4 in Module 2 of [Guidance on mental health policy and strategic action plans \(25\)](#)).

#### Example indicator

**Name** Deinstitutionalization of psychiatric and social care institutions.

**Definition** Percentage of people once resident in psychiatric or social care institutions who have transitioned to community-based services under individualized support plans.

**Data source(s)** Ministry of Health or Social Welfare deinstitutionalization plan registry; service transition logs and discharge planning records; community service provider intake and enrolment records; individualized support plan database or monitoring system.

### 4. Collaborate with the health sector to fund social activities prescribed to people at high risk of poor general or mental health.

Health professionals can prescribe social activities to individuals who may benefit from them, particularly those at high risk of negative health and mental health outcomes. Social prescribing enables health professionals to refer people to link workers in the social protection sector, who can then connect them with programmes that promote mental health and well-being (274, 299, 300, 454). Examples of social prescribing activities include volunteering in schools or museums, participating in musical or dance performances, and engaging in artmaking or photography.

#### Example indicator

**Name** Individuals receive funds for prescribed social activities.

**Definition** Percentage of individuals at high risk of poor general or mental health who receive funding (full or partial) for participation in prescribed social activities. Examples might include volunteering, cultural or arts programmes.

**Data source(s)** Social protection and health prescription registries; social prescribing programme enrolment and monitoring records; financial reimbursement and claims records; service user records or care plans.

## **5. Provide funds and support to people who cannot afford social care, long-term health care, or to fully participate in society.**

Many people in disadvantaged groups, including people with disabilities, with mental health conditions, and people from groups that face discrimination, lack money for social care, long-term health care, and other services. This financial shortfall has a significant impact on their overall health and mental well-being.

Social protection can provide tailored financial assistance to these individuals. Examples include care vouchers; cost compensation and payments to supporters and carers; tax reductions and paid leave for caregivers; cash transfers to access social care and high-quality long-term health care services; and mechanisms such as health insurance coverage or healthcare fee waivers ([2, 445](#)).

In addition to needing financial support for care, people with disabilities or mental health conditions, and people from groups that face discrimination, may not have sufficient resources to fully participate in society. Addressing this requires extra resources to overcome physical, attitudinal, and communication challenges that contribute to social exclusion and poor mental health outcomes. Tailored financial assistance, such as reasonable accommodation allowances, mobility and caregiver allowances, and support pensions, should be made available and accessible to individuals who need them.

Supportive services are also crucial in helping individuals navigate social protection programmes and resources. This includes peer support to navigate the benefits system, employment or education services, and financial literacy services, with information provided in accessible formats. These combined efforts are vital in promoting mental well-being and ensuring that everyone, regardless of their financial situation or marginalized status, can live with dignity and participate fully in their community.

### **Example indicator**

**Name** Access to financial assistance and supportive services for people with disabilities and mental health conditions, and other at-risk groups.

**Definition** Percentage of eligible individuals from priority populations, including people with mental health conditions, disabilities, and people from groups at risk of discrimination, who have received supportive services or financial assistance such as care vouchers, mobility allowances, or cash transfers, to facilitate social care, long-term health care, and community participation.

**Data source(s)** Social protection payment logs; service provider beneficiary and claims records; programme enrolment and eligibility databases; community case management or care coordination systems.

## **6. Protect survivors of violence, especially children and survivors of gender-based violence, and ensure they receive tailored mental health and social support.**

Common forms of violence that require targeted solutions include child abuse, youth bullying, intimate partner violence, rape or sexual assault, forced marriage, honor killings, violence against older adults and violence in institutional settings such as mental health services, nursing homes, and prisons (455).

Certain groups, including children; women; gender-diverse people and others belonging to the LGBTIQ+ community; migrants, refugees and asylum seekers; and people with disabilities, are disproportionately affected by violence.

Specialized and tailored services can be developed or adapted in collaboration with the mental health and other sectors to support survivors. These services may include safe housing, telephone and internet helplines, and referrals to counselling, psychosocial support, or legal aid services. Close collaboration and strong referral networks are crucial, so that survivors of violence can access services and avoid bureaucratic processes and long wait times.

Mechanisms are needed to identify children at risk of violence and to ensure quick and effective action to protect them, such as removing them from the harmful environment, placing them in foster families, and initiating legal procedures against the perpetrators.

### **Example indicator**

**Name** Survivors of violence access protection and tailored support services.

**Definition** Percentage of people recorded as survivors of violence, including children, survivors of gender-based violence, and individuals from at-risk groups, who receive both formal protection services (such as child protection interventions, safe housing, or legal support) and tailored mental health and social support services (for example, trauma-informed counselling, peer-support, or reintegration assistance).

**Data source(s)** Child protection and social welfare service records; gender-based violence response programme databases; shelter and safe housing intake records; mental health service intake logs; NGO reports; case management or care coordination systems.

Box 15 offers additional resources on addressing mental health from within the social protection sector.

## Box 15. Resources for addressing mental health from within the social protection sector

- Community engagement: a health promotion guide for universal health coverage in the hands of the people. <https://iris.who.int/handle/10665/334379> (456)
- Deinstitutionalization of people with mental health conditions in the WHO South-East Asia Region. <https://iris.who.int/handle/10665/376123> (457)
- From loneliness to social connection: charting a path to healthier societies: report of the WHO Commission on Social Connection. <https://iris.who.int/handle/10665/381746>.
- Guidance on community mental health services: promoting person-centred and rights-based approaches. <https://iris.who.int/handle/10665/341648> (176)
- Guidance on mental health policy and strategic action plans. Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans. <https://iris.who.int/handle/10665/380466> (25)
- One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module. <https://iris.who.int/handle/10665/329591> (305)
- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)
- Peer support groups by and for people with lived experience: WHO QualityRights guidance module. <https://iris.who.int/handle/10665/329594> (458)
- Social isolation and loneliness among older people: advocacy brief. <https://iris.who.int/handle/10665/343206> (459)
- Transition from institutional care to community-based services in 27 EU Member States: Final report. Research report for the European Expert Group on Transition from Institutional to Community-based Care. <https://deinstitutionalisationdotcom.files.wordpress.com/2020/05/eeg-di-report-2020-1.pdf> (460)
- World mental health report: transforming mental health for all. <https://iris.who.int/handle/10665/356119> (2)
- World report on social determinants of health equity. <https://iris.who.int/handle/10665/381152> (461)



# Mental health and the **urban and rural development** sector



## Overview

At the time of preparing this Guidance, more than half of the world's population already lived in urban areas, with the figure expected to rise to 70% by 2050 (462). Urbanization, the rapid increase in city dwellers and the transformation of many rural areas into urban ones, can drive economic growth and reduce poverty and inequality by creating more opportunities for employment, education, and an improved quality of life (463). However, if not properly managed, rapid urban growth can lead to significant challenges, including environmental losses, high pollution levels, increased crime, social and economic inequalities, and social exclusion, all of which damage population mental health and well-being (464).

Widespread inequities exist both within cities and between urban and rural areas. While many studies have found that people living in cities generally have better access to healthcare and often experience better overall health outcomes than those in rural areas, urban living can also be associated with increased risks for certain mental health conditions. These differences highlight significant health inequities between settings (465).

Nonetheless, people living in poor urban areas, particularly those living in informal settlements or slums, often have limited access to basic services, good-quality housing, employment and education opportunities, healthy food options, clean water, and sanitation facilities. Access to natural spaces is also limited for those in poorer urban communities (465, 466), even when such spaces are more abundant in wealthier neighbourhoods. This lack of access contributes to poorer physical and mental health outcomes, despite the urban location.

In contrast to the challenges faced in urban poor areas, people living in rural and remote settings encounter their own distinct barriers to mental healthcare. These include limited availability, lack of accessible and affordable transport, and high levels of social stigma. These inequities contribute to poorer outcomes for people needing mental health care in these communities.

Policies and strategic actions should prioritize creating sustainable, inclusive, and mentally healthy cities and human settlements where people have equitable access to basic services. These should include general and mental health services and support, quality education, employment, affordable, safe and adequate housing, efficient and accessible transportation, nutritious food, and natural spaces. Conversely, policies and strategic actions should strive to reduce health-harming factors like air, noise, and light pollution, lack of safety, housing insecurity and inadequate transport systems (467).

Urban and rural development policy therefore plays a key role in shaping environments that influence structural and social determinants of health. The Guidance highlights these critical links, recognizing that many core activities of the sector already contribute to protecting and promoting mental health.

The policy directives and strategic actions outlined in this Guidance are aligned with the UN Sustainable Development Goals, particularly SDG 11: Sustainable Cities and Communities, which addresses the challenges of increasing urbanization and aims to make cities and human settlements inclusive, safe, resilient, and sustainable. The numbering uses the prefix UR (urban and rural) to help avoid confusion when discussing policy directives for specific sectors or from other guidance.

Strategic actions can be integrated into sectoral policies, supporting both improved mental health outcomes and the broader objectives of urban and rural development. In particular, this Guidance provides strategic actions for creating sustainable, inclusive, and mentally healthy cities and human settlements, with an emphasis on housing, safe and inclusive urban and rural environments as well as access to services, mental health awareness, and overall inclusion. Their implementation will help achieve targets under SDG 11, and also contributes to other goals such as health (SDG 3), poverty reduction (SDG 1), and overall well-being.

It is important to note that the roles and responsibilities of sectors might vary from country to country and that some topics covered here in this Guidance might sometimes fall under the responsibility of a different sector. For example, issues around housing might fall under a dedicated housing sector, or might be integrated across multiple sectors. Conversely, topics addressed elsewhere in this Guidance may be relevant to the urban and rural development sector. To support navigation and help the reader find all relevant information, Fig. 1 in the Introduction to this Guidance offers a [directory of key issues](#), indicating where each is discussed.

The Guidance includes adaptable examples of indicators for strategic actions, recognizing the critical role of monitoring and evaluation in ensuring accountability and driving continuous improvement. Clear, measurable indicators let sectors track progress, assess impact, and determine whether intended outcomes are being achieved. For more general health and equity indicators related to the work and responsibilities of each sector see Table 3 in [Operational framework for monitoring social determinants of health equity \(23\)](#).

## Policy directive UR1 Create safe, affordable and accessible housing

### Strategic actions

#### 1. Subsidize housing for low-income households.

Many low-income households are finding it increasingly difficult to secure and maintain adequate housing due to rising living costs and rent (468). Housing insecurity does significant harm to mental health (438). Low-income households often include young adults in education, single-parent families, older adults, and people with disabilities or mental health conditions. Indeed, many people with mental health conditions or psychosocial disabilities are houseless or live in insecure housing situations (440). The urban and rural development sector, in collaboration with other relevant sectors, has a crucial role in addressing this issue by creating subsidized housing options, including direct housing subsidies, rent supplements and vouchers, non-profit housing and co-operative housing (469). It is important that these housing opportunities are available across all neighbourhoods and are prioritized for low-income households, particularly those with mental health conditions or psychosocial disabilities. For further discussion, see Mental health and the social protection sector in this Guidance.

#### Example indicator

**Name** Subsidized housing support for low-income households.

**Definition** Percentage of eligible individuals or households, including those with mental health conditions or psychosocial disabilities, that receive housing subsidies such as rent supplements, housing vouchers, public or non-profit housing or other forms of financial housing assistance designed to ensure stable and affordable living conditions.

**Data source(s)** Housing subsidy programme registries; rent voucher distribution logs; municipal housing authority records; social service case management systems.

## 2. Create fair and non-discriminatory housing laws including for people with mental health conditions.

The urban and rural development sector has a crucial role in ensuring fair housing access for everyone, including people with mental health conditions or psychosocial disabilities, who often face discrimination in this area (470). Key actions can include the following.

- **Prohibiting housing discrimination.** All forms of discrimination in housing should be prohibited, whether when renting or buying a home, applying for a mortgage, or seeking housing assistance.
- **Providing reporting mechanisms.** There should be easy and accessible ways for people to report housing discrimination, harassment, or rights violations. There should also be support for people who may need help in filing complaints, such as people with disabilities or those with limited language skills.
- **Offering redress.** Ensuring redress for people who have experienced housing discrimination is essential for a fair housing market. Redress can include compensation, reinstatement of housing opportunities, public apologies, penalties for discriminatory landlords, and access to legal aid.

It is also important to address gentrification, where upgrades to housing push up rents and living costs, potentially displacing financially-vulnerable residents. This displacement can harm mental health, causing stress, anxiety, and insecurity (471). Urban planners can carefully assess the impact of gentrification and work to mitigate its downsides, for example by implementing affordable housing policies, protecting long-term residents from displacement, and involving local communities in shaping improvements to ensure they benefit everyone.

### Example indicator

**Name** Fair and non-discriminatory housing law.

**Definition** Achieved if national or subnational housing legislation explicitly prohibits discrimination, including on grounds of mental health conditions, and if an accessible reporting and redress mechanism has been established.

**Data source(s)** National or local housing legislations and regulatory frameworks; reports from housing authorities and human rights commissions; programme operation and accessibility reports; complaint and redress system records; demographic coverage audits.

### **3. Address housing health and safety risks in low-income or vulnerable communities that lead to poor mental and physical health.**

Living in unsafe or unhealthy housing can lead to serious mental and physical health problems. The main risk factors include: household crowding; low indoor temperatures and poor insulation; high indoor temperatures; injury hazards; inadequate or dangerous energy supply; poor accessibility; inadequate clean water supply; poor indoor air quality; noise; and contamination including from mould and asbestos (472).

Unsafe housing contributes to increased emotional distress and mental health issues and people with existing mental health conditions or disabilities are more likely to live in these high-risk environments, worsening their conditions (473). To improve safety, building control policies need to be developed and consistently enforced, with inspections to ensure that identified risks in residential and commercial buildings are addressed and that new buildings meet high health and safety standards. This includes buildings where people with low incomes or those with mental health conditions and disabilities may reside.

Furthermore, buildings should incorporate architectural or design features that deter suicide attempts and reduce the risk of accidents. Measures might include installing rooftop barriers, limiting window openings at certain heights above the ground, and eliminating potential ligature points (46, 474). For in-depth guidance on addressing housing-related health and safety hazards see [WHO housing and health guidelines](#) (472).

#### **Example indicator**

**Name** Housing health and safety risk remediation.

**Definition** Percentage of residential units in low-income or vulnerable communities that have undergone a formal health and safety assessment and have and have had all serious hazards identified during the assessment fully remediated.

**Data source(s)** Housing inspection and environmental health audit reports; remediation work order and contractor completion logs; municipal housing compliance certification records; social service or public health department databases.

### **4. Create assistance programmes and support for people who are houseless or face housing insecurity.**

Cross-sector collaboration, particularly with the social protection sector, is essential for creating effective assistance programmes and support for people who are houseless or face housing insecurity.

Numerous studies have shown that houselessness is closely linked to poor mental health outcomes, including high levels of emotional distress, anxiety, depression, substance use, and psychological trauma (475). People with diagnosed mental health conditions or psychosocial disabilities are especially vulnerable to houselessness (440). They often face significant difficulties and discrimination when seeking adequate and accessible housing. This discrimination within mainstream accommodation is compounded by the lack of supported or subsidized housing options (476).

When developing assistance programmes for people who are houseless or face housing insecurity, it is crucial to ensure that services are readily available and accessible to people with mental health conditions or psychosocial disabilities. These services should be distributed equitably to ensure broad access.

Collaborations with the mental health and social protection sectors can: establish community outreach services that directly support people in need within their communities; crisis lines that offer immediate crisis support through easily accessible phone or online services; shelters and community services that provide temporary housing, that connect people to social or subsidized housing opportunities, and that offer financial and job counseling; and referrals to rights-based mental health services and support.

By focusing on collaborative efforts, it is possible to improve mental health for people experiencing homelessness or housing insecurity and work toward more equitable and supportive communities. For further discussion, refer to Mental health and the social protection sector within this Guidance, and [World report on social determinants of health equity \(461\)](#).

**Example indicator**

**Name** Assistance programmes for people experiencing homelessness or housing insecurity.

**Definition** Percentage of people identified as homeless or unstably housed who receive a coordinated package of support services such as community outreach, crisis line support, temporary shelter placement, referral to housing, or psychosocial support.

**Data source(s)** Homelessness service registries; outreach programme logs; crisis response logs; shelter intake and referral records.

**5. Develop accessible housing for people with mental health conditions and disabilities.**

Access to adequate housing is recognized as a basic human right in multiple international human rights instruments ([1](#), [477](#), [478](#)). This right is further reinforced by SDG 11, which aims to make cities and human settlements inclusive, safe, and accessible for all ([15](#)). Despite these commitments, people with mental health conditions or disabilities, including those with psychosocial disabilities, often struggle to find housing that meets their needs. Housing barriers prevent them from living independently and fully participating in their communities ([479](#)).

The urban and rural development sector can collaborate with other sectors and stakeholders (including the social protection sector, mental health services and local authorities), to improve access to inclusive housing. A key action is to integrate the housing needs of persons with disabilities into urban and rural planning activities. This can be achieved through policy and strategic planning. For example, building regulations covering design and construction of new buildings, and renovations of existing residential spaces, could specify accessibility features. Some aspects should be universal, while other features can be tailored to buildings designed for specific groups, such as housing for people with sensory or mobility impairments. Regulations might cover standards on ramped entrances, elevators, automatic doors, and other accommodations for people with limited mobility, as well as adaptations for people with sensory impairments such as visual and auditory impairments.

The urban and rural development sector can also collaborate with other stakeholders (including from mental health services and social protection) to ensure that people with psychosocial disabilities and mental health conditions have access to long-term support options alongside accessible and affordable housing. These provisions should focus on ensuring basic needs are met, promoting independence and people's full inclusion in the community.

Importantly, creating accessible and inclusive housing does not only provide good quality physical infrastructure. It is also foundational to mental health and well-being. When people with disabilities live in built environments that support their autonomy, mobility, and dignity, they are more likely to experience improved mental health outcomes, reduced isolation, and greater overall life satisfaction (480). A good practice model of this approach is Ireland's [National Housing Strategy for Disabled People \(2022–2027\)](#) (481).

**Example indicator**

**Name** Accessible housing for people with disabilities.

**Definition** Percentage of newly built or renovated housing units that comply with enhanced accessibility standards ensuring suitability for people with disabilities. These might include provision of ramps, elevators, automatic doors, and sensory aids.

**Data source(s)** Building permit and architectural plans registry; housing inspection and compliance records; accessibility certification registers; urban development and zoning reports from local authorities.

## Policy directive UR2 Create healthy, safe and inclusive environments that foster mental health and well-being in urban and rural areas

### Strategic actions

#### 1. Incorporate access to urban nature.

Improving access to nature, such as street trees, flowers, urban gardens, views of natural environments from windows, pocket parks, water features, and walkable green areas, is crucial for enhancing both general health and mental well-being (213, 482). Urban nature benefits mental health by promoting physical exercise, encouraging outdoor activities that benefit both body and mind, helping people relax and lower their stress levels, and enhancing social connections, thereby strengthening community ties and social cohesion (483). SDG 11 target 11.7 aims to “provide universal access to safe, inclusive, and accessible green and public spaces” in cities and communities by 2030 (462).

However, such spaces need to be well-designed and generally need maintaining. Without careful implementation, natural spaces can also pose safety risks (for example drowning risks in ponds), can contribute to higher crime rates (for example if they lack lighting), or, paradoxically, they can even increase property values beyond general affordability.

**Example indicator**

**Name** Accessible natural spaces in all neighbourhoods.

**Definition** Percentage of neighbourhoods that have at least one publicly accessible natural space or feature (for example, parks, street trees, community garden, waterfronts, ponds).

**Data source(s)** Municipal planning records and land use maps; local authorities park and green spaces inventories; public work maintenance records; geographic information system (GIS) analyses of natural space coverage.

## **2. Create accessible opportunities for exercise and physical activity for all, including for people with mental health conditions or with disabilities.**

Physical activity is linked to many positive outcomes for physical and mental well-being. Mental health benefits include improving mood, boosting self-esteem, reducing depression and anxiety, and even helping with symptoms of dementia ([219](#), [467](#), [484](#), [485](#)). Therefore, it is essential to promote physical activity among all age groups in urban and rural design policies. For example, physical activity in public spaces can be encouraged by creating safe and well-maintained walking paths and pedestrian lanes for active transport, installing stepped paths, walking loops, outdoor gyms, and playgrounds in parks, and providing dedicated spaces like football fields, tennis courts, and running routes in communities. When designing these spaces, it is important to consider all age groups, demographics, and people with disabilities, including those with psychosocial disabilities, to ensure that everyone has accessible and inclusive options for physical activity.

### **Example indicator**

**Name** Accessible exercise and physical activity infrastructure in communities.

**Definition** Percentage of neighbourhoods that have at least one accessible service or space for exercise and physical activity (such as walking paths, outdoor gyms, playgrounds, or sports fields) that are designed for all users, including people with mental health conditions and with disabilities.

**Data source(s)** Municipal planning documents and recreational infrastructure maps; public space and service inventories; accessibility audit records or universal design compliance logs.

## **3. Enhance safety and security through urban and rural design.**

Promoting safety and security through thoughtful urban and rural planning is essential for improving mental health and well-being. Exposure to crime or even the fear of crime can lead to chronic stress, anxiety, and reduced quality of life ([486](#)). Urban and rural development can play a key role in addressing this by implementing concepts such as Crime Prevention Through Environmental Design, which uses strategic design of public spaces and buildings, landscaping, lighting, and visibility to deter criminal behaviour and foster safer environments. This approach has been widely studied and shown to be effective in reducing violent crime, decreasing fear of crime, and enhancing perceived safety and community well-being in both large densely populated urban areas and local community settings ([487-489](#)).

Road safety is another critical aspect. Poorly designed and unsafe road infrastructure, high traffic density, and inadequate enforcement of traffic laws and regulations increase the risk of road traffic accidents, which are not only a major cause of physical injury but are also associated with a significant and long-term mental health impacts ([490](#)). It is therefore essential to prioritize road safety in urban and rural planning and, in collaboration with the health and mental health sectors, establish mechanisms to provide immediate and sustained access to good quality physical and mental health support for people involved in traffic accidents ([491](#)).

When individuals can move through their environment with confidence and clarity, it reinforces a sense of orientation, autonomy, and emotional security ([492](#), [493](#)). Environments that are difficult to navigate can contribute to feelings of confusion, frustration, disorientation and insecurity, especially for older adults, children, and people with disabilities, including those with psychosocial disabilities. To support mental health and well-being, urban and rural planning should prioritize legible and accessible wayfinding systems, such as clear signage, inclusive mapping in multiple languages and formats, and pedestrian-friendly infrastructure. Even within buildings, good design standards can help people orientate themselves, which can be particularly important during emergencies.

**Example indicator**

**Name** Safety-focused urban and rural design measures.

**Definition** Percentage of neighbourhoods where public spaces have undergone a formal safety and security design assessment and have implemented recommended environmental improvements (for example, adequate lighting, clear signage, unobstructed sightlines, accessible pathways).

**Data source(s)** Urban and rural planning safety audit reports; Crime Prevention Through Environmental Design assessment records; municipal or regional public space improvement logs; community safety feedback or perception surveys.

#### 4. Mitigate pollution and improve access to sustainable water and sanitation systems.

Air, noise, and light pollution are significant contributors to poor mental and physical health, leading to problems such as disturbed sleep, increased stress and even depression ([199](#), [200](#), [217-219](#), [482](#)). Experiencing water insecurity and inadequate sanitation also harms health, including mental health, resulting in higher levels of stress, depression, and anxiety ([201](#), [202](#)). Urban planners, in close collaboration with the environmental sector, have long employed various strategies to mitigate air, noise, and light pollution.

Actions for air quality include enforcing emission regulations, creating low emission zones, separating residential from industrial areas, and increasing active and public transport.

For noise pollution, maximum sound levels, time limits construction work, building insulation standards, protective infrastructures such as street trees and walls are often used.

To address light pollution, streetlights may be shielded from above, illuminated advertisements may be restricted in residential zones. Clean energy technologies also enable better lighting design, such as dimmable LED streetlights. Together, these improvements contribute to healthier, quieter, and more restful environments that promote mental well-being.

Furthermore, programmes within the urban and rural development sector that improve access to clean water, sanitary facilities, and sustainable waste disposal and recycling systems play a crucial role in enhancing physical health and also, in a less direct way, mental health and well-being ([494](#)).

For a related discussion, see Mental health and the environment, conservation, and climate protection sector in this Guidance, particularly Policy directive ECC2.

**Example indicator**

**Name** Neighbourhoods with pollution mitigation and sustainable WASH infrastructure.

**Definition** Percentage of neighbourhoods that have implemented at least one large scale environmental pollution mitigation measure (targeting air, noise, or light pollution) and provide reliable access to clean drinking water, safe sanitation facilities, and sustainable waste management or recycling systems.

**Data source(s)** Municipal or regional environmental programme records; water and sanitation infrastructure inventories; pollution monitoring logs; waste management and recycling service reports.

## Policy directive UR3 Planning that fosters community engagement, access to services, mental health awareness, and overall inclusion

### Strategic actions

#### 1. Expand inclusive, accessible commuting and navigation.

Urban and rural planning promotes both mental and physical health when it enhances accessibility, encourages active commuting, and improves ease of navigation, particularly for people with disabilities.

Many countries are making efforts to improve urban walk-ability and bike-ability by creating protected and well-maintained bike lanes, sidewalks, pedestrian areas, and walkways etc. Some are providing public bikes or bike-sharing opportunities. These initiatives not only make cities more navigable but also contribute to significant mental health benefits, such as reducing stress and enhancing overall well-being (234, 495, 496). Continuing collaboration with other sectors can expand such efforts and support broader health benefits.

Some areas have upgraded navigation infrastructure in either indoor or outdoor settings, including well-positioned signage, clear public transportation indicators, and accessible public maps. This can give people a greater sense of safety and agency. Making these enhancements more widely available would further improve mental well-being. See also the Strategic action on enhancing safety and security through urban and rural design under Policy directive UR2.

There has been progress in creating more inclusive environments for people with disabilities although challenges remain. Many countries are taking steps to make public buildings, services and transportation infrastructure more accessible. Supports might include well-maintained and functioning ramps, elevators, visual and auditory aids, and professional assistance, including guides and sign language interpreters. People with hidden disabilities are increasingly recognized as needing support, with initiatives like the Hidden Disability Sunflower enabling discrete communication of their needs (497). Subsidized or free transport options for people with disabilities, including those with psychosocial disabilities and mental health conditions, can reduce financial barriers and so promote social inclusion (304). Additionally, transport personnel are increasingly receiving disability awareness and anti-stigma training, helping to address discrimination and improve the support they offer. All these initiatives are crucial in ensuring that everyone, regardless of ability, can navigate their communities with confidence and ease. By expanding inclusive transport strategies, as emphasized in the SDGs (15), the urban and rural planning sector can further enhance these improvements.

Importantly, despite the CRPD Article 9 mandate for equal access to the physical environment, transportation, and public services, many people with disabilities, including those with mental health conditions, continue to face barriers (498). In many rural or remote places in particular, transport systems remain inaccessible, unaffordable or simply are too scarce to be effective. This limits people's participation in social and economic life, raising the risks of social isolation, loneliness, and poor mental health.

**Example indicator**

**Name** Inclusive commuting and navigation infrastructure.

**Definition** Percentage of neighbourhoods that have implemented a network of inclusive commuting and navigation features designed to support equitable mobility and enhance well-being and mental health. These might include continuous protected bike lanes, accessible sidewalks, tactile paving, real-time transport information, audible crossing signals, and clear multilingual signage and public maps.

**Data source(s)** Municipal transportation and infrastructure registries; accessibility audit reports; bike-share, sidewalk, and public transport network inventories; public transport usage log; NGOs and OPDs reports.

## **2. Foster mental health through accessible, well-maintained community spaces and social interaction.**

Having spaces where people can gather, connect, and participate in cultural activities is essential for mental health. Regular, meaningful social interaction can boost self-esteem, overall well-being, and reduce feelings of anxiety, isolation and loneliness. Additionally, staying connected to a community can benefit cognitive functioning and intellectual performance ([330–332](#), [430](#), [431](#)). Cities and communities should be designed to facilitate social interaction, connectedness, and belonging. For example, community centres can be established as multi-use public spaces where people engage in social, recreational, and cultural activities. Public parks and gardens can be welcoming outdoor areas where residents can relax and meet. Providing street benches, inviting shop fronts, and neighbourhood amenities can encourage people to interact and feel part of a lively community. By developing accessible spaces, a stronger sense of community can be cultivated, thereby enhancing mental health and well-being across the population.

**Example indicator**

**Name** Accessible community spaces for social interaction.

**Definition** Percentage of neighbourhoods with at least one publicly accessible, well-maintained communal space, such as a community center, plaza, library, or multipurpose hall, that regularly hosts inclusive social activities to foster mental health.

**Data source(s)** Municipal public space and service inventories; community event calendars; service maintenance and accessibility records.

### 3. Plan needs-based funding to address inequities within cities and between urban and rural areas.

Socioeconomic status, neighbourhood, and other population characteristics drive substantial health inequities within and between human settlements in urban and rural areas. For example, health and mental health services and support can vary greatly between neighbourhoods within cities, while access tends to be even more limited in rural areas. The lack of services significantly affects health outcomes (465, 499).

Disparities in educational and social services parallel those in mental health and general health services, with significant differences existing between urban and rural areas and among neighbourhoods within cities. For instance, urban areas and higher-income neighbourhoods often have better access to high-quality education and childcare services compared with less affluent or rural areas (500). This inequitable access disadvantages students from rural areas, especially groups that face discrimination, in terms of social, economic, and health outcomes, including mental health.

Urban and rural development policy, in collaboration with relevant sectors, can focus on needs-based funding to ensure that mental health and psychosocial services are allocated based on specific needs, rather than solely on population size. This approach better-serves rural and remote areas. Additionally, integrating mental health services into primary care settings or co-locating physical and mental health services can maximize resource efficiency, improve care quality, reduce stigma, and encourage more individuals to seek help. Expanding access to telehealth and digital services and supporting mobile outreach teams are also critical strategies for effectively serving rural and remote areas (499).

Urban and rural planning can also facilitate a fair distribution of educational, childcare, and social services across all regions, providing equal opportunities for all, regardless of their location (501). By focusing on these measures, disparities can be reduced, promoting better mental health, educational, and social outcomes for all communities, in alignment with international human rights instruments and the SDGs.

#### Example indicator

**Name** Equitable access to health, mental-health, and social services.

**Definition** Percentage of urban and rural regions that demonstrate no significant disparities in the geographic availability and accessibility of mental health, general health, and social services across neighborhoods.

**Data source(s)** Service coverage and service location audits; health and social services GIS mapping and access models; equity assessment reports; population surveys on unmet service needs or barriers to access.

#### 4. Implement suicide prevention programmes for at-risk populations.

Research consistently shows that suicide rates are higher in rural areas than in urban regions. Certain groups, such as farmers (502), miners (503), and indigenous populations (504) are at particularly high risk. Farmers can face specific circumstances that challenge their mental health and well-being, including social isolation, long working hours, and variable income due to unpredictable environmental and economic conditions. Additionally, farming communities are often reluctant to seek help during emotional distress or mental health crises (502).

It is crucial to develop and implement culturally competent suicide prevention initiatives, focusing on at-risk populations such as indigenous populations and farming and mining communities, where suicide rates are particularly high. Programmes must address the specific mental health and psychosocial challenges these populations face. They should also address access to means of suicide, such as firearms and pesticides, as studies have shown strong association between access to those means and higher suicide rates in rural populations (505, 506). Suicide prevention programmes should also provide culturally competent and acceptable care and support for people experiencing suicidal ideation, for survivors of suicide and for family members. Local community-based services or community-led initiatives can offer low-threshold support for people who might be reluctant to turn to a medical professional for help.

##### Example indicator

**Name** Suicide prevention programmes for high-risk populations.

**Definition** Percentage of identified high-risk population groups in rural, remote, and urban areas that have access to suicide prevention programmes tailored to their specific cultural, social, and geographic needs.

**Data source(s)** National suicide prevention programme registry; service delivery and outreach coverage reports; demographic and geographic programme participation records.

Box 16 offers additional resources on addressing mental health from within the urban and rural development sector.

## Box 16. Resources for addressing mental health from within the urban and rural development sector

- A guide to urban health strategy, forthcoming 2025. (507)
- City leadership for health and sustainable development: critical issues for successful Healthy Cities initiatives in the WHO European Region. <https://iris.who.int/handle/10665/378637> (508)
- Creating healthy cities. <https://www.who.int/activities/creating-healthy-cities> (232)
- Disability, accessibility and sustainable urban development. <https://social.desa.un.org/issues/disability/disability-issues/disability-accessibility-and-sustainable-urban-development> (479)
- Fair play: building a strong physical activity system for more active people. <https://iris.who.int/handle/10665/346169> (485)
- From loneliness to social connection: charting a path to healthier societies: report of the WHO Commission on Social Connection. <https://iris.who.int/handle/10665/381746>.
- Green and blue spaces and mental health: new evidence and perspectives for action. <https://iris.who.int/handle/10665/342931> (483)
- Integrating health in urban and territorial planning: a sourcebook. <https://iris.who.int/handle/10665/331678> (482)
- LIVE LIFE: An implementation guide for suicide prevention in countries. <https://www.who.int/publications/i/item/9789240026629> (46)
- Make your city child friendly. <https://www.childfriendlycities.org/> (509)
- Nature-based solutions and health. <https://iris.who.int/handle/10665/381437> (213)
- Operational framework for monitoring social determinants of health equity. <https://iris.who.int/handle/10665/375732> (23)
- Pan African action plan for active mobility. <https://wedocs.unep.org/20.500.11822/46513> (510)
- Promoting walking and cycling: a toolkit of policy options. <https://iris.who.int/handle/10665/381335> (234)
- Regional laboratory on urban governance for health and well-being. <https://ughw.org/> (511)
- Toolbox for spatial analysis on urban health. Toolbox I: Indicator, index and metrics of urban health variables. <https://hn303.github.io/eMCities-spatial-toolbox/> (512)
- Urban design for health: inspiration for the use of urban design to promote physical activity and healthy diets in the WHO European Region. <https://iris.who.int/handle/10665/361995> (219)
- Urban planning for health: experiences from 12 European cities on building resilience. <https://www.cityknow-how.com/urban-planning-for-health-experiences-from-12-european-cities-on-building-resilience/> (513)
- WHO European healthy cities network. <https://www.who.int/europe/groups/who-european-healthy-cities-network> (236)
- WHO housing and health guidelines. <https://apps.who.int/iris/handle/10665/276001> (472)
- World report on social determinants of health equity. <https://iris.who.int/handle/10665/381152> (461)



# References<sup>2</sup>

1. Convention on the Rights of Persons with Disabilities (A/RES/61/106). New York: United Nations, General Assembly; 2006 (<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html>).
2. World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/356119>). License: CC BY-NC-SA 3.0 IGO.
3. Marginalized groups. In: Glossary & Thesaurus [website]. Vilnius: European Institute for Gender Equality; n.d. (<https://eige.europa.eu/thesaurus/terms/1280?lang=en>).
4. Human rights-based approach. In: United Nations Sustainable Development Group [website]. New York: United Nations Sustainable Development Group; n.d. (<https://unsdg.un.org/2030-agenda/universal-values/human-rights-based-approach>).
5. Ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people. New York/Geneva: World Health Organization; 2015 (<https://www.who.int/news/item/29-09-2015-ending-violence-and-discrimination-against-lesbian-gay-bisexual-transgender-and-intersex-people>). License: CC BY-NC-SA 3.0 IGO.
6. One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module: module slides. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329643>) 31 May 2023. License: CC BY-NC-SA 3.0 IGO.
7. Boardman J, Dave S. Person-centred care and psychiatry: some key perspectives. *BJPsych Int.* 2020;17:65–8 (<https://doi.org/10.1192/bjpi.2020.21>).
8. Recovery and the right to health: WHO QualityRights core training: mental health and social services: course guide. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329577>). License: CC BY-NC-SA 3.0 IGO.
9. Link BG, Phelan JC. Conceptualizing stigma. *Annual review of Sociology.* 2001;27:363–85 (<https://doi.org/10.1146/annurev.soc.27.1.363>).
10. Mental health, disability and human rights: WHO QualityRights core training - for all services and all people: course guide. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329546>). License: CC BY-NC-SA 3.0 IGO.
11. Closing the gap in a generation: health equity through action on the social determinants of health – Final report of the commission on social determinants of health. Geneva: World Health Organization; 2008 ([https://iris.who.int/bitstream/handle/10665/69832/WHO\\_IER\\_CSDH\\_08.1\\_eng.pdf?sequence=1](https://iris.who.int/bitstream/handle/10665/69832/WHO_IER_CSDH_08.1_eng.pdf?sequence=1)) 10 December 2024.
12. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), article 12: Equal recognition before the law; p. 27 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>).
13. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), article 12: Equal recognition before the law; para. 29 (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>).
14. Report of the Special Rapporteur on the rights of persons with disabilities; Catalina Devandas Aguilar, 12 December 2017; para. 27 (A/HRC/37/56). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/en/A/HRC/37/56>).
15. The 17 Sustainable Development Goals. In: Sustainable Development Goals [website]. Geneva United Nations Sustainable Development Goals; n.d. (<https://sdgs.un.org/goals>).
16. Social determinants of mental health. Geneva: World Health Organization; 2014 (<https://iris.who.int/handle/10665/112828>). License: CC BY-NC-SA 3.0 IGO.
17. Campion J, Javed A, Lund C, Sartorius N, Saxena S, Marmot M et al. Public mental health: required actions to address implementation failure in the context of COVID-19. *Lancet Psychiatry.* 2022;9:169–82 ([https://doi.org/10.1016/S2215-0366\(21\)00199-1](https://doi.org/10.1016/S2215-0366(21)00199-1)).
18. Bloom D, Cafiero E, Jane-Llopis E, et al. The global economic burden of non-communicable diseases Geneva: World Economic Forum; 2011 ([https://www3.weforum.org/docs/WEF\\_Harvard\\_HE\\_GlobalEconomicBurdenNonCommunicableDiseases\\_2011.pdf](https://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf)).
19. International Bill of Human Rights. New York: United Nations, General Assembly; 1996 (<https://www.ohchr.org/en/what-are-human-rights/international-bill-human-rights>).
20. Guidance on mental health policy and strategic action plans: module 3: process for developing, implementing, and evaluating mental health policy and strategic action plans. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/380467>). License: CC BY-NC-SA 3.0 IGO.
21. Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P et al. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry.* 2018;5:357–69 ([https://doi.org/10.1016/S2215-0366\(18\)30060-9](https://doi.org/10.1016/S2215-0366(18)30060-9)).
22. Pathways to Wellbeing – National Mental Health Promotion Plan 2024–2030 Dublin: Department of Health, Government of Ireland; 2024 (<https://www.gov.ie/en/department-of-health/publications/pathways-to-wellbeing-national-mental-health-promotion-plan/>).
23. Operational framework for monitoring social determinants of health equity. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/375732>). License: CC BY-NC-SA 3.0 IGO.
24. Guidance on mental health policy and strategic action plans: module 1: introduction, purpose and use of the guidance. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/380465>). License: CC BY-NC-SA 3.0 IGO.

<sup>2</sup> All references were accessed on 26 August 2025.

25. Guidance on mental health policy and strategic action plans: module 2: key reform areas, directives, strategies, and actions for mental health policy and strategic action plans. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/380466>). License: CC BY-NC-SA 3.0 IGO.
26. Guidance on mental health policy and strategic action plans: module 4: country case scenarios. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/380468>). License: CC BY-NC-SA 3.0 IGO.
27. Guidance on mental health policy and strategic action plans: module 5: comprehensive directory of policy areas, directives, strategies and actions for mental health. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/380469>). License: CC BY-NC-SA 3.0 IGO.
28. Fitter minds, fitter jobs : from awareness to change in integrated mental health, skills and work policies. Chapter 1: What does a mental health-in-all-policies approach look like? Paris: Organisation for Economic Cooperation and Development 2021.
29. Investing in mental health: evidence for action. Geneva: World Health Organization; 2013 (<https://iris.who.int/handle/10665/87232>). License: CC BY-NC-SA 3.0 IGO.
30. Mental health investment case: a guidance note. Geneva: World Health Organization & United Nations Development Programme; 2021 (<https://iris.who.int/handle/10665/340246>). License: CC BY-NC-SA 3.0 IGO.
31. Knapp M, Wong G. Economics and mental health: the current scenario. *World Psychiatry*. 2020;19:3–14 (<https://doi.org/10.1002/wps.20692>).
32. A new benchmark for mental health systems: tackling the social and economic costs of mental ill-health. Chapter 6: strong leadership and good governance. Paris: Organisation for Economic Cooperation and Development 2021 ([https://www.oecd-ilibrary.org/social-issues-migration-health/a-new-benchmark-for-mental-health-systems\\_4ed890f6-en](https://www.oecd-ilibrary.org/social-issues-migration-health/a-new-benchmark-for-mental-health-systems_4ed890f6-en)).
33. Un chez soi d'abord. In: Ministère de la Transition écologique et de la Cohésion des territoires [website]. Paris: Ministère de la Transition écologique et de la Cohésion des territoires; 2020 (<https://www.ecologie.gouv.fr/chez-soi-dabord>).
34. Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/345301>). License: CC BY-NC-SA 3.0 IGO.
35. Guidance and technical packages on community mental health services. In: World Health Organization [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services>).
36. Mental health, human rights and legislation: guidance and practice. Geneva: World Health Organization and the United Nations (represented by the Office of the United Nations High Commissioner for Human Rights); 2023 (<https://iris.who.int/handle/10665/373126>). License: CC BY-NC-SA 3.0 IGO.
37. Thornicroft G. Stigma and discrimination limit access to mental health care. *Epidemiol Psychiatr Soc*. 2008;17:14–9 (<https://doi.org/10.1017/S1121189X00002621>).
38. Drew N, Funk M, Tang S, Lamichhane J, Chávez E, Katontoka S et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *Lancet*. 2011;378:1664–75 ([https://doi.org/10.1016/S0140-6736\(11\)61458-X](https://doi.org/10.1016/S0140-6736(11)61458-X)).
39. Mfoafo-M'Carthy M, Huls S. Human rights violations and mental illness: implications for engagement and adherence. *SAGE Open*. 2014;1–18 (<https://doi.org/10.1177/2158244014526209>).
40. Bündnispartner. In: Ein starkes Netzwerk [website]. Berlin: Aktionsbündnis Seelische Gesundheit; n.d. (<https://www.seelischegesundheit.net/aktionsbuenndnis/buendnispartner/>).
41. Longden E, Read J. People with problems, not patients with illnesses: Using psychosocial frameworks to reduce the stigma of psychosis. *Isr J Psychiatry Relat Sci*. 2017;54:24–30 (<https://pubmed.ncbi.nlm.nih.gov/28857755/>).
42. Chisholm D, Docrat S, Abdulmalik J, Alem A, Gureje O, Gureje D et al. Mental health financing challenges, opportunities and strategies in low- and middle-income countries: findings from the Emerald project. *BJPsych Open*. 2019;5:e68 (<https://doi.org/10.1192/bjo.2019.24>).
43. Financing mental health: the current situation and ways forward. London: United for Global Mental Health; 2023 (<https://unitedgmh.org/app/uploads/2023/10/Financing-of-mental-health-V2.pdf>).
44. Health in all policies: training manual. Geneva: World Health Organization; 2015 (<https://www.who.int/publications/i/item/9789241507981>). License: CC BY-NC-SA 3.0 IGO.
45. Implementing health in all policies: a pilot toolkit. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/366435>). License: CC BY-NC-SA 3.0 IGO.
46. LIVE LIFE: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/341726>). License: CC BY-NC-SA 3.0 IGO.
47. Mental health and wellbeing strategy 2025 to 2035. Cardiff: Welsh Government; 2025 (<https://www.gov.wales/mental-health-and-wellbeing-strategy-2025-2035>).
48. WHO policy brief on the health aspects of decriminalization of suicide and suicide attempts. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/372848>). License: CC BY-NC-SA 3.0 IGO.
49. Dow R, Warran K, Letrondo P, Fancourt D. The arts in public health policy: progress and opportunities. *Lancet Public Health*. 2023;8:e12–e8 ([https://doi.org/10.1016/S2468-2667\(22\)00313-9](https://doi.org/10.1016/S2468-2667(22)00313-9)).
50. Heritage, mental health and well-being. Brief report from the UK National Commission for UNESCO and PRAXIS at the University of Leeds. *Heritage and Our Sustainable Future*, issue 6. London: UNESCO UK; 2021 (<https://unesco.org.uk/resources/mental-health-and-wellbeing-report>).

51. Fancourt D, Finn S. What is the evidence on the role of the arts in improving health and well-being? A scoping review. Geneva: WHO Regional Office for Europe; 2019 (<https://iris.who.int/handle/10665/329834>).
52. Global action plan on physical activity 2018–2030: more active people for a healthier world. Geneva: World Health Organization & United Nations Development Programme; 2018 (<https://iris.who.int/handle/10665/272722>). License: CC BY-NC-SA 3.0 IGO.
53. Eather N, Wade L, Pankowiak A, Eime R. The impact of sports participation on mental health and social outcomes in adults: a systematic review and the 'mental health through sport' conceptual model. *Syst Rev*. 2023;12:102 (<https://doi.org/10.1186/s13643-023-02264-8>).
54. Cultural heritage. In: Glossary [website]. Montreal: UNESCO Institute of Statistics; n.d. (<https://uis.unesco.org/en/glossary-term/cultural-heritage>).
55. Rivera-Segarra E, Mascayano F, Alnasser L, et al. Global mental health research and practice: a decolonial approach. *Lancet Psychiatry*. 2022;9:595–600 ([https://doi.org/10.1016/S2215-0366\(22\)00043-8](https://doi.org/10.1016/S2215-0366(22)00043-8)).
56. Gurbuz-Dogan RN, Ali A, Candy B, King M. The effectiveness of Sufi music for mental health outcomes. A systematic review and meta-analysis of 21 randomised trials. *Complement Ther Med*. 2021;57:102664 (<https://doi.org/10.1016/j.ctim.2021.102664>).
57. Promoting mental health literacy in rural and urban India. In: Promoting mental health literacy in rural and urban India [website]. Mumbai: Mental Health Literacy Project India Foundation; n.d. (<https://www.mehelp.in/>).
58. Mehl-Madrona L, Mainguy B. Introducing healing circles and talking circles into primary care. *Perm J*. 2014;18:4–9 (<https://doi.org/10.7812/TPP/13-104>).
59. Heritage, health and wellbeing. A Heritage Alliance report. London: The Heritage Alliance; 2020 ([https://www.theheritagealliance.org.uk/wp-content/uploads/2020/10/Heritage-Alliance-AnnualReport\\_2020\\_Online.pdf](https://www.theheritagealliance.org.uk/wp-content/uploads/2020/10/Heritage-Alliance-AnnualReport_2020_Online.pdf)).
60. Griffith DM, Semlow AR. Art, anti-racism and health equity: „don't ask me why, ask me how!". *Ethn Dis*. 2020;30:373–80 (<https://doi.org/10.18865/ed.30.3.373>).
61. Chapter 2 culture counts: the influence of culture and society on mental health. In: Office of the Surgeon General (US), Center for Mental Health Services (US), National Institute of Mental Health (US), editors. *Mental health: culture, race, and ethnicity: a supplement to mental health: a report of the surgeon general*. Rockville: Substance Abuse and Mental Health Services Administration (US); 2001.
62. Crowley K, Jackson R, O'Connell S, et al. Cultural heritage and risk assessments: gaps, challenges, and future research directions for the inclusion of heritage within climate change adaptation and disaster management. *Climate Resilience and Sustainability*. 2022;1 (<https://doi.org/10.1002/cli2.45>).
63. Pajardi D, A. DA, Gagliardini G, Pepi R, Colli A. Mental health risks for cultural heritage professionals within the framework of disaster risk reduction: an exploratory study on the emotional impact of ruins after the 2016 earthquake in central Italy. *International Journal of Disaster Risk Reduction*. 2023;92 (<https://doi.org/10.1016/j.ijdrr.2023.103705>).
64. Creative health: the arts for health and wellbeing. London: All-party parliamentary group on arts, health and wellbeing; 2017 ([https://ncch.org.uk/uploads/Creative\\_Health\\_Inquiry\\_Report\\_2017\\_-\\_Second\\_Edition.pdf](https://ncch.org.uk/uploads/Creative_Health_Inquiry_Report_2017_-_Second_Edition.pdf)).
65. Dâmaso M, Dowden S, Smith C. Culture for health and well-being compendium. A guide for practitioners. Brussels: Culture Action Europe; 2023 ([https://www.cultureforhealth.eu/app/uploads/2023/06/C4H\\_Compndium\\_V4\\_LP.pdf](https://www.cultureforhealth.eu/app/uploads/2023/06/C4H_Compndium_V4_LP.pdf)).
66. Thriving together series: music for stress relief. In: Thriving together series: music for stress relief [website]. Fairfax: Center for the Advancement of Well-Being, George Mason University; n.d. (<https://wellbeing.gmu.edu/thriving-together-series-music-for-stress-relief/>).
67. Teti M, French B, Kabel A, Farnan R. Portraits of well-being: photography as a mental health support for women with HIV. *J Creat Ment Health*. 2016;12:48–61 (<https://doi.org/10.1080/15401383.2016.1206493>).
68. Mughal R, Polley M, Sabey A, Chatterjee HJ. How arts, heritage and culture can support health and wellbeing through social prescribing. London: NASP; 2022 (<https://socialprescribingacademy.org.uk/media/5xhmkfwh/how-arts-heritage-and-culture-can-support-health-and-wellbeing-through-social-prescribing.pdf>).
69. Latimer K, Larok R, Nyeko JP, Murungi L, Luwangula R, Lukungu B et al. A sport-for-protection program reduces anxiety and depression in youth affected by displacement: A randomized controlled trial of the Game Connect program in Uganda. *J Affect Disord*. 2025;376:84–91 (<https://doi.org/10.1016/j.jad.2025.02.001>).
70. Seoul's over-65s disco 'like medicine' for seniors. In: Seoul's over-65s disco 'like medicine' for seniors [website]. London: BBC; 2019 (<https://www.bbc.com/news/av/world-asia-49448760>).
71. Borg M, Muri A, Rype A, Karlsson B. "You don't have to dribble with your thoughts alone anymore.". WAPR Bulletin 52. Milan: World Association for Psychosocial Rehabilitation; 2024 (<https://www.wapr.org/wp-content/uploads/2024/06/hr3.pdf>).
72. Carta MG, Maggiani F, Pilutzu L, Moro MF, Mura M, Cadoni F et al. Sailing for rehabilitation of patients with severe mental disorders: results of a cross over randomized controlled trial. *Clin Pract Epidemiol Ment Health*. 2014;10: 73–9 (<https://doi.org/10.2174/1745017901410010073>).
73. Special Olympics research overview. Washington, D.C.: Special Olympics; n.d. ([http://www.idso.org/idso/SOIID\\_FILES/Special-Olympics-Research-Overview%20\(1\)1.pdf](http://www.idso.org/idso/SOIID_FILES/Special-Olympics-Research-Overview%20(1)1.pdf)).
74. Social prescribing and physical activity: scoping an agenda for policy, practice and research. Sheffield: Advanced Wellbeing Research Centre; 2022 (<https://www.shu.ac.uk/centre-regional-economic-social-research/publications/social-prescribing-and-physical-activity-scoping-an-agenda-for-policy-practice-and-research>).
75. Sport for Development and Peace (SDP). New York: United Nations Department of Economic and Social Affairs; n.d. (<https://sdgs.un.org/partnerships/sport-development-and-peace-sdp>).

76. Saxena I. The need for mental health in S4D programs in India. In: International Platform on Sport and Development (sportanddev) [website]. Copenhagen: International Platform on Sport and Development (sportanddev); 2021 (<https://www.sportanddev.org/latest/news/need-mental-health-s4d-programs-india>).
77. Marks S, Mountjoy M, Marcus M. Sexual harassment and abuse in sport: the role of the team doctor. *Br J Sports Med.* 2012;46: 905–8 (<https://doi.org/10.1136/bjsports-2011-090345>).
78. Fasting K, Brackenridge CH, Sundgot-Borgen J. Prevalence of sexual harassment among Norwegian female elite athletes in relation to sport type. *Int Rev Sport Sociol.* 2004;39:373–86 (<https://doi.org/10.1177/1012690204049804>).
79. Leahy T, Pretty G, Tenenbaum G. Prevalence of sexual abuse in organised competitive sport in Australia. *J Sex Aggress.* 2002;8:16–36 (<https://doi.org/10.1080/13552600208413337>).
80. Safeguarding athletes from harassment and abuse in sport IOC Toolkit for IFs and NOCs. Lausanne: International Olympic Committee; n.d. (<https://library.olympics.com/Default/doc/SYRACUSE/171450/safeguarding-athletes-from-harassment-and-abuse-in-sport-ioc-toolkit-for-ifs-and-nocs-related-to-cre?lg=en-GB#:~:text=This%20toolkit%20aims%20to%20assist%20National%20Olympic%20Committees,safeguard%20athletes%20from%20harassment%20and%20abuse%20in%20sport.>).
81. Tackling violence against women and girls in sport: A handbook for policy makers and sports practitioners. New York: UN Women and UNESCO; 2023 (<https://www.unwomen.org/en/digital-library/publications/2023/07/tackling-violence-against-women-and-girls-in-sport-a-handbook-for-policy-makers-and-sports-practitioners>).
82. Sagoe D, Molde H, Andreassen CS, Torsheim T, Pallesen S. The global epidemiology of anabolic-androgenic steroid use: a meta-analysis and meta-regression analysis. *Ann Epidemiol.* 2014;24:383–98 (<https://doi.org/10.1016/j.annepidem.2014.01.009>).
83. Pereira E, Moyses SJ, Ignacio SA, et al. Prevalence and profile of users and nonusers of anabolic steroids among resistance training practitioners. *BMC Public Health.* 2019;19:1650 (<https://doi.org/10.1186/s12889-019-8004-6>).
84. Performing anxiety – a resource for audience-facing arts projects about mental health. Edinburgh: Scottish Mental Health Arts Festival; 2024 (<https://www.mhfestival.com/explore/performing-anxiety/>).
85. Sport Coach+ – safe and supportive sport to promote the mental health of young people affected by displacement. Lausanne and Copenhagen: Olympic Refugee Foundation and IFRC Reference Centre for Psychosocial Support; 2024 (<https://www.sportcoachplus.org/>).
86. Armed forces personnel, total. In: Data [website]. Washington, DC: The World Bank; n.d. ([https://data.worldbank.org/indicator/ms.mil.totl.pl?most\\_recent\\_value\\_desc=true](https://data.worldbank.org/indicator/ms.mil.totl.pl?most_recent_value_desc=true)).
87. Livingston WS, Tannahill HS, Meter DJ, Fargo JD, Blais RK. The association of military sexual harassment/assault with suicide ideation, plans, attempts, and mortality among US service members/veterans: a meta-analysis. *Trauma, Violence, & Abuse.* 2023;24:2616–29 (<https://doi.org/10.1177/15248380221109790>).
88. Hendriks LJ, Williamson V, Murphy D. Adversity during military service: the impact of military sexual trauma, emotional bullying and physical assault on the mental health and well-being of women veterans. *BMJ Mil Health.* 2023;169:419–24 (<https://doi.org/10.1136/bmjilitary-2021-001948>).
89. Collette TL, von Esenwein SA, Sprague-Jones J, Moore KE, Sterling E. Incidence rates of emotional, sexual, and physical abuse in active-duty military service members, 1997–2015. *Aggression and Violent Behavior.* 2022;66:101745 (<https://doi.org/10.1016/j.avb.2022.101745>).
90. Stander VA, Thomsen CJ. Sexual harassment and assault in the U.S. military: a review of policy and research trends. *Mil Med.* 2016;181:20–7 (<https://doi.org/10.7205/MILMED-D-15-00336>).
91. Prevalence of sexual assault in the military: risk and protective factors, data sources, and data uses. In: How to strengthen sexual assault prevention activities in the military [website]. Santa Monica: RAND Corporation; n.d. (<https://www.rand.org/pubs/tools/TLA746-2/handbook/resources/data-on-sexual-assault-in-the-military.html>).
92. Mengeling MA, Booth BM, Torner JC, Sadler AG. Reporting sexual assault in the military: who reports and why most servicewomen don't. *Am J Prev Med.* 2014;47:17–25 (<https://doi.org/10.1016/j.amepre.2014.03.001>).
93. Sharp M-L, Fear NT, Rona RJ, Wessely S, Greenberg N, Jones N et al. Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiol Rev.* 2015;37:144–62 (<https://doi.org/10.1093/epirev/mxu012>).
94. Real warriors campaign. In: Healthmil [website]. Falls Church: Military Health System and Defense Health Agency; n.d. (<https://www.health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/Real-Warriors-Campaign>).
95. Cuyler M, Guerrero L. Mental health help-seeking intentions and organizational climate among military members. *Military Psychology.* 2019;31:315–25 (<https://doi.org/10.1080/08995605.2019.1630229>).
96. Randles R, Finnegan A. Veteran help-seeking behaviour for mental health issues: a systematic review. *BMJ Mil Health.* 2022;168:99–104 (<https://doi.org/10.1136/bmjilitary-2021-001903>).
97. Iversen AC, van Staden L, Hacker Hughes J, Greenberg N, Hotopf M, Rona RJ et al. The stigma of mental health problems and other barriers to care in the UK Armed Forces. *BMC Health Serv Res.* 2011;11:31 (<https://doi.org/10.1186/1472-6963-11-31>).
98. Open arms – veterans & families counselling. In: Australian Government Department of Veterans' Affairs [website]. Canberra: Australian Government Department of Veterans' Affairs; n.d. (<https://www.openarms.gov.au/>).
99. Coughlin SS. Racism and discrimination in the military and the health of US service members. *Mil Med.* 2021;186:147 (<https://doi.org/10.1093/milmed/usab037>).
100. Shavers VL, Shavers BS. Racism and health inequity among Americans. *J Natl Med Assoc.* 2006;98:386–96 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2576116/pdf/jnma00190-0078.pdf>, accessed Access 2006).

101. Daum J. Keine bunte Truppe. In: tagesschau.de [website]. Hamburg: Norddeutscher Rundfunk; 2023 (<https://www.tagesschau.de/investigativ/report-mainz/vollbild-bundeswehr-sexismus-erniedrigung-101.html>).
102. Gurung S, Ventuneac A, Rendina HJ, et al. Prevalence of military sexual trauma and sexual orientation discrimination among lesbian, gay, bisexual, and transgender military personnel: a descriptive study. *Sex Res Social Policy*. 2018;15:74–82 (<https://doi.org/10.1007/s13178-017-0311-z>).
103. Core pre-deployment training materials. In: United Nations Peacekeeping Resource Hub [website]. New York: United Nations Peacekeeping Resource Hub; n.d. (<https://peacekeepingresourcehub.un.org/en/training/pre-deployment/cptm/intro>).
104. Bøg M, Filges T, Jørgensen AMK. Deployment of personnel to military operations: impact on mental health and social functioning. *Campbell Syst Rev*. 2018;14:1–127 (<https://doi.org/10.4073/csr.2018.6>, accessed Access 2018).
105. Royal Commission into Defence and Veteran Suicide. Interim report. Sydney: Royal Commission into Defence and Veteran Suicide; 2022 (<https://defenceveteransuicide.royalcommission.gov.au/system/files/2023-05/interim-report-dvsrc-may-2023.pdf>).
106. Philipps D, Holston K. Pattern of brain damage is pervasive in navy SEALs who died by suicide. In: The New York Times [website]. New York: The New York Times; 2024 (<https://www.nytimes.com/2024/06/30/us/navy-seals-brain-damage-suicide.html?smid=nytcore-ios-share&referrerSource=articleShare&sgpr=c-cb>).
107. Barriers to mental health care. Falls Church: Military Health System and Defense Health Agency; n.d. (<https://www.health.mil/Reference-Center/Publications/2021/04/02/PHCoE-Barriers-to-Care-Mental-Health-Care>).
108. King EL, Hawkins LE. Identifying and mitigating moral injury risks in military behavioral health providers. *Mil Psychol*. 2023;35:169–79 (<https://doi.org/10.1080/08995605.2022.2093599>).
109. Barling J, Carson J. Mental capital and wellbeing: making the most of ourselves in the 21st century. London: The UK Government Office for Science; 2008 (<https://assets.publishing.service.gov.uk/media/5a7c59eced915d6969f44488/mental-capital-wellbeing-report.pdf>).
110. Kelloway EK, Turner N, Barling J, Loughlin C. Transformational leadership and employee psychological well-being: the mediating role of employee trust in leadership. *Work & Stress*. 2012;26:39–55 (<https://doi.org/10.1080/02678373.2012.660774>).
111. WHO guidelines on mental health at work. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/363177>). License: CC BY-NC-SA 3.0 IGO.
112. Stratton E, Lampit A, Choi I, Calvo RA, Harvey SB, Glozier N. Effectiveness of eHealth interventions for reducing mental health conditions in employees: a systematic review and meta-analysis. *PLoS One*. 2017;12:e0189904 (<https://doi.org/10.1371/journal.pone.0189904>).
113. More technical problems found with VA's disability claims system. In: Veterans [website]. Arlington: MilitaryTimes; 2023 (<https://www.militarytimes.com/veterans/2023/09/06/more-technical-problems-found-with-vas-disability-claims-system/>).
114. Nichter B, Tsai J, Pietrzak RH. Prevalence, correlates, and mental health burden associated with homelessness in U.S. military veterans. *Psychol Med*. 2023;53:3952–62 (<https://doi.org/10.1017/S0033291722000617>).
115. Tsai J, Rosenheck RA. Risk factors for homelessness among US veterans. *Epidemiol Rev*. 2015;37:177–95 (<https://doi.org/10.1093/epirev/mxu004>).
116. Veteran transition strategy. Canberra: Australian Government Department of Defence, Department of Veterans' Affairs, and Commonwealth Superannuation Corporation; 2023 (<https://www.defence.gov.au/about/strategic-planning/veterans-transition-strategy>).
117. Protections against employment discrimination for service members and veterans. Washington, DC: U.S. Equal Employment Opportunity Commission; n.d. (<https://www.eeoc.gov/protections-against-employment-discrimination-service-members-and-veterans>).
118. Britch R, Richards K, Williams K, Wolfe HL. Prioritizing veteran social well-being: a call to action. *Med Care*. 2024;62:S15–S7 (<https://doi.org/10.1097/MLR.0000000000002058>).
119. Defence and Veteran Mental Health and Wellbeing Strategy 2024–2029. Canberra: Department of Defence and Department of Veterans' Affairs; 2024 (<https://www.dva.gov.au/sites/default/files/2024-12/exposure-draft-defence-and-veteran-mental-health-and-wellbeing-strategy-2024-2029.pdf>).
120. Mental Health Protect™: free training to support veteran mental health. In: Mental Health First Aid Australia [website]. Melbourne: Mental Health First Aid Australia; n.d. (<https://www.mhfa.com.au/mental-health-protect/>).
121. Sexual misconduct support and resource centre. In: Department of National Defence Canada [website]. Ottawa: Department of National Defence Canada; n.d. (<https://www.canada.ca/en/department-national-defence/services/benefits-military/health-support/sexual-misconduct-response.html>).
122. Suicide prevention and intervention guide for Canadian armed forces leadership. Ottawa: Department of National Defence Canada; 2021 (<https://www.canada.ca/en/department-national-defence/corporate/reports-publications/health/suicide-prevention-intervention-guide-caf-leadership.html>).
123. Veterans transition action plan. Ottawa: Veterans Affairs Canada, Government of Canada; 2022 (<https://www.veterans.gc.ca/en/about-vac/reports-policies-and-legislation/departmental-reports/veterans-transition-action-plan>).
124. Prevention plan of action 2.0 (2022–2024). Washington, D.C.: U.S. Department of Defense; 2022 ([https://www.prevention.mil/Portals/130/Documents/PPoA\\_2.0.pdf?ver=BROSEoYyqVnF9ATV8mLb\\_Q%3d%3d](https://www.prevention.mil/Portals/130/Documents/PPoA_2.0.pdf?ver=BROSEoYyqVnF9ATV8mLb_Q%3d%3d)).
125. Transition assistance program. In: US Department of Veterans Affairs [website]. Washington, D.C.: U.S. Department of Veterans Affairs; n.d. (<https://discover.va.gov/transition-programs/transition-assistance-program>).
126. Defence people health and wellbeing strategy 2022–2027. London: Ministry of Defence; 2022 (<https://www.gov.uk/government/publications/defence-people-health-and-wellbeing-strategy-2022-to-2027>).

127. Veterans' strategy action plan 2022 to 2024. London: Office for Veterans' Affairs, Government of the United Kingdom; 2022 (<https://www.gov.uk/government/publications/veterans-strategy-action-plan-2022-to-2024/veterans-strategy-action-plan-2022-to-2024-html>).
128. Mental health in schools training package. In: Mental health and substance use [website]. Geneva: World Health Organization; n.d. (<https://www.emro.who.int/mnh/publications/mental-health-in-schools-training-package.html>).
129. Solmi M, Radua J, Olivola M, et al. Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. *Mol Psychiatry*. 2022;27:281–95 (<https://doi.org/10.1038/s41380-021-01161-7>).
130. Adolescent mental health. Fact sheet. In: World Health Organization [website]. Geneva: World Health Organization; 2023 (<https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>).
131. The state of the world's children 2021: on my mind – promoting, protecting and caring for children's mental health. New York: UNICEF; 2021 (<https://www.unicef.org/reports/state-worlds-children-2021>).
132. National children's mental health and wellbeing strategy. Sydney: National Mental Health Commission; 2024 (<https://www.mentalhealthcommission.gov.au/publications/national-childrens-mental-health-and-wellbeing-strategy>).
133. Inclusive education. Every child has the right to quality education and learning. In: Inclusive education [website]. New York: UNICEF; n.d. (<https://www.unicef.org/education/inclusive-education>).
134. What you need to know about inclusion in education. In: Inclusion in education [website]. Paris: UNESCO; 2023 (<https://www.unesco.org/en/inclusion-education/need-know>).
135. Jerrim J, Sims S, Taylor H, Allen R. How does the mental health and wellbeing of teachers compare to other professions? . *Rev Educ*. 2020;8:179–206 (<https://doi.org/10.1002/rev3.3228>).
136. Impact of COVID-19 on poor mental health in children and young people 'tip of the iceberg'. In: Press release [website]. New York: UNICEF; 2021 (<https://www.unicef.org/press-releases/impact-covid-19-poor-mental-health-children-and-young-people-tip-iceberg>).
137. School-based violence prevention: a practical handbook. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/324930>). License: CC BY-NC-SA 3.0 IGO.
138. Violence, threats, and harassment are taking a toll on teachers, survey shows. In: School Climate & Safety [website]. Washington, D.C.: Education Week; 2022 (<https://www.edweek.org/leadership/violence-threats-and-harassment-are-taking-a-toll-on-teachers-survey-shows/2022/03>).
139. Zhang X, Yue H, Hao X, Liu X, Bao H. Exploring the relationship between mental health literacy and psychological distress in adolescents: a moderated mediation model. *Prev Med Rep*. 2023;33 (<https://doi.org/10.1016/j.pmedr.2023.102199>).
140. The global state of play: report and recommendations on quality physical education. Paris: UNESCO and Loughborough University; 2024 (<https://doi.org/10.54678/GSKR7671>).
141. Galán-Muros V, Davis K, Bouckaert M. Supporting the mental health and well-being of higher education students. Paris: UNESCO International Institute for Higher Education in Latin America and the Caribbean (IESALC); 2024 (<https://unesdoc.unesco.org/ark:/48223/pf0000391501>).
142. Five essential pillars for promoting and protecting mental health and psychosocial well-being in schools and learning environments. New York: United Nations Children's Fund, World Health Organization & United Nations Educational, Scientific and Cultural Organization; 2022 (<https://www.unicef.org/reports/promoting-and-protecting-mental-health-schools-and-learning-environments>). License: CC BY-NC-SA 3.0 IGO.
143. Stop bullying on the spot. In: US Department of Health and Human Services [website]. Washington, DC: U.S. Department of Health and Human Services; n.d. (<https://www.stopbullying.gov/>).
144. Fuxman S, Schneider SK, Heyman M. Ruderman white paper reveals: students with disabilities are almost twice as likely to be victims of cyberbullying. Boston: Ruderman Family Foundation; 2021 ([https://rudermanfoundation.org/white\\_papers/ruderman-white-paper-reveals-students-with-disabilities-are-almost-twice-as-likely-to-be-victims-of-cyberbullying/](https://rudermanfoundation.org/white_papers/ruderman-white-paper-reveals-students-with-disabilities-are-almost-twice-as-likely-to-be-victims-of-cyberbullying/)).
145. Campus mental health action planning. New York: The JED Foundation 2011 ([https://sprc.org/wp-content/uploads/2023/01/CampusMHAP\\_Web-final-2.pdf](https://sprc.org/wp-content/uploads/2023/01/CampusMHAP_Web-final-2.pdf)).
146. Colleges and universities. In: Suicide Prevention Resource Center [website]. Oklahoma City: Suicide Prevention Resource Center; n.d. (<https://sprc.org/settings/colleges-and-universities/>).
147. Guidelines on mental health promotive and preventive interventions for adolescents: helping adolescents thrive. Geneva: World Health Organization; 2020 (<https://iris.who.int/handle/10665/336864>). License: CC BY-NC-SA 3.0 IGO.
148. WHO menu of cost-effective interventions for mental health. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/343074>). License: CC BY-NC-SA 3.0 IGO.
149. See me see change: tackling mental health stigma and discrimination in schools. In: See Me [website]. Glasgow: Scottish Action for Mental Health; n.d. (<https://www.seemescotland.org/young-people/smsc>).
150. Peer education for young people. In: Jigsaw [website]. Dublin: Jigsaw; n.d. (<https://jigsaw.ie/research-evaluation/peer-education/>).
151. QualityRights materials for training, guidance and transformation. In: World Health Organization [website]. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools>).
152. WHO QualityRights e-training on mental health, WHO Academy. In: Mental Health and Substance Use [website]. Geneva: World Health Organization; n.d. (<https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training>; <https://whoacademy.org/>).

153. Goodenow C, Grady KE. The relationship of school belonging and friends' values to academic motivation among urban adolescent students. *J Exp Educ*. 1993;62:60–71 (<https://doi.org/10.1080/00220973.1993.9943831>).
154. Allen KA, Greenwood CJ, Berger E, et al. Adolescent school belonging and mental health outcomes in young adulthood: findings from a multi-wave prospective cohort study. *School Mental Health*. 2024;16:149–60 (<https://doi.org/10.1007/s12310-023-09626-6>).
155. Black DS, Grenard JL, Sussman S, Rohrbach LA. The influence of school-based natural mentoring relationships on school attachment and subsequent adolescent risk behaviors. *Health Educ Res*. 2010;25:892–902 (<https://doi.org/10.1093/her/cyq040>).
156. Glazzard J, Rose A, Ogilvie P. The impact of peer mentoring on students' physical activity and mental health. *J Public Ment Health*. 2019 (<https://doi.org/10.1108/JPMH-10-2018-0073>).
157. School-based mentoring In: School-based mentoring [website]. Washington, DC: National Mentoring Resource Center; n.d. (<https://nationalmentoringresourcecenter.org/resource/school-based-mentoring/>).
158. Bullying: What is it and how to stop it. How to prevent and deal with bullying. In: UNICEF [website]. New York: UNICEF; n.d. (<https://www.unicef.org/parenting/child-care/bullying>).
159. Professional learning resource for school staff. In: Programmes for families, children and young people [website]. Glasgow: Mental Health Foundation; n.d. (<https://www.mentalhealth.org.uk/our-work/programmes/families-children-and-young-people/professional-learning-resource-school-staff>).
160. The benefits of investing in school-based mental health support. New York: UNICEF; 2023 (<https://www.unicef.org/reports/benefits-investing-school-based-mental-health-support>).
161. Framework on embedding a whole-school approach to emotional and mental well-being. Cardiff: Welsh Government; 2021 (<https://www.gov.wales/framework-embedding-whole-school-approach-emotional-and-mental-wellbeing>).
162. About YAM. In: Youth Aware of Mental health (YAM) [website]. Stockholm: Mental Health in Mind International AB; n.d. (<https://www.y-a-m.org/>).
163. Mental health at work: policy brief. Geneva: World Health Organization and International Labour Organization; 2022 (<https://iris.who.int/handle/10665/362983>). License: CC BY-NC-SA 3.0 IGO.
164. Harvey SB, Modini M, Joyce S, Milligan-Saville JS, Tan L, Mykletun L et al. Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. *Occup Environ Med*. 2017;74:301–10 (<https://doi.org/10.1136/oemed-2016-104015>).
165. Harvey SB, Joyce S, Tan L, et al. Developing a mentally healthy workplace: a review of the literature. Sydney: National Mental Health Commission and the Mentally Healthy Workplace Alliance; 2014 (<https://www.mentalhealthcommission.gov.au/publications/developing-mentally-healthy-workplace-review-literature>).
166. Fit mind, fit job: from evidence to practice in mental health and work. Paris: Organisation for Economic Co-operation and Development (OECD); 2015 (<https://doi.org/10.1787/9789264228283-en>).
167. Freund R, Favara M, Porter C, Scott D, Le Thuc D. The mental cost of job loss: assessing the impact on young adults in Vietnam. IZA Discussion Paper No. 15522. Bonn: IZA Institute of Labor Economics; 2022 (<https://docs.iza.org/dp15522.pdf>).
168. Modini M, Joyce S, Mykletun A, et al. The mental health benefits of employment: results of a systematic meta-review. *Australas Psychiatry*. 2016;24:331–6 (<https://doi.org/10.1177/1039856215618523>).
169. Funk M, Drew N, Freeman M, et al. Mental health and development : targeting people with mental health conditions as a vulnerable group / Michelle Funk ... [et al]; Geneva: World Health Organization & United Nations Development Programme; 2010 (<https://iris.who.int/handle/10665/44257>). License: CC BY-NC-SA 3.0 IGO.
170. Goal 8: promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all. In: Sustainable Development Goals [website]. Geneva United Nations Sustainable Development Goals; n.d. (<https://sdgs.un.org/goals/goal8>).
171. Convention on the Rights of Persons with Disabilities, art. 27 (A/RES/61/106). New York: United Nations, General Assembly; 2006 (<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-27-work-and-employment.html>).
172. Labour market inclusion of people with disabilities. Geneva: International Labour Organization; 2018 ([https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40dgreports/%40inst/documents/publication/wcms\\_646041.pdf](https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40dgreports/%40inst/documents/publication/wcms_646041.pdf)).
173. Business as unusual: making workplaces inclusive of people with disabilities. Geneva: International Labour Organization; 2014 (<https://www.ilo.org/publications/business-unusual-making-workplaces-inclusive-people-disabilities>).
174. Puig-Barrachina V, Giró P, Artazcoz L, et al. The impact of active labour market Policies on health outcomes: a scoping review. *Eur J Public Health*. 2020;30:36–42 (<https://doi.org/10.1093/eurpub/ckz026>).
175. Bond GR, Al-Abdulmunem M, Marbacher J, Christensen TN, Sveinsdottir V, Drake RE. A systematic review and meta-analysis of IPS supported employment for young adults with mental health conditions. *Adm Policy Ment Health*. 2023;50:160–72 (<https://doi.org/10.1007/s10488-022-01228-9>).
176. Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/341648>). License: CC BY-NC-SA 3.0 IGO.
177. Nielsen MB, Einarsen S. Outcomes of exposure to workplace bullying: a meta-analytic review. *Work Stress*. 2012;26:309–32 (<https://doi.org/10.1080/02678373.2012.734709>).
178. Leigh JP, Leigh WA, Du J. Minimum wages and public health: a literature review. *Prev Med*. 2019;122–34 (<https://doi.org/10.1016/j.ypmed.2018.10.005>).

179. Goodman JM, Poma LD. Paid parental leave and mental health: the importance of equitable policy design. *Lancet Public Health*. 2023;8:e2–e3 ([https://doi.org/10.1016/S2468-2667\(22\)00319-X](https://doi.org/10.1016/S2468-2667(22)00319-X)).
180. Heshmati A, Honkaniemi H, Juárez SP. The effect of parental leave on parents' mental health: a systematic review. *Lancet Public Health*. 2023;8:e57–e75 ([https://doi.org/10.1016/S2468-2667\(22\)00311-5](https://doi.org/10.1016/S2468-2667(22)00311-5)).
181. C155 – Occupational Safety and Health Convention, 1981 (No. 155). Geneva: International Labour Organization; 1981 ([https://normlex.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100\\_ILO\\_CODE:C155](https://normlex.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C155)).
182. Nieuwenhuijsen K, Bruinvels D, Frings-Dresen M. Psychosocial work environment and stress-related disorders, a systematic review. *Occup Med (Lond)*. 2010;60:277–86 (<https://doi.org/10.1093/occmed/kqq081>).
183. Low job control. In: WorkSafe [website]. Brisbane: WorkSafe; n.d. (<https://www.worksafe.qld.gov.au/safety-and-prevention/mental-health/Psychosocial-hazards/low-job-control>).
184. Knight C, Parker SK. How work redesign interventions affect performance: An evidence-based model from a systematic review. *Human Relations*. 2019;74:001872671986560 (<https://doi.org/10.1177/0018726719865604>).
185. Gayed A, Milligan-Saville JS, Nicholas J, et al. Effectiveness of training workplace managers to understand and support the mental health needs of employees: a systematic review and meta-analysis. *Occup Environ Med*. 2018;75:462–70 (<https://doi.org/10.1136/oemed-2017-104789>).
186. Stratton E, Lampit A, Choi I, et al. Effectiveness of eHealth interventions for reducing mental health conditions in employees: a systematic review and meta-analysis. *PLoS One*. 2017 (<https://doi.org/10.1371/journal.pone.0189904>).
187. Barling J, Carson J. The impact of management style on mental wellbeing at work. State-of-Science Review: SR-C3. In: Sahakian B, Cooper C, Goswami U, editors. *Mental Capital and Wellbeing*. London: The UK Government Office for Science; 2009.
188. Allen J, Jimmieson NL, Bordia P, Irmer BE. Uncertainty during organizational change: managing perceptions through communication. *J Change Manag*. 2007;7:187–210 (<https://doi.org/10.1080/14697010701563379>).
189. Psychosocial factors at work : recognition and control: report of the Joint ILO/WHO Committee on Occupational Health, Ninth Session, Geneva, 18-24 September 1984. Geneva: International Labour Organization; 1986 (<https://digitallibrary.un.org/record/194660?ln=en>).
190. Joseph B, Walker A, Fuller-Tyszkiewicz M. Evaluating the effectiveness of employee assistance programmes: a systematic review. *Eur J Work Organ Psychol*. 2018;27:1–15 (<https://doi.org/10.1080/1359432X.2017.1374245>).
191. Chen YC, Chu HC, Wang PT. Employee assistance programs: a meta-analysis. *J Employ Couns*. 2021;58:144–66 (<https://doi.org/10.1002/joec.12170>).
192. A review of good workplace practices to support individuals experiencing mental health problems. Bilbao: European Agency for Safety and Health at Work; 2024 (<https://osha.europa.eu/en/publications/review-good-workplace-practices-support-individuals-experiencing-mental-health-problems>).
193. Guidance for workplaces on how to support individuals experiencing mental health problems. Bilbao: European Agency for Safety and Health at Work; 2024 (<https://osha.europa.eu/en/publications/guidance-workplaces-how-support-individuals-experiencing-mental-health-problems>).
194. How workplaces can support workers experiencing mental health problems. Bilbao: European Agency for Safety and Health at Work; 2023 (<https://osha.europa.eu/en/publications/how-workplaces-can-support-workers-experiencing-mental-health-problems>).
195. SOLVE: Integrating health promotion into workplace OSH policies. Geneva: International Labour Organization; 2012 (<https://www.ilo.org/resource/training-material/solve-integrating-health-promotion-workplace-osh-policies-participants>).
196. Stronger, fairer, greener Wales: a plan for employability and skills. Cardiff: Welsh Government; 2022 (<https://www.gov.wales/stronger-fairer-greener-wales-plan-employability-and-skills>).
197. United Nations System Mental Health and Well-being Strategy for 2024 and beyond. New York: United Nations System Chief Executives Board for Coordination (UNSCB); 2023 ([https://www.un.org/sites/un2.un.org/files/un\\_system\\_mental\\_health\\_and\\_well\\_being\\_strategy\\_for\\_2024.pdf](https://www.un.org/sites/un2.un.org/files/un_system_mental_health_and_well_being_strategy_for_2024.pdf)).
198. Mental health and climate change: policy brief. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/354104>). License: CC BY-NC-SA 3.0 IGO.
199. Jariwala HJ, Syed HS, Pandya MJ, Gajera YM. Noise pollution & human health: a review. Conference: Noise and Air Pollution: Challenges and Opportunities. 2017 ([https://www.researchgate.net/profile/Hiral-Jariwala/publication/319329633\\_Noise\\_Pollution\\_Human\\_Health\\_A\\_Review/links/59a54434a6fdcc773a3b1c49/Noise-Pollution-Human-Health-A-Review.pdf](https://www.researchgate.net/profile/Hiral-Jariwala/publication/319329633_Noise_Pollution_Human_Health_A_Review/links/59a54434a6fdcc773a3b1c49/Noise-Pollution-Human-Health-A-Review.pdf), accessed Access 2017).
200. Tancredi S, Urbano T, Vinceti M, Filippini T. Artificial light at night and risk of mental disorders: a systematic review. *Sci Total Environ*. 2022;833 (<https://doi.org/10.1016/j.scitotenv.2022.155185>).
201. Kimutai J, Lund C, Moturi WN, et al. Evidence on the links between water insecurity, inadequate sanitation and mental health: a systematic review and meta-analysis. *PLoS ONE*. 2023;18:e0286146 (<https://doi.org/10.1371/journal.pone.0286146>).
202. Brewis A, Teji Roba K, Wutich A, et al. Household water insecurity and psychological distress in Eastern Ethiopia: Unfairness and water sharing as undertheorized factors. *SSM – Mental Health*. 2021;1 (<https://doi.org/10.1016/j.ssmmh.2021.100008>).
203. Global framework for urban water, sanitation and hygiene. In: UNICEF [website]. New York: UNICEF; n.d. (<https://www.unicef.org/documents/global-framework-urban-water-sanitation-and-hygiene>).
204. State of the world's indigenous peoples: volume VI – climate crisis. New York: United Nations Department of Economic and Social Affairs; 2024 (<https://social.desa.un.org/publications/state-of-the-worlds-indigenous-peoples-volume-vi-climate-crisis>).
205. Hayes K, Poland B. Addressing mental health in a changing climate: incorporating mental health indicators into climate change and health vulnerability and adaptation assessment. *Int J Environ Res Public Health*. 2011;15:1806 (<https://doi.org/10.3390/ijerph15091806>).

206. Hough E, Counts N. How climate change affects our mental health, and what we can do about it. New York: The Commonwealth Fund; 2023 (<https://www.commonwealthfund.org/publications/explainer/2023/mar/how-climate-change-affects-mental-health>).
207. Cianconi P, Betrò S, Janiri L. The impact of climate change on mental health: a systematic descriptive review. *Clin Pract Epidemiol Ment Health*. 2020;11 (<https://doi.org/10.3389/fpsy.2020.00074>).
208. Obradovich N, Migliorini R, Paulus MP, Rahwan I. Empirical evidence of mental health risks posed by climate change. *Proc Natl Acad Sci U S A*. 2018;115:10953–8 (<https://doi.org/10.1073/pnas.1801528115>).
209. Thompson R, Lawrance EL, Roberts LF, Grailey K, Ashrafian H, Maheswaran H et al. Ambient temperature and mental health: a systematic review and meta-analysis. *Lancet Planet Health*. 2023;7:e580–e9 ([https://doi.org/10.1016/S2542-5196\(23\)00104-3](https://doi.org/10.1016/S2542-5196(23)00104-3)).
210. Trohanis Z, Escobar M, Otano C, Balog-Way S. Inclusive early warning systems: a lifeline for all. In: Sustainable cities [website]. Washington, DC: World Bank Blogs; 2023 (<https://blogs.worldbank.org/en/sustainablecities/inclusive-early-warning-systems-lifeline-all>).
211. Technical note, linking disaster risk reduction (DRR) and mental health and psychosocial support (MHPSS): practical tools, approaches and case studies. Geneva: Inter-Agency Standing Committee; 2021 (<https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/technical-note-linking-disaster-risk-reduction-drr-and-mental-health-and-psychosocial-support-mhpss>).
212. Sendai framework for disaster risk reduction 2015-2030. Geneva: United Nations Office for Disaster Risk Reduction; 2015 (<https://www.undrr.org/publication/sendai-framework-disaster-risk-reduction-2015-2030>).
213. Nature-based solutions and health. Copenhagen: World Health Organization Regional Office for Europe; 2025 (<https://iris.who.int/handle/10665/381437>). License: CC BY-NC-SA 3.0 IGO.
214. van den Berg AE, Hartig T, Staats H. Preference for nature in urbanized societies: stress, restoration, and the pursuit of sustainability. *J Soc Issues*. 2007;63:79–96 (<https://doi.org/10.1111/j.1540-4560.2007.00497.x>).
215. Kim J, Kaplan R. Physical and psychological factors in sense of community: new urbanist kentlands and nearby orchard village. *Environ Behav*. 2004;36:103–13 (<https://doi.org/10.1177/0013916503260236>).
216. Convention on Biological Diversity. New York: United Nations; 1992 ([https://prod.drupal.www.infra.cbd.int/sites/default/files/2022-12/221222-CBD-PressRelease-COP15-Final.pdf?\\_gl=1\\*1humy18\\*\\_ga\\*MTE5ODU0ODE4MC4xNzUxMDU1NDU4\\*\\_ga\\_7S1TPRE7F5\\*czE3NTEwNTU0NTgkbzEkZzEkdDE3NTEwNTU1MDUkajEzjGwwjGgw](https://prod.drupal.www.infra.cbd.int/sites/default/files/2022-12/221222-CBD-PressRelease-COP15-Final.pdf?_gl=1*1humy18*_ga*MTE5ODU0ODE4MC4xNzUxMDU1NDU4*_ga_7S1TPRE7F5*czE3NTEwNTU0NTgkbzEkZzEkdDE3NTEwNTU1MDUkajEzjGwwjGgw)).
217. Air pollution's impact on mental health. In: APA Blogs [website]. Washington, DC: American Psychiatric Association; 2023 (<https://www.psychiatry.org/news-room/apa-blogs/air-pollutions-impact-on-mental-health>).
218. Transport, health and environment. In: Fact Sheets [website]. Geneva: World Health Organization; 2023 (<https://www.who.int/europe/news-room/fact-sheets/item/transport-health-and-environment>).
219. Urban design for health: inspiration for the use of urban design to promote physical activity and healthy diets in the WHO European Region. Geneva: WHO Regional Office for Europe; 2022 (<https://iris.who.int/handle/10665/361995>).
220. Dutchen S. Confronting health care's carbon footprint. In: Harvard medicine [website]. Boston: Harvard medicine; 2023 (<https://magazine.hms.harvard.edu/articles/confronting-health-cares-carbon-footprint>).
221. Health care climate footprint report. Reston: Health Care Without Harm; 2019 (<https://global.noharm.org/resources/health-care-climate-footprint-report>).
222. Operational framework for building climate resilient and low carbon health systems. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/373837>). License: CC BY-NC-SA 3.0 IGO.
223. Hoppe BO, Prussia L, Manning C, et al. "It's hard to give hope sometimes": climate change, mental health, and the challenges for mental health professionals. *Ecopsychology*. 2023;15:22–38 (<https://doi.org/10.1089/eco.2022.0032>).
224. Crandon TJ, Dey C, Scott JG, et al. The clinical implications of climate change for mental health. *Nat Hum Behav*. 2022;6:1474–81 (<https://doi.org/10.1038/s41562-022-01477-6>).
225. Hickman C, Marks E, Pihkala P, et al. Climate anxiety in children and young people and their beliefs about government responses to climate change: a global survey. *Lancet Planet Health*. 2021;5:e863–73 ([https://doi.org/10.1016/S2542-5196\(21\)00278-3](https://doi.org/10.1016/S2542-5196(21)00278-3)).
226. Raducu R, Soare C, Chichirez CM, Purcarea MR. Climate change and social campaigns. *J Med Life*. 2020;13 (<https://doi.org/10.25122/jml-2020-0173>).
227. Coventry PA, Brown JE, Pervin J, Brabyn S, Pateman R, Breedvelt J et al. Nature-based outdoor activities for mental and physical health: Systematic review and meta-analysis. *SSM Popul Health*. 2021;16 (<https://doi.org/10.1016/j.ssmph.2021.100934>).
228. A threat to progress: confronting the effects of climate change on child health and well-being. New York: United Nations Children's Fund (UNICEF); 2024 ([https://www.unicef.org/media/159341/file/A\\_Threat\\_to\\_Progress\\_190824%20EN.pdf](https://www.unicef.org/media/159341/file/A_Threat_to_Progress_190824%20EN.pdf)).
229. Blog: signed, sealed and 212 steps towards delivering the world's first net zero health service. In: News [website]. London: NHS England; 2022 (<https://www.england.nhs.uk/greenernhs/2022/06/blog-signed-sealed-and-212-steps-towards-delivering-the-worlds-first-net-zero-health-service/>).
230. Communicating on climate change and health: toolkit for health professionals. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/376283>). License: CC BY-NC-SA 3.0 IGO.
231. Climate change, mental health and wellbeing: examples of practical inclusive practices. Bensheim: Christian Blind Mission; 2021 ([https://cbm-global.org/wp-content/uploads/2021/12/Climate-change-and-Mental-Health\\_CBMGlobal.pdf](https://cbm-global.org/wp-content/uploads/2021/12/Climate-change-and-Mental-Health_CBMGlobal.pdf)).
232. Creating healthy cities. In: Activities [website]. Geneva: World Health Organization; n.d. (<https://www.who.int/activities/creating-healthy-cities>).

233. IASC guidelines on mental health and psychosocial support in emergency settings, 2007. Geneva: Inter-Agency Standing Committee; 2007 (<https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007>).
234. Promoting walking and cycling: a toolkit of policy options. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/381335>). License: CC BY-NC-SA 3.0 IGO.
235. Sustainability solutions for health care. In: Practice Greenhealth [website]. Reston: Practice Greenhealth; n.d. (<https://practicegreenhealth.org/>).
236. WHO European healthy cities network. In: Groups and networks [website]. Geneva: World Health Organization; n.d. (<https://www.who.int/europe/groups/who-european-healthy-cities-network>).
237. WHO global strategy on health, environment and climate change: the transformation needed to improve lives and wellbeing sustainably through healthy environments. Geneva: World Health Organization; 2020 (<https://iris.who.int/handle/10665/331959>). License: CC BY-NC-SA 3.0 IGO.
238. Hert MDE, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. 2011;10:52–77 (<https://doi.org/10.1002/j.2051-5545.2011.tb00014.x>).
239. Integrating mental health into primary care: a global perspective. Geneva: World Health Organization; 2008 (<https://iris.who.int/handle/10665/43935>). License: CC BY-NC-SA 3.0 IGO.
240. Report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, 16 July 2018 (A/73/161). Geneva: United Nations, Human Rights Council; 2018 (<https://undocs.org/en/A/73/161>).
241. Mental health atlas 2017. Geneva: World Health Organization; 2018 (<https://iris.who.int/handle/10665/272735>). License: CC BY-NC-SA 3.0 IGO.
242. Huskamp HA. Pharmaceutical cost management and access to psychotropic drugs: the U.S. context. *Int J Law Psychiatry*. 2005;28:484–95 (<https://doi.org/10.1016/j.ijlp.2005.08.004>).
243. Gater R, Chisholm D, Dowrick C. Mental health surveillance and information systems. *East Mediterr Health J*. 2013;21:512–6 (<https://doi.org/10.26719/2015.21.7.512>).
244. Firth J, Siddiqi N, Koyanagi A, Siskind D, Rosenbaum S, Galletly C et al. The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *Lancet Psychiatry*. 2019;6:675–712 ([https://doi.org/10.1016/S2215-0366\(19\)30132-4](https://doi.org/10.1016/S2215-0366(19)30132-4)).
245. Saxena S, Maj M. Physical health of people with severe mental disorders: leave no one behind. *World Psychiatry*. 2017;16:1–2 (<https://doi.org/10.1002/wps.20403>).
246. Comorbidities in drug use disorders; Commission on Narcotic Drugs; sixty-fifth session, 14–18 March 2022 (E/CN.7/2022/CRP.12). Vienna: UN Commission on Narcotic Drugs; 2022 ([https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC\\_Comorbidities\\_in\\_drug\\_use\\_disorders.pdf](https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC_Comorbidities_in_drug_use_disorders.pdf)).
247. Mitchell AJ, Malone D, Doebbeling CC. Quality of medical care for people with and without comorbid mental illness and substance misuse: systematic review of comparative studies. *Br J Psychiatry*. 2009;194:491–9 (<https://doi.org/10.1192/bjp.bp.107.045732>).
248. Fagiolini A, Goracci A. The effects of undertreated chronic medical illnesses in patients with severe mental disorders. *J Clin Psychiatry*. 2009;70 Suppl 3:22–9 (<https://doi.org/10.4088/JCP.7075su1c.04>).
249. Tabril T, Chekira A, Housni Touhami YO, El Allani L, Najid I, Hammani Z et al. [The role of the general practitioner in management of psychiatric disorders]. *Revue D'epidemiologie et de Sante Publique*. 2020;68:185–92 (<https://doi.org/10.1016/j.respe.2020.05.002>).
250. Lawrence D, Kisely S. Review: Inequalities in healthcare provision for people with severe mental illness. *J Psychopharmacol*. 2010;24:61–8 (<https://doi.org/10.1177/1359786810382058>).
251. Correll CU, Solmi M, Veronese N, Bortolato B, Rosson S, Santonastaso P et al. Prevalence, incidence and mortality from cardiovascular disease in patients with pooled and specific severe mental illness: a large-scale meta-analysis of 3,211,768 patients and 113,383,368 controls. *World Psychiatry*. 2017;16:163–80 (<https://doi.org/10.1002/wps.20420>).
252. Cuijpers P, Donker T, Weissman MM, Ravitz P, Cristea IA. Interpersonal psychotherapy for mental health problems: a comprehensive meta-analysis. *Am J Psychiatry*. 2016;173:680–7 (<https://doi.org/10.1176/appi.ajp.2015.15091141>).
253. Carpenter JK, Andrews LA, Witcraft SM, Powers MB, Smits JA, Hofmann SG. Cognitive behavioral therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depress Anxiety*. 2018;35:502-14 (10.1002/da.22728).
254. Linardon J, Wade TD, de la Piedad Garcia X, Brennan L. The efficacy of cognitive-behavioral therapy for eating disorders: a systematic review and meta-analysis. *J Consult Clin Psychol*. 2017;85:1080–94 (<https://doi.org/10.1037/ccp000245>).
255. Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. *Lancet Psychiatry*. 2019;6:538–46 ([https://doi.org/10.1016/S2215-0366\(19\)30032-X](https://doi.org/10.1016/S2215-0366(19)30032-X)).
256. Stopping antidepressants. In: Royal College of Psychiatrists [website]. London: Royal College of Psychiatrists; n.d. (<https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/stopping-antidepressants>).
257. Hengartner MP, Read J, Moncrieff J. Protecting physical health in people with mental illness. *Lancet Psychiatry*. 2019;6:890 ([https://doi.org/10.1016/S2215-0366\(19\)30398-0](https://doi.org/10.1016/S2215-0366(19)30398-0)).
258. Weinmann S, Read J, Aderhold V. Influence of antipsychotics on mortality in schizophrenia: systematic review. *Schizophr Res*. 2009;113:1–11 (<https://doi.org/10.1016/j.schres.2009.05.018>).
259. Stassen HH, Bachmann S, Bridler R, Cattapan K, Herzig D, Schneeberger A et al. Detailing the effects of polypharmacy in psychiatry: longitudinal study of 320 patients hospitalized for depression or schizophrenia. *Eur Arch Psychiatry Clin Neurosci*. 2022;272:603–19 (<https://doi.org/10.1007/s00406-021-01358-5>).

260. Halli-Tierney AD, Scarbrough C, Carroll D. Polypharmacy: evaluating risks and deprescribing. *Am Fam Physician*. 2019;100:32–8 (<https://www.aafp.org/pubs/afp/issues/2019/0701/p32.html>, accessed Access 2019).
261. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Dainius Pūras, 28 March 2017 (A/HRC/35/21). Geneva: United Nations, Human Rights Council; 2017 (<https://undocs.org/A/HRC/35/21>).
262. Svensson SA, Hedenrud TM, Wallerstedt SM. Attitudes and behaviour towards psychotropic drug prescribing in Swedish primary care: a questionnaire study. *BMC Fam Pract*. 2019;20 (<https://doi.org/10.1186/s12875-018-0885-4>).
263. He Ara Oranga: report of the government inquiry into mental health and addiction. Wellington: The Government Inquiry into Mental Health and Addiction; 2018 (<https://www.mentalhealth.inquiry.govt.nz/inquiry-report/>).
264. Turjanski N, Lloyd G. Psychiatric side-effects of medications: recent developments. *Adv Psychiatr Treat*. 2005;11:58–70 (<https://doi.org/10.1192/apt.11.1.58>).
265. WHO guidelines on physical activity and sedentary behaviour. Geneva: World Health Organization & United Nations Development Programme; 2020 (<https://iris.who.int/handle/10665/336656>). License: CC BY-NC-SA 3.0 IGO.
266. Firth J, Marx W, Dash S, Carney R, Teasdale SB, Solmi M et al. The effects of dietary improvement on symptoms of depression and anxiety: a meta-analysis of randomized controlled trials. *Psychosom Med*. 2019;81:265–80 (<https://doi.org/10.1097/PSY.0000000000000673>).
267. Grajek M, Krupa-Kotara K, Białek-Dratwa A, Sobczyk K, Grot M, Kowalski O et al. Nutrition and mental health: a review of current knowledge about the impact of diet on mental health. *Front Nutr*. 2022;9:943998 (<https://doi.org/10.3389/fnut.2022.943998>).
268. Scott AJ, Webb TL, Martyn-St James M, Rowse G, Weich S. Improving sleep quality leads to better mental health: a meta-analysis of randomised controlled trials. *Sleep Med Rev*. 2021;60:101556 (<https://doi.org/10.1016/j.smrv.2021.101556>).
269. Albakri U, Drotos E, Meertens R. Sleep health promotion interventions and their effectiveness: an umbrella review. *Int J Environ Res Public Health*. 2021;18:5533 (<https://doi.org/10.3390/ijerph18115533>).
270. Pandor A, Kaltenthaler E, Higgins A, Lorimer K, Smith S, Wylie K et al. Sexual health risk reduction interventions for people with severe mental illness: a systematic review. *BMC Public Health*. 2015;15:138 (<https://doi.org/10.1186/s12889-015-1448-4>).
271. Hameed S, Maddams A, Lowe H, Davies L, Khosla R, Shakespeare T. From words to actions: systematic review of interventions to promote sexual and reproductive health of persons with disabilities in low- and middle-income countries. *BMJ Glob Health*. 2020;5:e002903 (<https://doi.org/10.1136/bmjgh-2020-002903>).
272. Li SYH, Bressington D. The effects of mindfulness-based stress reduction on depression, anxiety, and stress in older adults: a systematic review and meta-analysis. *Int J Ment Health Nurs*. 2019;28:635–56 (<https://doi.org/10.1111/inm.12568>).
273. Büssing A, Michalsen A, Khalsa SB, Telles S, Sherman KJ. Effects of yoga on mental and physical health: a short summary of reviews. *Evid Based Complement Alternat Med*. 2012;2012:165410 (<https://doi.org/10.1155/2012/165410>).
274. A toolkit on how to implement social prescribing. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/354456>). License: CC BY-NC-SA 3.0 IGO.
275. Cuthbert S, Kellas A, Page LA. Green care in psychiatry. *Br J Psychiatry*. 2021;218:73–4 (<https://doi.org/10.1192/bjp.2020.166>).
276. Britton E, Kindermann G, Domegan C, Carlin C. Blue care: a systematic review of blue space interventions for health and wellbeing. *Health Promot Int*. 2020;35:50–69 (<https://doi.org/10.1093/heapro/day103>).
277. International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. Geneva: World Health Organization; 2020 (<https://iris.who.int/handle/10665/331635>). License: CC BY-NC-SA 3.0 IGO.
278. Guide to starting and managing needle and syringe programmes. Geneva: World Health Organization, UNAIDS & UNODC; 2007 (<https://iris.who.int/handle/10665/43816>). License: CC BY-NC-SA 3.0 IGO.
279. Lightfoot K, Panagiotaki G, Nobes G. Effectiveness of psychological interventions for smoking cessation in adults with mental health problems: a systematic review. *Br J Health Psychol*. 2020;25:615–38 (<https://doi.org/10.1111/bjhp.12431>).
280. WHO clinical treatment guideline for tobacco cessation in adults. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/377825>). License: CC BY-NC-SA 3.0 IGO.
281. Stein B, Müller MM, Meyer LK, Söllner W. Psychiatric and psychosomatic consultation liaison services in general hospitals: a systematic review and meta-analysis of effects on symptoms of depression and anxiety. *Psychother Psychosom*. 2020;89:6–16 (<https://doi.org/10.1159/000503177>).
282. Strunz M, Jiménez NP, Gregorius L, Hewer W, Pollmanns J, Viehmann K et al. Interventions to promote the utilization of physical health care for people with severe mental illness: a scoping review. *Int J Environ Res Public Health*. 2022;20:126 (<https://doi.org/10.3390/ijerph20010126>).
283. Lamontagne-Godwin F, Burgess C, Clement S, Gasston-Hales M, Greene C, Manyande A et al. Interventions to increase access to or uptake of physical health screening in people with severe mental illness: a realist review. *BMJ Open*. 2018;8:e019412 (<https://doi.org/10.1136/bmjopen-2017-019412>).
284. Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/376208>). License: CC BY-NC-SA 3.0 IGO.
285. Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/374250>). License: CC BY-NC-SA 3.0 IGO.
286. de Jongh A, Amann BL, Hofmann A, Farrell D, Lee CW. The status of EMDR therapy in the treatment of posttraumatic stress disorder 30 years after its introduction. *Journal of EMDR Practice and Research*. 2019;13:261–9 (<https://doi.org/10.1891/1933-3196.13.4.261>).

287. Barlow J, Bergman H, Kornør H, Wei Y, Bennett C. Group-based parent training programmes for improving emotional and behavioural adjustment in young children. *Cochrane Database Syst Rev.* 2016;16:CD003680 (<https://doi.org/10.1002/14651858.CD003680.pub3>).
288. Rathgeber M, Bürkner PC, Schiller EM, Holling H. The efficacy of emotionally focused couples therapy and behavioral couples therapy: a meta-analysis. *J Marital Fam Ther.* 2019;45:447–63 (<https://doi.org/10.1111/jmft.12336>).
289. Miklowitz DJ, Chung B. Family-focused therapy for bipolar disorder: reflections on 30 years of research. *Fam Process.* 2016;55:483–99 (<https://doi.org/10.1111/famp.12237>).
290. Cheng ST, Li KK, Or PPL, Losada A. Do caregiver interventions improve outcomes in relatives with dementia and mild cognitive impairment? A comprehensive systematic review and metaanalysis. *Psychol Aging.* 2022;37:929–53 (<https://doi.org/10.1037/pag0000696>).
291. Baruch E, Pistrang N, Barker C. Psychological interventions for caregivers of people with bipolar disorder: a systematic review and meta-analysis. *J Affect Disord.* 2018;236:187–98 (<https://doi.org/10.1016/j.jad.2018.04.077>).
292. Problem management plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity, WHO generic field-trial version 1.0. Geneva: World Health Organization; 2016 (<https://iris.who.int/handle/10665/206417>). License: CC BY-NC-SA 3.0 IGO.
293. Group problem management plus (group PM+): group psychological help for adults impaired by distress in communities exposed to adversity, Generic field-trial version 1.0. Geneva: World Health Organization; 2020 (<https://iris.who.int/handle/10665/334055>). License: CC BY-NC-SA 3.0 IGO.
294. Rabelo JL, Cruz BF, Ferreira JDR, Viana BM, Barbosa IG. Psychoeducation in bipolar disorder: a systematic review. *World J Psychiatry.* 2021;11:1407–24 (<https://doi.org/10.5498/wjp.v11.i12.1407>).
295. Person-centred recovery planning for mental health and well-being: self-help tool: WHO QualityRights. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329598>). License: CC BY-NC-SA 3.0 IGO.
296. Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329602>). License: CC BY-NC-SA 3.0 IGO.
297. Supported decision-making and advance planning: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329609>). License: CC BY-NC-SA 3.0 IGO.
298. House A. Safety planning-type interventions for suicide prevention: meta-analysis. *Br J Psychiatry.* 2022;220:246 (<https://doi.org/10.1192/bjp.2021.197>).
299. Chatterjee HJ, Camic PM, Lockyer B, Thomso LJM. Non-clinical community interventions: a systematised review of social prescribing schemes. *Arts & Health.* 2018;10:97–123 (<https://doi.org/10.1080/17533015.2017.1334002>).
300. Bickerdike L, Booth A, Wilson PM, Farley K, Wright K. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open.* 2017;7:e013384 (<https://doi.org/10.1136/bmjopen-2016-013384>).
301. Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and metaanalysis of randomised controlled trials. *J Epidemiol Community Health.* 2019;73:379–87 (<https://doi.org/10.1136/jech-2018-210981>).
302. Dailey WF, Morris JA, Hoge MA. Workforce development innovations with direct care workers: better jobs, better services, better business. *Community Ment Health J.* 2015;51:647–53 (<https://doi.org/10.1007/s10597-014-9798-4>).
303. Siskind D, Harris M, Pirkis J, Whiteford H. Personalised support delivered by support workers for people with severe and persistent mental illness: a systematic review of patient outcomes. *Epidemiol Psychiatr Sci.* 2012;21:97–110 (<https://doi.org/10.1017/s2045796011000734>).
304. Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/364834>). License: CC BY-NC-SA 3.0 IGO.
305. One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329591>). License: CC BY-NC-SA 3.0 IGO.
306. Peer support groups by and for people with lived experience: WHO QualityRights guidance module: module slides. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329644>). License: CC BY-NC-SA 3.0 IGO.
307. Shalaby RAH, Agyapong VIO. Peer support in mental health: literature review. *JMIR Ment Health.* 2020;7:e15572 (<https://doi.org/10.2196/15572>).
308. Beckers T, Maassen N, Koekkoek B, Tiemens B, Hutschemaekers G. Can social support be improved in people with a severe mental illness? A systematic review and meta-analysis. *Curr Psychol.* 2022;1–11 (<https://doi.org/10.1007/s12144-021-02694-4>).
309. Swinkels LTA, Hoeve M, Ter Harmsel JF, Schoonmade LJ, Dekker JJM, Popma A et al. The effectiveness of social network interventions for psychiatric patients: a systematic review and meta-analysis. *Clin Psychol Rev.* 2023;104:102321 (<https://doi.org/10.1016/j.cpr.2023.102321>).
310. Ikiugu MN, Nissen RM, Bellar C, Maassen A, Van Peurseum K. Clinical effectiveness of occupational therapy in mental health: a meta-analysis. *Am J Occup Ther.* 2017;71:7105100020p1–p10 (<https://doi.org/10.5014/ajot.2017.024588>).
311. Swarbrick M, Noyes S. Effectiveness of occupational therapy services in mental health practice. *Am J Occup Ther.* 2018;72:7205170010p1–p4 (<https://doi.org/10.5014/ajot.2018.725001>).
312. A bottom-up approach to employment: an example of good practice. . Geneva: World Health Organization. Regional Office for Europe; 2018 (<https://iris.who.int/handle/10665/329685>). License: CC BY-NC-SA 3.0 IGO.
313. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization & United Nations Children's Fund; 2020 (<https://iris.who.int/handle/10665/337641>). License: CC BY-NC-SA 3.0 IGO.

314. Powell N, Dalton H, Lawrence-Bourne J, Perkins D. Co-creating community wellbeing initiatives: what is the evidence and how do they work? *Int J Ment Health Syst.* 2024;18 (<https://doi.org/10.1186/s13033-024-00645-7>).
315. Brinchmann B, Widding-Havneraas T, Modini M, Rinaldi M, Moe CF, McDaid D et al. A meta-regression of the impact of policy on the efficacy of individual placement and support. *Acta Psychiatr Scand.* 2020;141:206–20 (<https://doi.org/10.1111/acps.13129>).
316. Suijkerbuijk YB, Schaafsma FG, van Mechelen JC, Ojajarvi A, Corbière M, Anema JR. Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis. *Cochrane Database Syst Rev.* 2017;9:CD011867 (10.1002/14651858.CD011867.pub2).
317. Denary W, Fenelon A, Schlesinger P, Purtle J, Blankenship KM, Keene DA. Does rental assistance improve mental health? Insights from a longitudinal cohort study. *Soc Sci Med.* 2021;282:114100 (<https://doi.org/10.1016/j.socscimed.2021.114100>).
318. Schapiro R, Blankenship K, Rosenberg A, Keene D. The effects of rental assistance on housing stability, quality, autonomy, and affordability. *Hous Policy Debate.* 2022;32:456–72 (<https://doi.org/10.1080/10511482.2020.1846067>).
319. Wollburg C, Steinert JJ, Reeves A, Nye E. Do cash transfers alleviate common mental disorders in low- and middle-income countries? A systematic review and meta-analysis. *PLoS ONE.* 2023;18:e0281283 (<https://doi.org/10.1371/journal.pone.0281283>).
320. McGuire J, Kaiser C, Bach-Mortensen AM. A systematic review and meta-analysis of the impact of cash transfers on subjective well-being and mental health in low- and middle-income countries. *Nat Hum Behav.* 2022;6:359–70 (<https://doi.org/10.1038/s41562-021-01252-z>).
321. Micai M, Gila L, Caruso A, Fulceri F, Fontecedro E, Castelpietra G et al. Benefits and challenges of a personal budget for people with mental health conditions or intellectual disability: a systematic review. *Front Psychiatry.* 2022;13:974621 (<https://doi.org/10.3389/fpsy.2022.974621>).
322. Cook JA, Shore S, Burke-Miller JK, Jonikas JA, Hamilton M, Ruckdeschel B et al. Mental health self-directed care financing: efficacy in improving outcomes and controlling costs for adults with serious mental illness. *Psychiatr Serv.* 2019;70:191–201 (<https://doi.org/10.1176/appi.ps.201800337>).
323. New evidence shows larger benefits of disability insurance income. Stanford: Institute for Economic Policy Research; 2018 (<https://siepr.stanford.edu/publications/policy-brief/new-evidence-shows-larger-benefits-disability-insurance-income>).
324. Gelber A, Moore TJ, Pei Z, Strand A. Disability insurance income saves lives. *Journal of Political Economy.* 2023;131:11 (<https://doi.org/10.1086/725172>).
325. Horowitz M, Taylor DM. The maudslay deprescribing guidelines: antidepressants, benzodiazepines, gabapentinoids and Z-drugs. London: Wiley-Blackwell; 2024.
326. Munkholm K, Horowitz MA, Moncrieff J. Maintenance antipsychotic trials and the effect of withdrawal. *Lancet.* 2022;400:995 ([https://doi.org/10.1016/S0140-6736\(22\)01467-2](https://doi.org/10.1016/S0140-6736(22)01467-2)).
327. Horowitz MA. Step change in guidance on withdrawing antidepressants. *Br J Gen Pract.* 2023;73:204 (<https://doi.org/10.3399/bjgp23X732669>).
328. Horowitz MA, Framer A, Hengartner MP, Sørensen A, Taylor D. Estimating risk of antidepressant withdrawal from a review of published data. *CNS Drugs.* 2023;37:143–57 (<https://doi.org/10.1007/s40263-022-00960-y>).
329. Hengartner MP, Plöderl M. Prophylactic effects or withdrawal reactions? An analysis of time-to-event data from antidepressant relapse prevention trials submitted to the FDA. *Ther Adv Psychopharmacol.* 2021;11:20451253211032051 (<https://doi.org/10.1177/20451253211032051>).
330. Perlman D, Peplau LA. Toward a social psychology of loneliness. In: Duck S, Gilmour R, editors. *Personal relationships in disorder.* London: Academic Press; 1981.
331. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspect Psychol Sci.* 2015;10:227–37 (<https://doi.org/10.1177/1745691614568352>).
332. About loneliness. In: Loneliness [website]. Stratford: MIND; n.d. (<https://www.mind.org.uk/information-support/tips-for-everyday-living/loneliness/about-loneliness/>).
333. Loneliness and social isolation — tips for staying connected. In: Loneliness and social isolation [website]. Bethesda, Maryland: National Institute on Aging; n.d. (<https://www.nia.nih.gov/health/loneliness-and-social-isolation/loneliness-and-social-isolation-tips-staying-connected>).
334. Policy brief: COVID-19 and the need for action on mental health. New York: United Nations; 2020 (<https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf>).
335. Doing what matters in times of stress: an illustrated guide. Geneva: World Health Organization; 2020 (<https://iris.who.int/handle/10665/331901>). License: CC BY-NC-SA 3.0 IGO.
336. Educating medical and nursing students to provide mental health, neurological and substance use care: a practical guide for pre-service education. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/380914>). License: CC BY-NC-SA 3.0 IGO.
337. IASC handbook, mental health and psychosocial support coordination. New York: Inter-Agency Standing Committee; 2023 (<https://reliefweb.int/report/world/iasc-handbook-mental-health-and-psychosocial-support-coordination>).
338. Integration of mental health and HIV interventions: key considerations. Geneva: World Health Organization and UNAIDS; 2022 (<https://iris.who.int/handle/10665/353571>). License: CC BY-NC-SA 3.0 IGO.
339. Mental health and psychosocial support: minimum service package Geneva: United Nations Inter-Agency Standing Committee; 2022 (<https://www.mhpssm.org/en/downloads>).
340. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP). Geneva: World Health Organization; 2025 forthcoming (<https://iris.who.int/handle/10665/250239>). License: CC BY-NC-SA 3.0 IGO.

341. mhGAP training manuals for the IG. Geneva: World Health Organization; 2025 forthcoming (<https://iris.who.int/handle/10665/259161>). License: CC BY-NC-SA 3.0 IGO.
342. mhGAP e-training on integrating mental health into primary care. Geneva: WHO Academy; 2025 forthcoming (<https://whoacademy.org/>).
343. Preventing suicide: a resource for primary health care workers. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/67603>). License: CC BY-NC-SA 3.0 IGO.
344. Humeniuk R, Henry-Edwards S, Ali R, Poznyak V, Monteiro MG. The alcohol, smoking and substance involvement screening test (ASSIST): manual for use in primary care. Geneva: World Health Organization; 2010 (<https://iris.who.int/handle/10665/44320>). License: CC BY-NC-SA 3.0 IGO.
345. WHO operational handbook on tuberculosis: module 6: tuberculosis and comorbidities: mental health conditions. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/373829>). License: CC BY-NC-SA 3.0 IGO.
346. Saleh AZ, Appelbaum PS, Liu X, et al. Deaths of people with mental illness during interactions with law enforcement. *Int J Law Psychiatry*. 2018;58:110–6 (<https://doi.org/10.1016/j.ijlp.2018.03.003>).
347. EU funds for migrants' mental health: some considerations. Brussels: Mental Health Europe & European Public Health Alliance; 2020 ([https://www.mhe-sme.org/wp-content/uploads/2020/02/EU-funds-for-migrants-MH\\_considerations\\_new.pdf](https://www.mhe-sme.org/wp-content/uploads/2020/02/EU-funds-for-migrants-MH_considerations_new.pdf)).
348. Schininá G. Migration governance and mental health. In: Bhugra D, editor. *Oxford Textbook of Migrant Psychiatry*. Oxford: Oxford University Press; 2021.
349. 10 things we know about race and policing in the U.S. In: Short reads [website]. Washington, D.C.: Pew Research Center; 2020 (<https://www.pewresearch.org/short-reads/2020/06/03/10-things-we-know-about-race-and-policing-in-the-u-s/>).
350. Wang L. Chronic punishment: the unmet health needs of people in state prisons. In: Reports. Northampton: Prison Policy Initiative; 2022 (<https://www.prisonpolicy.org/reports/chronicpunishment.html#mentalhealth>).
351. Behavioral health crisis alternatives: shifting from police to community responses. New York: Vera Institute of Justice; 2020 (<https://www.vera.org/behavioral-health-crisis-alternatives>).
352. Case study: cahoots. In: Vera Institute of Justice [website]. New York: Vera Institute of Justice; 2020 (<https://www.vera.org/behavioral-health-crisis-alternatives/cahoots>).
353. Case study: robust crisis care and diverting 911 calls to crisis lines. In: Vera Institute of Justice [website]. New York: Vera Institute of Justice; 2020 (<https://www.vera.org/behavioral-health-crisis-alternatives/robust-crisis-care-and-diverting-911-calls-to-crisis-lines>).
354. Dalgin RS, Maline S, Driscoll P. Sustaining recovery through the night: impact of a peer-run warm line. *Psychiatr Rehabil J*. 2011;35:65–8 (<https://doi.org/10.2975/35.1.2011.65.68>).
355. Christian H, Knuiman M, Divitini M, et al. A longitudinal analysis of the influence of the neighborhood environment on recreational walking within the neighborhood: results from RESIDE. *Environ Health Perspect*. 2017;125:077009 (<https://doi.org/10.1289/EHP823>).
356. Case study: CRU and familiar faces. In: Vera Institute of Justice [website]. New York: Vera Institute of Justice; 2020 (<https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces>).
357. Satinsky E, Fuhr DC, Woodward A, et al. Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. *Health Policy*. 2019;123:851–63 (<https://doi.org/10.1016/j.healthpol.2019.02.007>).
358. Bartolomei J, Baeriswyl-Cottin R, Framorando D, et al. What are the barriers to access to mental healthcare and the primary needs of asylum seekers? A survey of mental health caregivers and primary care workers. *BMC Psychiatry*. 2016;16:336 (<https://doi.org/10.1186/s12888-016-1048-6>).
359. Mapping of mental health policies for third-country national migrants. Brussels: European Mental Health Network; 2022 (<https://emn.ie/publications/mapping-of-mental-health-policies-for-third-country-national-migrants-emn-inform/>).
360. Mental health of refugees and migrants: risk and protective factors and access to care. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/373279>). License: CC BY-NC-SA 3.0 IGO.
361. Cole C, Klotz E, Junghanss J, et al. Patient communication ability as predictor of involuntary admission and coercive measures in psychiatric inpatient treatment. *J Psychiatr Res*. 2022;153:11–7 (<https://doi.org/10.1016/j.jpsychires.2022.06.048>).
362. Laurentsyeva N, Venturini A. The social integration of immigrants and the role of policy – a literature review. *Intereconomics*. 2017;52:285–92 (<https://doi.org/10.1007/s10272-017-0691-6>).
363. Migrant workers. In: Business and Human Rights Navigator [website]. New York: United Nations Global Compact; n.d. (<https://bhr-navigator.unglobalcompact.org/issues/migrant-workers/>).
364. Refugee and migrant mental health. In: Fact sheets [website]. Geneva: World Health Organization; 2025 (<https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-mental-health>).
365. Walther L, Fuchs LM, Schupp J, von Scheve C. Living conditions and the mental health and well-being of refugees: evidence from a large-scale German survey. *J Immigr Minor Health*. 2020;22:903–13 (<https://doi.org/10.1007/s10903-019-00968-5>).
366. Waddoups AB, Yoshikawa H, Strouf K. Developmental effects of parent–child separation. *Annu Rev Dev Psychol*. 2019;1:387–410 (<https://doi.org/10.1146/annurev-devpsych-121318-085142>).
367. Mental health and psychosocial support: minimum service package (MHPSS MSP) Geneva: UNICEF, UNHCR, WHO, & IASC Reference Group on MHPSS in Emergency Settings; 2022 (<https://www.mhpssmsp.org/en/all-activities>).
368. Psychological preparation for natural disasters. Melbourne: Australian Psychological Society; 2018 (<https://psychology.org.au/getmedia/c24bf1ba-a5fc-45d5-a982-835873148b9a/psychological-preparation-for-natural-disasters.pdf>).

369. Malkina-Pykh I, Pykh Y. An integrated model of psychological preparedness for threat and impacts of climate change disasters. *Disaster Management*. 2013;133 (<https://doi.org/10.2495/DMAN130121>).
370. *Mental health and psychosocial support in disaster situations in the Caribbean*. Washington, D.C.: Pan American Health Organization; 2012 (<https://iris.paho.org/handle/10665.2/3188>).
371. Sritharan J, Jegathesan T, Vimalaswaran D, Sritharan A. Mental health concerns of frontline workers during the COVID-19 pandemic: a scoping review. *Glob J Health Sci*. 2020;12:89–105 (<https://doi.org/10.1176/appi.ps.202000274>).
372. IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. IASC information note on disability and inclusion in MHPSS. Geneva: Inter-Agency Standing Committee; 2024 (<https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-information-note-disability-and-inclusion-mhps>).
373. Mental health and psychosocial support for migrants at border crossing points/points of entry: a toolkit. Geneva: International Organization for Migration (IOM); 2023 (<https://migrantprotection.iom.int/en/resources/guideline/mental-health-and-psychosocial-support-migrants-crossing-pointsports-entry>).
374. *Mental health in emergencies*. In: Fact sheets [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies>).
375. *Mental health promotion and mental health care in refugees and migrants: technical guidance*. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/342277>). License: CC BY-NC-SA 3.0 IGO.
376. Emilian C, Al-Juffali N, Fazel S. Prevalence of severe mental illness among people in prison across 43 countries: a systematic review and meta-analysis. *Lancet Public Health*. 2025;10:e97–e110 ([https://doi.org/10.1016/S2468-2667\(24\)00280-9](https://doi.org/10.1016/S2468-2667(24)00280-9)).
377. Convention on the Rights of Persons with Disabilities. General comment n°1 (2014), article 12: Equal recognition before the law (CRPD/C/GC/1); 31 March–11 April 2014. Geneva: Committee on the Rights of Persons with Disabilities; 2014 (<https://undocs.org/CRPD/C/GC/1>).
378. Arboleda-Flóres J. Psychiatry and the law – do the fields agree in their views on coercive treatment? In: Kallert TW, Mezzich E, Monahan J, editors. *Coercive treatment in psychiatry: Clinical, legal and ethical aspects*, first edition. Hoboken: Wiley; 2011:83.
379. Sugiura K, Mahomed F, Saxena S, Patel V. An end to coercion: rights and decision-making in mental health care. *Bull World Health Organ*. 2020;98:52–8 (<https://doi.org/10.2471/BLT.19.234906>).
380. Cacioppo JT, Cacioppo S. Social relationships and health: the toxic effects of perceived social isolation. *Soc Personal Psychol Compass*. 2014;8:58–72 (<https://doi.org/10.1111/spc3.12087>).
381. Wang L, Quandt KR. Building exits off the highway to mass incarceration: diversion programs explained. In: Reports. Northampton: Prison Policy Initiative; 2021 (<https://www.prisonpolicy.org/reports/diversion.html>).
382. No entry: a national survey of criminal justice diversion programs and initiatives. Chicago: Center for Health and Justice; 2013 ([https://www.centerforhealthandjustice.org/tascblog/Images/documents/Publications/CHJ%20Diversion%20Report\\_web.pdf](https://www.centerforhealthandjustice.org/tascblog/Images/documents/Publications/CHJ%20Diversion%20Report_web.pdf)).
383. Nascimento AM, Andrade J, de Castro Rodrigues A. The psychological impact of restorative justice practices on victims of crimes—a systematic review. *Trauma Violence Abuse*. 2023;24:1929–47 (<https://doi.org/10.1177/15248380221082085>).
384. Restorative justice's impact on participant health. Ottawa: Public Safety Canada. Government of Canada; 2021 (<https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/rstrtv-nhlth/index-en.aspx>).
385. Steele L. *Disability, criminal justice and law: reconsidering court diversion*. London: Routledge; 2020.
386. Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT); 18 December 2002. Geneva: United Nations; 2023 (<https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-against-torture-and-other-cruel>).
387. Convention on the Rights of Persons with Disabilities, art. 33 (A/RES/61/106). New York: United Nations, General Assembly; 2006 (<https://social.desa.un.org/issues/disability/crpd/article-33-national-implementation-and-monitoring>).
388. Initiatives for improving the mental health of traumatized crime victims. In: Factsheets [website]. Washington, D.C.: Office for Victim Assistance; n.d. ([https://ovc.ojp.gov/sites/g/files/xykuh226/files/pubs/OVC\\_Archives/factsheets/mentalhe.htm](https://ovc.ojp.gov/sites/g/files/xykuh226/files/pubs/OVC_Archives/factsheets/mentalhe.htm)).
389. Understanding mental health services for victims of crime. Washington, D.C.: Office for Victim Assistance; n.d. (<https://www.justice.gov/file/982316/dl?inline=>).
390. Clark C, Ryan L, Kawachi I, et al. Witnessing community violence in residential neighborhoods: a mental health hazard for urban women. *J Urban Health* 2008;85:22–38 (<https://doi.org/10.1007/s11524-007-9229-8>).
391. Working in “a meat grinder”: a research roundup showing prison and jail jobs aren’t all that states promise they will be. In: Briefings. Northampton: Prison Policy Initiative; 2022 ([https://www.prisonpolicy.org/blog/2022/05/09/correctional\\_jobs/](https://www.prisonpolicy.org/blog/2022/05/09/correctional_jobs/)).
392. Zhong S, Senior M, Yu R, Perry A, Hawton K, Shaw J et al. Risk factors for suicide in prisons: a systematic review and meta-analysis. *Lancet Public Health*. 2021;6:e164–e74 ([https://doi.org/10.1016/S2468-2667\(20\)30233-4](https://doi.org/10.1016/S2468-2667(20)30233-4)).
393. *National suicide prevention strategies: progress, examples and indicators*. Geneva: World Health Organization; 2018 (<https://iris.who.int/handle/10665/279765>). License: CC BY-NC-SA 3.0 IGO.
394. *Preventing suicide: a community engagement toolkit*. Geneva: World Health Organization; 2018 (<https://iris.who.int/handle/10665/272860>). License: CC BY-NC-SA 3.0 IGO.
395. Lerman AE, Harney J, Sadin M. Prisons and mental health: violence, organizational support, and the effects of correctional work. *Crim Justice Behav*. 2022;49:181–99 (<https://doi.org/10.1177/00938548211037718>).

396. Prisons and health. Copenhagen: World Health Organization Regional Office for Europe; 2014 (<https://apps.who.int/iris/handle/10665/128603>). License: CC BY-NC-SA 3.0 IGO.
397. Correctional recreation: an overview. Murray: Murray State University 2017 (<https://digitalcommons.murraystate.edu/cgi/viewcontent.cgi?article=1018&context=bis437>).
398. Carter MJ, Russell JK. What is the perceived worth of recreation? Results from a county jail study. *Corrections Today*. 2005;67:80–91 (<https://www.ojp.gov/ncjrs/virtual-library/abstracts/what-perceived-worth-recreation-results-county-jail-study>, accessed Access 2005).
399. Physical environment in prisons. In: Blog. Kingston: The John Howard Society of Canada; 2019 (<https://johnhoward.ca/blog/prison-physical-environment-research/>).
400. Digard L, Vanko E, Sullivan S. Rethinking restrictive housing: lessons from five U.S. jail and prison systems New York: Vera Institute of Justice; 2018 (<https://perma.cc/XHZ3-P4KM>).
401. James K, Vanko E. The impacts of solitary confinement. New York: Vera Institute of Justice; 2021 (<https://www.vera.org/downloads/publications/the-impacts-of-solitary-confinement.pdf>).
402. Siennick SE, Picon M, Brown JM, Mears DP. Revisiting and unpacking the mental illness and solitary confinement relationship. *Justice Q*. 2022;39:772–801 (<https://doi.org/10.1080/07418825.2020.1871501>).
403. James K, Vanko E. Punishment of people with serious mental illness in New York state prisons. New York: #HALTsolitary Campaign and MHASC (Mental Health Alternatives to Solitary Confinement) Campaigns; 2022 (<https://drive.google.com/file/d/16yzZ-Lj8-jwVBvG3ptPfu6kUfjw01CL/view>).
404. Bronson J, Berzofsky M. Indicators of mental health problems reported by prisoners and jail inmates, 2011-12. Washington, D.C.: U.S. Department of Justice; 2022 (<https://bjs.ojp.gov/content/pub/pdf/imhprj1112.pdf>).
405. Ring K, Gill M. Using time to reduce crime: federal prisoner survey results show ways to reduce recidivism Washington, D.C.: Families Against Mandatory Minimums; 2017 ([https://www.prisonpolicy.org/scans/famm/Prison-Report\\_May-31\\_Final.pdf](https://www.prisonpolicy.org/scans/famm/Prison-Report_May-31_Final.pdf)).
406. Remch R, Mautz C, Burke EG, Junker G, Kaniuka A, Proescholdbell S et al. Impact of a prison therapeutic diversion unit on mental and behavioral health outcomes. *Am J Prev Med*. 2021;61:619–27 (<https://doi.org/10.1016/j.amepre.2021.05.023>).
407. The social reintegration of offenders and crime prevention. Vancouver: The International Centre for Criminal Law Reform and Criminal Justice Policy; 2007 (<https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/scl-rntgrtn/index-en.aspx#s4>).
408. n.d. Practice profile: rehabilitation programs for adults convicted of a crime. In: *Crime Solutions*. Washington, D.C.: U.S. Department of Justice; 2020 (<https://crimesolutions.ojp.gov/ratedpractices/101#pd>).
409. Feder M. What are community corrections programs? In: Blog. Phoenix: University of Phoenix; 2022 (<https://www.phoenix.edu/blog/what-are-community-based-corrections-programs.html>).
410. Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*. 2012;11:123–8 (<https://doi.org/10.1016/j.wpsyc.2012.05.009>).
411. Peer support roles in criminal justice settings. Rockville: SAMSHA; 2017 ([https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2019/06/WebinarSupportingDocument\\_PeerRolesinCJSettings508.pdf](https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2019/06/WebinarSupportingDocument_PeerRolesinCJSettings508.pdf)).
412. Restorative justice. In: *Crime prevention and criminal justice*. Geneva: United Nations Office for Drugs and Crime; n.d. (<https://www.unodc.org/unodc/en/justice-and-prison-reform/cpcj-restorative-justice.html>).
413. What is restorative justice? . In: Provincial Court of Alberta. Calgary: Provincial Court of Alberta; n.d. (<https://rjalbertacourts.ca/what-is-restorative-justice>).
414. Criminal justice assessment toolkit: social reintegration. Vienna: United Nations Office on Drugs and Crime (UNODC); 2006 ([https://www.unodc.org/documents/justice-and-prison-reform/cjat\\_eng/4\\_Social\\_Reintegration.pdf](https://www.unodc.org/documents/justice-and-prison-reform/cjat_eng/4_Social_Reintegration.pdf)).
415. Critoph S, Rope O. Mental health in prison: a short guide for prison staff. London: Penal Reform International; 2018 (<https://www.penalreform.org/resource/mental-health-in-prison-a-short-guide-for/>).
416. Promoting the health of young people in custody. Copenhagen: World Health Organization Regional Office for Europe; 2003 (<https://iris.who.int/handle/10665/107532>). License: CC BY-NC-SA 3.0 IGO.
417. Handbook on prisoners with special needs. Vienna: United Nations Office on Drugs and Crime (UNODC); 2009 ([https://www.unodc.org/pdf/criminal\\_justice/Handbook\\_on\\_Prisoners\\_with\\_Special\\_Needs.pdf](https://www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf)).
418. The sustainable development goals report 2022. New York: United Nations Department of Economic and Social Affairs; 2022 (<https://unstats.un.org/sdgs/report/2022/>).
419. Shields-Zeeman L, Smit F. The impact of income on mental health. *Lancet Public Health*. 2022;7:e486–e7 ([https://doi.org/10.1016/S2468-2667\(22\)00094-9](https://doi.org/10.1016/S2468-2667(22)00094-9)).
420. Phelan JC, Link BG, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. *J Health Soc Behav*. 2010;51:Suppl:S28–S40 (<https://doi.org/10.1177/0022146510383498>).
421. Funk M, Drew N, Knapp M. Mental health, poverty and development. *J Public Ment Health*. 2012;11:166–85 (<https://doi.org/10.1108/17465721211289356>).
422. Alegria M, NeMoyer A, Falgàs Bagué I, Wang Y, Alvarez K. Social determinants of mental health: where we are and where we need to go. *Curr Psychiatry Rep*. 2018;20:95 (<https://doi.org/10.1007/s11920-018-0969-9>).
423. Han S, Lee H-S. Social capital and depression: does household context matter? *Asia Pac J Public Health*. 2015;27:NP2008–NP18 (<https://doi.org/10.1177/1010539513496140>).

424. Brydsten A, Hammarström A, San Sebastian M. Health inequalities between employed and unemployed in northern Sweden: a decomposition analysis of social determinants for mental health. *Int J Equity Health*. 2018;17:59 (<https://doi.org/10.1186/s12939-018-0773-5>).
425. Williams DR, Etkins OS. Racism and mental health. *World Psychiatry*. 2021;20:194–5 (<https://doi.org/10.1002/wps.20845>).
426. Tebbe EA, Budge SL. Factors that drive mental health disparities and promote well-being in transgender and nonbinary people. *Nat Rev Psychol*. 2022;1:694–707 (<https://doi.org/10.1038/s44159-022-00109-0>).
427. Cho Y, Molina TS. The importance of existing social protection programs for mental health in pandemic times. Policy research working paper series 10669. Washington, D.C.: The World Bank; 2024 (<https://ideas.repec.org/p/wbk/wbrwps/10669.html>).
428. Simpson J, Albani V, Bell Z, et al. Effects of social security policy reforms on mental health and inequalities: a systematic review of observational studies in high-income countries. *Soc Sci Med*. 2021;272:113717 (<https://doi.org/10.1016/j.socscimed.2021.113717>).
429. Social protection and growth: research synthesis. Barton: Australian Government Department of Foreign Affairs 2014 (<https://www.dfat.gov.au/sites/default/files/social-protection-and-growth-research-synthesis.pdf>).
430. Saeri AK, Cruwys T, Barlow FK, Stronge S, Sibley CG. Social connectedness improves public mental health: investigating bidirectional relationships in the New Zealand attitudes and values survey. *Aust N Z J Psychiatry*. 2018;52:365–74 (<https://doi.org/10.1177/0004867417723990>).
431. Perkins JM, Subramanian SV, Christakis NA. Social networks and health: a systematic review of sociocentric network studies in low- and middle-income countries. *Soc Sci Med*. 2015;125:60–78 (<https://doi.org/10.1016/j.socscimed.2014.08.019>).
432. Warner LM, Yeung DY, Jiang D, et al. Effects of volunteering over six months on loneliness, social and mental health outcomes among older adults: The HEAL-HOA dual randomized controlled trial. *Am J Geriatr Psychiatry*. 2024;32:598–610 (<https://doi.org/10.1016/j.jagp.2023.12.022>).
433. Noguchi T, Bone JK, Saito T, et al. Arts and cultural engagement and subsequent social deficits among older adults: a three-year longitudinal study using the Japan Gerontological Evaluation Study. *Soc Sci Med*. 2024;356:117139 (<https://doi.org/10.1016/j.socscimed.2024.117139>).
434. Tubić T, Modrić T, Sekulić D, et al. Loneliness in sports active and non-active school-age children: Can sport protect children against loneliness? *Front Psychiatry*. 2023;13:1063714 (<https://doi.org/10.3389/fpsy.2022.1063714>).
435. Ekinci NE. Examining effect of participating to recreational activities on loneliness level of middle school students. *Univ J Educ Res*. 2023;6:1887–90 (<https://doi.org/10.13189/ujer.2018.060905>).
436. Phang J, Kwan Y, Yoon S, et al. Digital intergenerational program to reduce loneliness and social isolation among older adults: realist review. *JMIR Aging*. 2023;6:e39848 (<https://doi.org/10.2196/39848>).
437. Djundeva M, Ellwardt L. Social support networks and loneliness of Polish migrants in the Netherlands. *J Ethn Migr Stud*. 2019;46:1281–300 (<https://doi.org/10.1080/1369183X.2019.1597691>).
438. Padgett DK. Homelessness, housing instability and mental health: making the connections. *BJPsych Bull*. 2020;44:197–201 (<https://doi.org/10.1192/bjb.2020.49>).
439. Bassuk E, Richard M, Tsertsvadze A. The prevalence of mental illness in homeless children: a systematic review and meta-analysis. *J Am Acad Child Adolesc Psychiatry*. 2015;54:86–96.e2 (<https://doi.org/10.1016/j.jaac.2014.11.008>).
440. Homelessness, mental health and substance use: understanding the connections. Toronto: Homeless Hub; 2021 (<https://homelesshub.ca/resource/homelessness-mental-health-and-substance-use-understanding-connections/>).
441. Loubière S, Lemoine C, Boucekine M, Boyer L, Girard V, Tinland A et al. Housing first study group. Housing first for homeless people with severe mental illness: Extended 4-year follow-up and analysis of recovery and housing stability from the randomized un chez soi d'abord trial. *Epidemiol Psychiatr Sci*. 2022;31:e14 (<https://doi.org/10.1017/S2045796022000026>).
442. Patterson M, Moniruzzaman A, Palepu A, et al. Housing First improves subjective quality of life among homeless adults with mental illness: 12-month findings from a randomized controlled trial in Vancouver, British Columbia. *Soc Psychiatry Psychiatr Epidemiol*. 2013;48:1245–59 (<https://doi.org/10.1007/s00127-013-0719-6>).
443. Padgett DK, Henwood BF, Tsemberis SJ. *Housing First. Ending homelessness, transforming systems and changing lives* Oxford: Oxford University Press; 2016.
444. Gibson K, Abraham Q, Asher I, et al. *Child poverty and mental health: a literature review*. Auckland: New Zealand Psychological Society and Child Poverty Action Group; 2017 (<https://hdl.handle.net/10289/11484>).
445. Kwan C, Walsh CA. Old age poverty: a scoping review of the literature. *Cogent Soc Sci*. 2018;4:1478479 (<https://doi.org/10.1080/23311886.2018.1478479>).
446. Gmitroski T, Bradley C, Heinemann L, et al. Barriers and facilitators to employment for young adults with mental illness: a scoping review. *BMJ Open*. 2018;8:e024487 (<https://doi.org/10.1136/bmjopen-2018-024487>).
447. Wahlbeck K, Cresswell-Smith J, Haaramo P, Parkkonen J. Interventions to mitigate the effects of poverty and inequality on mental health. *Soc Psychiatry Psychiatr Epidemiol*. 2017;52:505–51 (<https://doi.org/10.1007/s00127-017-1370-4>).
448. Richardson T, Elliott P, Roberts R. The relationship between personal unsecured debt and mental and physical health: a systematic review and meta-analysis. *Clin Psychol Rev*. 2013;33:1148–62 (<https://doi.org/10.1016/j.cpr.2013.08.009>).
449. Reibling N, Beckfield J, Huijts T, Schmidt-Catran A, Thomson KH, Wendt C. Depressed during the depression: has the economic crisis affected mental health inequalities in Europe? Findings from the European Social Survey (2014) special module on the determinants of health. *Eur J Public Health*. 2017;27:47–54 (<https://doi.org/10.1093/eurpub/ckw225>).
450. Milner A, Page A, LaMontagne AD. Cause and effect in studies on unemployment, mental health and suicide: a meta-analytic and conceptual review. *Psychol Med*. 2014;44:909–17 (<https://doi.org/10.1017/S0033291713001621>).

451. Bond GR, Drake RE, Becker DR. An update on individual placement and support. *World Psychiatry*. 2020;19:390–1 (<https://doi.org/10.1002/wps.20784>).
452. Care homes and hospitals 'failing people with dementia'. In: *The Guardian* [website]. London: The Guardian; 2013 (<http://www.theguardian.com/society/2013/mar/12/care-homes-hospitals-failing-dementia>).
453. Innovation in deinstitutionalization: a WHO expert survey. Geneva: World Health Organization; 2014 (<https://iris.who.int/handle/10665/112829>). License: CC BY-NC-SA 3.0 IGO.
454. HSE social prescribing framework. Dublin: HSE; 2022 (<https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/hse-social-prescribing-framework.pdf>).
455. Violence prevention at CDC. In: *Violence Prevention* [website]. Atlanta: Centers for Disease Control and Prevention; n.d. ([https://www.cdc.gov/violence-prevention/?CDC\\_AAref\\_Val=https://www.cdc.gov/violenceprevention/about/index.html](https://www.cdc.gov/violence-prevention/?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/about/index.html)).
456. Community engagement: a health promotion guide for universal health coverage in the hands of the people. Geneva: World Health Organization; 2020 (<https://iris.who.int/handle/10665/334379>). License: CC BY-NC-SA 3.0 IGO.
457. Deinstitutionalization of people with mental health conditions in the WHO South-East Asia Region. New Delhi: World Health Organization. Regional Office for South-East Asia; 2024 (<https://iris.who.int/handle/10665/376123>). License: CC BY-NC-SA 3.0 IGO.
458. Peer support groups by and for people with lived experience: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329594>). License: CC BY-NC-SA 3.0 IGO.
459. Social isolation and loneliness among older people: advocacy brief. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/343206>). License: CC BY-NC-SA 3.0 IGO.
460. Šiška J, Beadle-Brown J. Transition from institutional care to community-based services in 27 EU Member States: Final report. Research report for the European Expert Group on Transition from Institutional to Community-based Care. 2020 (<https://deinstitutionalisationdotcom.files.wordpress.com/2020/05/eeg-di-report-2020-1.pdf>).
461. World report on social determinants of health equity. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/381152>). License: CC BY-NC-SA 3.0 IGO.
462. Goal 11: make cities inclusive, safe, resilient and sustainable. In: *United Nations Sustainable Development Group* [website]. New York: United Nations Sustainable Development Group; n.d. (<https://www.un.org/sustainabledevelopment/cities/>).
463. Urbanisation. In: *EEA Glossary* [website]. Copenhagen: European Environment Agency; n.d. (<https://www.eea.europa.eu/help/glossary/eea-glossary/urbanisation>).
464. Urbanization: expanding opportunities, but deeper divides. In: *United Nations Department of Economic and Social Affairs* [website]. New York: United Nations Department of Economic and Social Affairs; n.d. (<https://www.un.org/nl/desa/urbanization-expanding-opportunities-deeper-divides>).
465. Hidden cities: unmasking and overcoming health inequities in urban settings. Geneva: World Health Organization & United Nations; 2010 (<https://iris.who.int/handle/10665/44439>). License: CC BY-NC-SA 3.0 IGO.
466. Housing: shared interests in health and development. Geneva: World Health Organization; 2011 (<https://iris.who.int/handle/10665/44705>). License: CC BY-NC-SA 3.0 IGO.
467. How urban design can impact mental health. In: *Centre for Urban Design and Mental Health* [website]. Amsterdam: Centre for Urban Design and Mental Health; n.d. (<https://www.urbandesignmentalhealth.com/how-urban-design-can-impact-mental-health.html>).
468. Hill K, Webber R. From pandemic to cost of living crisis: low-income families in challenging times. Loughborough: Loughborough University; 2022 (<https://hdl.handle.net/2134/22353907.v1>).
469. Olsen EO. Housing programs for low-income households. Chicago: University of Chicago Press; 2003 (<https://www.nber.org/system/files/chapters/c10259/c10259.pdf>).
470. Housing discrimination under the fair housing act. In: *Fair housing and equal opportunity* [website]. Washington, D.C.: U.S. Department of Housing and Urban Development; n.d. ([https://www.hud.gov/program\\_offices/fair\\_housing\\_equal\\_opp/fair\\_housing\\_act\\_overview](https://www.hud.gov/program_offices/fair_housing_equal_opp/fair_housing_act_overview)).
471. Tran LD, Rice TH, Ong PM, et al. Impact of gentrification on adult mental health. *Health Serv Res*. 2020;55:432–44 (<https://doi.org/10.1111/1475-6773.13264>).
472. WHO housing and health guidelines. Geneva: World Health Organization; 2018 (<https://iris.who.int/handle/10665/276001>). License: CC BY-NC-SA 3.0 IGO.
473. Preece J, Bimpson E. Housing insecurity and mental health: an evidence review. Glasgow: UK Collaborative Center for Housing Evidence; 2019 (<https://housingevidence.ac.uk/publications/housing-insecurity-and-mental-health-an-evidence-review/>).
474. Booth M, Kalutara P, Abbasi N. Re-thinking spatial design in homes to include means and access restriction with material impacts as passive suicide prevention methods: a systematic review of design for Australian homes. *Buildings*. 2023;13:1452 (<https://doi.org/10.3390/buildings13061452>).
475. Onapa H, Sharpley CF, Bitsika V, et al. The physical and mental health effects of housing homeless people: A systematic review. *Health Soc Care Community*. 2021;2:448–68 (<https://doi.org/10.1111/hsc.13486>).
476. Turning the Key: assessing housing and related supports for persons living with mental health problems and illnesses. Ottawa: Mental Health Commission of Canada; 2011 ([https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/PrimaryCare\\_Turning\\_the\\_Key\\_Summary\\_ENG\\_0\\_1.pdf](https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/PrimaryCare_Turning_the_Key_Summary_ENG_0_1.pdf)).

477. The Universal Declaration of Human Rights (Resolution 217A (III)), 10 December 1948. New York: United Nations, General Assembly; 1948 (<http://www.un.org/en/universal-declaration-human-rights/>).
478. International Covenant on Economic, Social and Cultural Rights, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966. Geneva: United Nations, General Assembly; 1976 (<https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights>).
479. Disability, accessibility and sustainable urban development. In: Social inclusion [website]. New York: United Nations Department of Economic and Social Affairs; n.d. (<https://social.desa.un.org/issues/disability/disability-issues/disability-accessibility-and-sustainable-urban-development>).
480. Forster GK, Aarø LE, Alme MN, Hansen T, Nilsen TS, Vedaa Ø. Built environment accessibility and disability as predictors of well-being among older adults: a Norwegian cross-sectional study. *Int J Environ Res Public Health*. 2023;20:5898 (<https://doi.org/10.3390/ijerph20105898>).
481. National housing strategy for disabled people 2022–2027. Dublin: Department of Housing, Local Government and Heritage; Department of Health; and Department of Children, Equality, Disability, Integration and Youth; 2022 (<https://www.gov.ie/en/publication/60d76-national-housing-strategy-for-disabled-people-2022-2027/>).
482. Integrating health in urban and territorial planning: a sourcebook. Geneva: UN-HABITAT and World Health Organization; 2020 (<https://iris.who.int/handle/10665/331678>). License: CC BY-NC-SA 3.0 IGO.
483. Green and blue spaces and mental health: new evidence and perspectives for action. Copenhagen: World Health Organization Regional Office for Europe; 2021 (<https://iris.who.int/handle/10665/342931>). License: CC BY-NC-SA 3.0 IGO.
484. Stathopoulou G, Powers MB, Berry AC, et al. Exercise interventions for mental health: a quantitative and qualitative review. *Clin Psychol Sci*. 2006;13:179–93 (<https://doi.org/10.1111/j.1468-2850.2006.00021.x>).
485. Fair play: building a strong physical activity system for more active people. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/346169>). License: CC BY-NC-SA 3.0 IGO.
486. Baranyi G, Di Marco MH, Russ TC, Dibben C, Pearce J. The impact of neighbourhood crime on mental health: a systematic review and meta-analysis. *Soc Sci Med*. 2023;282:114106 (<https://doi.org/10.1016/j.socscimed.2021.114106>).
487. Senna I, Iglesias F, Matsunaga LH. Measuring the effects of CPTED on fear of crime in public spaces. *Crime Prev Community Saf*. 2025;27:120–35 (<https://doi.org/10.1057/s41300-025-00223-0>).
488. Hou F, Marzbali MH, Maghsoodi Tilaki MJ, Abdullah A. Rethinking urban greening: Implications of crime prevention through environmental design for enhancing perceived safety in public open spaces. *Urban Sci*. 2025;9:9 (<https://doi.org/10.3390/urbansci9010009>).
489. Piroozfar P, Farr ERP, Aboagye-Nimo E, Osei-Berchie J. Crime prevention in urban spaces through environmental design: a critical UK perspective. *Cities*. 2019;95:102411 (<https://doi.org/10.1016/j.cities.2019.102411>).
490. Papadakaki M, Strukinskiene B, Alves T, Lund J. Mental health impairment and recovery after a road traffic injury: where do we stand in Europe? *Front Public Health*. 2024;12:1418920 (<https://doi.org/10.3389/fpubh.2024.1418920>).
491. Global status report on road safety 2023. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/375016>). License: CC BY-NC-SA 3.0 IGO.
492. Jamshidi S, Ensafi M, Pati D. Wayfinding in interior environments: an integrative review. *Front Psychol*. 2020;11:549628 (<https://doi.org/10.3389/fpsyg.2020.549628>).
493. Prandi C, Barricelli BR, Mirri S, Fogli D. Accessible wayfinding and navigation: a systematic mapping study. *Universal Access in the Information Society*. 2023;22:185–212 (<https://doi.org/10.1007/s10209-021-00843-x>).
494. WHO global water, sanitation and hygiene: annual report 2023. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/380619>). License: CC BY-NC-SA 3.0 IGO.
495. Zijlema WL, Avila-Palencia I, Triguero-Mas M, et al. Active commuting through natural environments is associated with better mental health: results from the PHENOTYPE project. *Environ Int*. 2018;121:721–7 (<https://doi.org/10.1016/j.envint.2018.10.002>).
496. Martin A, Goryakin Y, Suhrcke M. Does active commuting improve psychological wellbeing? Longitudinal evidence from eighteen waves of the British Household Panel Survey. *Prev Med*. 2014;69 (<https://doi.org/10.1016/j.ypmed.2014.08.023>).
497. Our sunflower is for everyone with a hidden disability. In: HIDDEN disabilities [website]. London: HIDDEN disabilities; n.d. (<https://hdsunflower.com/>).
498. Convention on the Rights of Persons with Disabilities, art. 9 (A/RES/61/106). New York: United Nations, General Assembly; 2006 (<https://social.desa.un.org/issues/disability/crpd/article-9-accessibility>).
499. Rural mental health. In: Topics [website]. Grand Forks: Rural Health Information Hub; n.d. (<https://www.ruralhealthinfo.org/topics/mental-health#integration>).
500. Morrissey TW, Allard SW, Pelletier E. Access to early care and education in rural communities: implications for children's school readiness. *RSF J Soc Sci*. 2022;8:100–23 (<https://doi.org/10.7758/RSF.2022.8.3.04>).
501. Collins PY, Sinha M, Concepcion T, Patton G, Way T, McCay L et al. Making cities mental health friendly for adolescents and young adults. *Nature Nature*. 2024;627:137–48 (<https://doi.org/10.1038/s41586-023-07005-4>).
502. First national study of farmer suicide rates using coronial data. In: National Rural Health Alliance [website]. Deakin: National Rural Health Alliance; 2021 (<https://www.ruralhealth.org.au/news/first-national-study-farmer-suicide-rates-using-coronial-data>).
503. King T, Maheen H, Taouk Y, et al. Suicide in the Australian mining industry: assessment of rates among male workers using 19 years of coronial data. *Saf Health Work*. 2023;14:193–200 (<https://doi.org/10.1016/j.shaw.2023.03.003>).

504. Pollock NJ, Naicker K, Loro A, Mulay S, Colman I. Global incidence of suicide among Indigenous peoples: a systematic review. *BMC Med.* 2018;16:145 (<https://doi.org/10.1186/s12916-018-1115-6>).
505. Nestadt PS, Triplett P, Fowler DR, Mojtabai R. Urban–rural differences in suicide in the state of Maryland: the role of firearms. *Am J Public Health.* 2017;107(10):1548–1553 (<https://doi.org/10.2105/AJPH.2017.303865>).
506. Lange S, Kim KV, Jiang H, Shield KD, Rehm J, Hennis AJM et al. Forecasting the impact of means restriction on the suicide mortality rate in the Region of the Americas: an ecological modeling study. *Lancet Reg Health Am.* 2024;36:100831 (<https://doi.org/10.1016/j.lana.2024.100831>).
507. A guide to urban health strategy. Geneva: World Health Organization; 2025 forthcoming (<https://iris.who.int/handle/10665/184033>). License: CC BY-NC-SA 3.0 IGO.
508. City leadership for health and sustainable development: critical issues for successful Healthy Cities initiatives in the WHO European Region. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/378637>). License: CC BY-NC-SA 3.0 IGO.
509. Make your city child friendly. In: UNICEF [website]. New York: UNICEF; n.d. (<https://www.childfriendlycities.org/>).
510. Pan African action plan for active mobility. Nairobi: United Nations Environment Programme; 2024 (<https://wedocs.unep.org/20.500.11822/46513>).
511. Regional laboratory on urban governance for health and well-being [website]. Bangkok: Regional laboratory on urban governance for health and well-being; n.d. (<https://ughw.org>).
512. Niu H. Toolbox for spatial analysis on urban health. Toolbox I: indicator, index and metrics of urban health variables. In: Spatial analysis toolbox [website]. Lisbon: eMOTIONAL CITIES and Cambridge University; n.d. (<https://hn303.github.io/eMCities-spatial-toolbox/>).
513. Urban planning for health: experiences from 12 European cities on building resilience. In: City Know-how [website]. Berlin: City Know-how; n.d. (<https://www.cityknow-how.com/urban-planning-for-health-experiences-from-12-european-cities-on-building-resilience/>).





