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

Impact of mental health challenges on the enjoyment of human rights by young people

Report of the Office of the United Nations High Commissioner for Human Rights*

Summary

The present study, submitted pursuant to Human Rights Council resolution 57/30, examines the impact of mental health challenges on the enjoyment of human rights by young people. The Office of the United Nations High Commissioner for Human Rights mapped key structural and systemic barriers, progress and promising practices and recommends that States and other stakeholders adopt a youth-centred, human rights-based approach to mental health, developed and implemented in partnership with young people.

* The present report was submitted to the conference services for processing after the deadline so as to include the most recent information.

I. Introduction

1. In its resolution 57/30, the Human Rights Council requested the Office of the United Nations High Commissioner for Human Rights (OHCHR), in consultation with States and relevant stakeholders, including relevant United Nations agencies, the United Nations Youth Office and the Assistant Secretary-General for Youth Affairs, the treaty bodies, the special procedures of the Human Rights Council, national human rights institutions, civil society and representatives of youth organizations, to conduct a detailed study on the impact of mental health challenges on the enjoyment of human rights by young people and to submit it prior to the sixty-third session.

2. The study draws on 277 submissions from States, national human rights institutions and other statutory bodies, United Nations entities and civil society, including young people.[1] Based on the consultation guidance developed by OHCHR, stakeholders conducted consultations with young people to inform the present study.[2] OHCHR also convened expert consultations in May 2026. The study builds on the existing work of OHCHR on youth rights and mental health and human rights,[3] as well as other related work by human rights mechanisms.[4] References throughout the study are illustrative, given the volume of submissions.

II. Young people and mental health

3. Youth is a developmental period characterized by emotional, physical, psychological and social changes and progressive transition towards greater autonomy, independence and identity. These include transitions across life stages and systems, including the education, employment, alternative care, health and criminal justice systems.[5] The impact is heightened due to the protection gap during these transitions. As child-specific safeguards end, young people may encounter fragmented or restrictive adult legal and institutional systems, limiting access to supports necessary for autonomy.

4. Young people constitute approximately 32 per cent – 2.6 billion[6] – of the world's population and are living through times of profound social, economic, political and environmental change. These shifts are reshaping how young people learn, work and connect, while exposing many to heightened stress, uncertainty and social exclusion, with considerable implications for mental health. Nevertheless, young people need to make pivotal decisions with long-term implications for their lives in spheres of education, work, relationships and participation in public life, often while support systems become less available or more fragmented. These transitions can increase exposure to mental health challenges, particularly where young people face poverty, violence, exclusion or intersecting forms of discrimination.

[1] All submissions are available from https://www.ohchr.org/en/calls-for-input/2026/call-inputs-impact-mental-health-challenges-enjoyment-human-rights-young. Submissions were received from 17 States and 18 national human rights institutions and other statutory bodies, 228 from civil society, six from United Nations entities and six from other stakeholders.

[2] See https://www.ohchr.org/en/calls-for-input/2026/call-inputs-impact-mental-health-challenges-enjoyment-human-rights-young.

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

[4] See A/79/162; A/HRC/44/39; A/HRC/55/50; A/HRC/56/58/Add.1, paras. 52–71, 91; A/HRC/58/58/Add.2, paras. 30–39 and 98 (d); and A/HRC/59/41, paras. 59–63 and 98 (a)–(g).

[5] See submissions from Colombia, Estonia, Ecuador, Slovenia, the Guardian for Children and Young People in South Australia, the National Human Rights Institution in the Kingdom of Bahrain, the National Youth Advocacy Service (England and Wales) and the United Nations Educational, Scientific and Cultural Organization.

[6] See https://social.desa.un.org/publications/world-youth-report-2025.

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5. Today's young people are also confronting far-reaching global uncertainty. They face political instability, armed conflicts and insecurity, multiple planetary crises, economic insecurity and cost-of-living concerns.[7] The coronavirus disease (COVID-19) pandemic created an unprecedented youth mental health crisis and disrupted key sources of stability and social connection. It generated substantial mental health needs, further burdening services strained by long-term underinvestment.[8]

6. Young people worldwide face complex mental health challenges, which can have an impact on multiple facets of their lives, often diminishing hope and agency. The impact varies across contexts, yet the cumulative effects can delay or disrupt pathways to autonomy, independence and participation. Young people experience anxiety, depression, burnout, stress, trauma-related distress, low self-confidence, eating disorders, body image concerns, psychosomatic disorders and disrupted sleep. Behavioural and substance addictions, including excessive digital use, gambling and gaming, are also confronted by young people. In addition, young people may encounter social isolation, loneliness, fear, overwhelm and uncertainty, particularly about the future.[9]

7. Across all regions, self-harm and suicidal ideation are matters of concern. According to the World Health Organization (WHO), suicide is the third leading cause of death among young people globally, highlighting that the prevention of suicide has not been adequately addressed due to a lack of awareness of suicide as a major public health problem and the taboo in many societies to openly discuss it.[10]

8. Young people also face heightened vulnerability to mental health conditions,[11] as a substantial proportion emerge during adolescence and early adulthood.[12] Continued brain development during this period influences mental health in multiple ways. Mental health challenges that arise or remain unsupported during this period can disrupt education, employment, social connection, participation, independent living and access to services, with lasting consequences throughout the life course. Conversely, timely, rights-based and youth-centred support can strengthen resilience, agency, inclusion and the foundation for the full enjoyment of rights across the life course.

9. Stigma, discrimination, coercive responses, inadequate care and support and structural barriers can have significant socioeconomic and psychological consequences on young people experiencing mental health challenges, some with long-term implications, including on the enjoyment of human rights. Young people face multiple and intersecting risk factors affecting their mental health.[13]

10. Mental health has historically been neglected in public health and health services delivery.[14] Globally, there are persistent gaps in the availability, accessibility, acceptability and quality of mental health services. This is compounded by limited quality, disaggregated data, insufficient funding and uneven participation. Failure to prioritize, combined with stigma, taboos and fear of disclosure and institutionalization, has left many young people without timely, appropriate or accessible support.[15] In recent years, growing awareness,

[7] See https://desapublications.un.org/publications/world-youth-report-youth-mental-health-and-well-being; and submissions.

[8] A/HRC/51/19, paras. 44–47.

[9] Based on analysis of submissions from all stakeholders.

[10] See https://www.who.int/news-room/fact-sheets/detail/suicide/.

[11] See https://unsdg.un.org/sites/default/files/2020-03/SG-Report-Socio-Economic-Impact-ofCovid19.pdf.

[12] See https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mentalhealth.pdf; https://pubmed.ncbi.nlm.nih.gov/34079068/; and https://pmc.ncbi.nlm.nih.gov/articles/PMC10529120/.

[13] See submissions; and https://www.oecd.org/content/dam/oecd/en/publications/reports/2026/05/child-adolescent-and-youth-mental-health-in-the-21st-century_81743169/1092c3cb-en.pdf.

[14] See https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667%2825%2900261-0/fulltext; and https://www.who.int/observatories/global-observatory-on-health-research-and-development/analyses-and-syntheses/mental-health/global-strategic-direction.

[15] See https://iris.who.int/server/api/core/bitstreams/40e5a13a-fe50-4efa-b56d-6e8cf00d5bfa/content; https://desapublications.un.org/publications/world-youth-report-youth-mental-health-and-well-being; and submissions.

Advance edited version

driven in part by youth-led advocacy, has helped to shift priorities, raising awareness and challenging cultural and social taboos and legal, policy and practical barriers.

11. Youth needs to be understood as a fluid and nonhomogeneous category, rather than a fixed age group. It is a transition from dependence to independence and full autonomy, shaped by age, development and socioeconomic and cultural context. This occurs at different times across different spheres of life and rights, for example, employment, education and sexual and reproductive health.[16]

12. There is no consistent global definition of "youth", nor a universal human rights instrument exclusively dedicated to youth rights. The human rights of young people refer to their full enjoyment of all fundamental human rights and freedoms. Most international human rights instruments apply to young people, both online and offline. There are also regional human rights and youth-specific frameworks.[17]

13. The right to health is enshrined in the Universal Declaration of Human Rights (art. 25 (1)), the International Covenant on Economic, Social and Cultural Rights (art. 12), the Convention on the Rights of the Child (art. 24), the Convention on the Rights of Persons with Disabilities (art. 25) and the Convention on the Elimination of All Forms of Discrimination against Women (art. 12).

14. The right to the enjoyment of the highest attainable standard of health is a fundamental human right indispensable for the realization of other rights.[18] It encompasses timely and appropriate healthcare and underlying determinants of health, including safe drinking water and adequate sanitation, adequate food, nutrition and housing, health-related education and information, including sexual and reproductive health, and healthy occupational and environmental conditions.[19] Its essential and interrelated elements, availability, accessibility, acceptability and quality, must be addressed holistically.[20] Relevant determinants include low socioeconomic status, violence and abuse, adverse childhood experiences, early childhood development and supportive family, work and other relationships.[21] These determinants play a critical role in shaping youth mental health and well-being, influencing the risk of experiencing mental health challenges and access to appropriate support and care.

15. The right to health contains freedoms, such as control over one's health and body and freedom from interference, torture and non-consensual medical treatment, and entitlements, including equal opportunity to enjoy the highest attainable standard of health.[22]

16. The International Covenant on Economic, Social and Cultural Rights requires States Parties to the Covenant to take steps, to the maximum of available resources, with a view to achieving the progressive realization of the right to health (art. 2 (1)).[23] Mental health is part of the right to health. Certain obligations, including respecting these freedoms and non-discrimination, are of immediate effect and not subject to progressive realization or resource availability. States Parties must ensure, at a minimum, essential levels of the right to health. Core obligations include ensuring non-discriminatory access to health facilities, goods and services, especially for marginalized groups, access to the minimum of essential food that is nutritionally adequate, access to basic shelter, housing and sanitation and essential medicines, equitable distribution of health facilities, goods and services and adopting and implementing a national public health strategy and plan of action.[24]

[16] A/HRC/39/33, paras. 13–15.
[17] Ibid., para. 16. For a full discussion, see paras. 13–22.
[18] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 1; and see https://www.ohchr.org/sites/default/files/Factsheet31.pdf.
[19] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 4, 10 and 11.
[20] Ibid., para. 12.
[21] See https://www.who.int/publications/i/item/9789241506809; A/HRC/41/34; and A/HRC/50/28.
[22] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 8 and 41.
[23] Ibid., para. 47.
[24] Ibid., general comment No. 14 (2000), para. 43.

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17. In the context of youth mental health, to use a youth lens is to recognize that transitions across age thresholds require continuity of care to prevent service gaps and loss of access and to ensure autonomy and inclusion. It also requires rights-based measures to address social and structural determinants across relevant sectors, accompanied by available, accessible, acceptable and high-quality services.

18. In Sustainable Development Goal 3, States committed to achieving to healthy lives and well-being for all, including by reducing premature mortality from noncommunicable diseases, promoting mental health and well-being, preventing and treating substance abuse, achieving universal health coverage and tracking suicide mortality.[25] The Sustainable Development Goals on poverty, hunger, education, inequality, decent work, safe communities, peace and justice and climate resilience all play important roles in addressing mental health.

19. Under the Pact for the Future, States committed to equitable access to essential services for all young people, especially health services, advancing progress towards universal health coverage and addressing the social and structural drivers of youth mental health and well-being.[26]

20. Growing momentum around young people and on mental health[27] has led to diverse multilateral initiatives. These include the United Nations Youth Strategy,[28] the policy brief on COVID-19 and the need for action on mental health,[29] the WHO comprehensive mental health action plan, 2013–2030,[30] the OHCHR-WHO *Mental Health, Human Rights and Legislation: Guidance and Practice*[31] and the United Nations Youth Office-led flagship initiative on youth mental health and well-being.[32] This comprehensive framework emphasizes human rights as a catalyst for change and the need for a renewed social contract, anchored in working with and for young people through trust, inclusion and meaningful participation.

III. Youth perspectives: views and thematic issues

21. OHCHR received the views of approximately 4,000 young people, from across all regions and diverse educational, employment and geographical backgrounds. Contributors emphasized the study's timely focus, with one describing mental health as "common, visible and deeply connected to enjoy[ing] basic human rights."

22. Young people across all regions reported anxiety, burnout, stress, depression, loneliness and social withdrawal, insomnia, trauma, substance use, self-harm and suicidal ideation. They also identified that some young people faced multiple, compounding challenges, especially in conflict and displacement settings.

23. Contributors noted that mental health conditions were shaped by structural social, cultural, economic and political factors, including social determinants of health. Young people described academic pressures and unsafe education systems, bullying, including online, unemployment, precarious work, poverty, food and housing insecurity, family violence and parental substance use, gender inequality, gender stereotypes, discrimination, colonial harm and exposure to conflict, trauma and violence. Loss of social connection across family, peer, community education and employment settings can deepen loneliness and distress.

[25] Targets 3.4, 3.5 and 3.8 of the Sustainable Development Goals and Goal indicator 3.4.2, respectively.
[26] General Assembly resolution 79/1, paras. 60 and 61.
[27] See https://www.un.org/en/content/action-for-human-rights/index.shtml; and A/75/982.
[28] See https://www.un.org/youthenvoy/wp-content/uploads/2018/09/18-00080_UN-Youth-Strategy_Web.pdf.
[29] See https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf.
[30] See https://www.who.int/publications/i/item/9789240031029.
[31] See https://www.ohchr.org/en/publications/policy-and-methodological-publications/mental-health-human-rights-and-legislation.
[32] See https://www.un.org/youthaffairs/en/youth-mental-health-and-well-being.

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24. Young people described pressures linked to social media use, including exposure to harmful content, cyberbullying, addictive design features, constant comparison, misinformation, surveillance and concerns around artificial intelligence. These can disrupt sleep, concentration, relationships and self-perception and may intensify anxiety, loneliness, low self-esteem and distress.

25. Young people underscored that compounding challenges, social determinants and structural barriers were mutually reinforcing and could create a cyclical, escalating pattern of rights restrictions. Root causes, such as poverty, discrimination, violence, conflict, displacement and multiple planetary crises, converge to drive distress, uncertainty, exclusion and loss of agency.

26. Young people noted that stigma continued to exist around mental health. Stigma can be reinforced by cultural beliefs, including mental health and sorcery, gender stereotypes and societal attitudes. This discourages open discussion and can deter young people from seeking support due to distrust, fear of dismissal or "burdening" others. Acquiring access to support can cause further stigmatization, discrimination and educational and societal exclusion. In one of the submissions, it was noted that "healing isn't always accompanied by inclusion". Disclosure requirements of mental health conditions in education, employment or other settings can lead to exclusion and deter young people from seeking support.

27. Young people described challenges as adversely affecting their participation in education, extracurricular and community activities and employment, highlighting the negative impact on self-esteem, motivation, physical health and relationships.

28. Young people expressed concern regarding their future, citing a disconnect between aspirations and local realities. Conflict, insecurity, multiple planetary crises, economic insecurity and overall uncertainty contribute to loss of hope, heightened stress, psychological distress and trauma, with "lives [...] in suspense." Mental health support can strengthen confidence, resilience and belonging, enabling participation and positive contributions to communities. One contributor noted that, "without care and recognition, rights remain inaccessible; with support, young people can thrive, participate and lead."

29. Young people identified barriers to mental healthcare, including limited availability of trained professionals and youth-friendly services, especially in rural and remote areas. Parental-consent requirements, inflexible service hours, long waiting times, high indirect costs, transportation challenges and geographical disparities constrain access. Administrative, linguistic and information barriers and digital exclusion can further restrict access. Lack of accessible facilities and sign language interpreters can affect young persons with disabilities. Limited insurance coverage for psychological treatment renders healthcare unaffordable for many. Quality gaps, including weak cross-sector coordination, fragmented services, uneven standards of care between facilities, providers and geographical settings, overreliance on biomedical approaches, and limited trauma-informed, community-based support, further undermine trust and access to timely, effective healthcare.

30. Young people called for comprehensive, rights-based action that recognized mental health as a cross-cutting human rights issue, human rights-based laws and policies with youth-specific provisions and the decriminalization of suicide. They emphasized that participation was integral to implementation and should be institutionalized in decision-making.

31. Young people requested sustainable funding and coordinated, cross-sectoral action that delivered accessible, inclusive, culturally appropriate, youth-friendly services closer to daily life, including through education, primary care, community-based services and expanded rural coverage. They emphasized prevention, early intervention, quality trauma-informed and youth-centred care, training for professionals working with young people, stigma reduction, partnerships with youth-led organizations and civil society and action on social determinants.

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IV. Challenges and discrimination experienced by young people related to mental health

A. Specific mental health risks affecting diverse young people

32. Discrimination, exclusion and stigma, often based on intersecting grounds, such as race, gender, disability, migration status, sexual orientation or gender identity, can marginalize specific groups of young people, restricting their participation, increasing social exclusion and deterring access to support. These dynamics undermine the right to equality and non-discrimination and can also have broader a human rights impact on the rights to education and employment, among others.

33. Socioeconomic precarity, poverty, work, food and housing insecurity and broader structural inequalities generate cumulative stress, deepen exclusion and reduce access to stable, supportive environments. These dynamics are compounded by exclusion from education and employment opportunities and inadequate social protection. For example, young people in poverty may combine education with precarious work while experiencing food or housing insecurity, leading to chronic stress, disrupted education and reduced access to support, with lasting effects on mental health and rights.

34. Academic pressures and competitive education systems can exacerbate mental health risks by contributing to sustained stress and burnout, reduced self-worth and feelings of failure. Such pressures lead to disengagement from education, affecting outcomes and long-term opportunities. Young people also face heightened stress and distress due to violence or dangerous conditions in educational settings. The transition from education to employment is a critical period in which young people may face limited opportunities, unemployment, precarious work, inadequate support and uncertainty about the future. These challenges may be compounded for young persons with disabilities, who may face environmental and institutional barriers, lack of reasonable accommodation, exclusion and discrimination. Such barriers may intensify distress, increase the risk of exclusion and discrimination and hinder the equal and effective enjoyment of human rights, including to education, employment, health, social security, independent living and participation in public life.[33]

35. Digital technologies and environments present opportunities and risks for youth mental health. They can improve access to information, services, healthcare, support and communities and reach those who are otherwise isolated. A U-shaped relationship indicates that moderate social media use is linked to the most favourable well-being, while both non-use and high use are associated with poorer outcomes, underscoring that both online isolation and excessive engagement can be detrimental. However, extensive engagement with social media and online environments, often interacting with offline factors, has been associated with negative mental health outcomes, including self-harm and depression, due to cyberbullying, social comparison and pressures and exposure to age-inappropriate or addictive content.[34]

36. The world is experiencing the highest number of armed conflicts since the Second World War, with profound consequences for young people's rights, safety, development and mental health.[35] Conflict, insecurity, displacement, humanitarian crises and violence cause or exacerbate trauma-related distress and other adverse outcomes, while disrupting family and community support systems, protective networks and spaces, education, employment and healthcare. Their effects may also extend beyond those directly affected, including through exposure via news and social media, contributing to fear, anxiety, grief and secondary trauma.[36]

[33] Based on a substantive analysis of submissions; and https://desapublications.un.org/publications/world-youth-report-youth-mental-health-and-well-being.

[34] See https://pmc.ncbi.nlm.nih.gov/articles/PMC8751553/; and A/HRC/57/28.

[35] See https://news.un.org/en/story/2026/05/1167589.

[36] Based on a substantive analysis of submissions; https://desapublications.un.org/publications/world-youth-report-youth-mental-health-and-well-being; and https://www.unhcr.org/europe/media/mental-health-and-psychosocial-support-europe.

Advance edited version

37. The erosion of social connections is a cross-cutting driver, reducing support and increasing vulnerability to stress. Supportive relationships across family, peer, educational, employment and community contexts constitute critical protective factors. Their erosion intensifies loneliness, social withdrawal and reduced resilience.[37] Losing or being excluded from safe spaces, including arts, sports, youth, cultural, spiritual and community settings, further weakens belonging and deepens isolation.

38. Young people facing multiple or intersecting barriers include: young women, LGBTIQ+ young people, young persons with disabilities, Indigenous and minority Roma and nomadic young people, young people of African descent, refugee, migrant, Stateless, internally displaced and returnee young people, street-connected young people, those in alternative care and care-leavers, young people in detention, poverty, rural areas, conflict or humanitarian contexts, including returnees, young people not in education, employment or training, young mothers and young people with no legal identity. These groups face cumulative barriers that can delay transitions to autonomy.

39. Young women may face specific mental health risks due to gender inequality, unequal power relations, stereotypes and exposure to gender-based violence, including domestic, sexual and online violence, affecting their sense of safety, belonging and agency. Caregiving expectations and norms around appearance, behaviour, sexuality, marriage, education and employment can restrict autonomy and participation and contribute to distress, shame, isolation and reduced access to support. Barriers to access to sexual and reproductive health and rights information and services can adversely affect mental health, generating stress, anxiety and psychological distress and undermining autonomy, dignity and the ability to make informed decisions about bodies and reproductive lives.[38] Exposure to violence and trauma, including gender-based, domestic and sexual violence, conflict-related harm and gendered bullying, can further increase psychological distress and trauma-related needs, particularly where safety, gender-responsive psychosocial support and accountability are limited. Young men are also experiencing increasing mental health pressures linked to rigid gender norms, social isolation and barriers to seeking support.

40. Young persons with disabilities experience disproportionate barriers in relation to mental health. Persistent stigma, ableism and discrimination, including in education and health systems, can lead to exclusion, institutionalization and exposure to coercive practices. These barriers, together with gaps in accessible, inclusive and community-based services, can restrict participation, autonomy and the equal enjoyment of rights.

41. Young people deprived of their liberty, including in custodial and institutional settings, face heightened mental health risks due to restrictive environments, isolation, loss of autonomy and disrupted family and education pathways. Inadequate conditions and limited access to support can intensify distress and trauma, with a significant impact on well-being and the enjoyment of rights.

42. Young migrants, particularly those in irregular situations, may face compounded challenges arising from family separation, migration-related trauma, legal status, discrimination, language barriers, insecure housing and exploitative or informal work. Limited access to education, healthcare, decent work, social protection and pathways to regular residence, together with fear of detention or removal and exclusion from services, can generate stress and deter young migrants from seeking mental health support.

[37] Committee on Economic, Social and Cultural Rights, general comment No. 27 (2025) on economic, social and cultural rights and the environmental dimension of sustainable development, paras. 67–70; and https://www.who.int/publications/i/item/978240112360.

[38] See https://esaro.unfpa.org/sites/default/files/pub-pdf/2date26-date4/FINAL_SRH%20and%20Mental%20Health%20for%20Young%20People%20UpdatedJanuary26.pdf.

Advance edited version

43. Discriminatory or punitive laws and practices, limited societal acceptance and social rejection can undermine the dignity, identity and belonging of LGBTIQ+ young people. Laws or practices that criminalize consensual same-sex relations, restrict gender expression or identity or limit the freedoms of expression, information, assembly and association can expose young people to stigma, bullying, violence and family rejection,[39] as well as intensify fear, isolation and distress, deter support-seeking and reporting abuse, deepen exclusion from education and healthcare, the community, services and public life and contribute to homelessness.

44. Young human rights defenders face distinct risks linked to their activism. Exposure to threats, insecurity, sustained rights violations and the economic and educational repercussions of their activism, including exclusion from education, combined with the precarious and often voluntary nature of their activism, contribute to stress, trauma-related harm and psychosocial challenges. Gaps in tailored self-care and in psychosocial and protection measures further exacerbate risks.[40]

B. Impact of these challenges on young people's human rights

45. Without adequate psychosocial support and enabling environments, young people experiencing mental health challenges may face significant barriers to the full enjoyment of their rights. The structural factors outlined above, together with stigma, discrimination and inadequate responses, can limit access to the rights to education, work, social protection, health, an adequate standard of living, participation, privacy, safety, dignity, information and culture and, in the most serious cases, life. These barriers may also undermine autonomy, legal capacity, equality and non-discrimination.

46. Across regions, self-harm and suicidal ideation among young people reflect risks linked to violence, including gender-based violence, socioeconomic insecurity, discrimination and gaps in timely, appropriate support.[41] Where support is lacking, or stigma or fear impede access, distress may escalate, raising concerns across a range of rights, including the right to life.

47. Discrimination shapes the social and institutional contexts in which youth mental health challenges are experienced. Stigma, ageism, structural inequalities and assumptions about competence can restrict access to education, employment, housing, social protection and health services. Concerns that the diagnosis or disclosure of mental health conditions may affect education, hiring, retention or career progression can further deter young people from seeking help.

48. The Committee on the Rights of Persons with Disabilities has expressed its concern that the use of mental health conditions or psychosocial disabilities as grounds for guardianship or similar substituted decision-making regimes may undermine the exercise of legal capacity and equal recognition before the law. Such arrangements may transfer authority over healthcare, finances and living arrangements to third parties, limiting the autonomy of young persons with disabilities and their ability to exercise control over decisions affecting their lives.[42]

49. Coercive practices, including forced treatment and the use of restraints and seclusion,[43] engage the right to liberty and security of the person and are often implemented in a manner that undermines free and informed consent, raising particular concerns for young people. The Committee on the Rights of Persons with Disabilities has also expressed its concern regarding coercive practices, including involuntary or forced treatment and the use of restraints and seclusion, noting their implications for liberty, security of the person, dignity

[39] See A/HRC/56/49.
[40] A/HRC/55/50, paras. 59 and 60.
[41] See submissions; and https://www.who.int/news-room/fact-sheets/detail/suicide.
[42] Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014) on equal recognition before the law, paras. 7, 13 and 26–29.
[43] Convention on the Rights of Persons with Disabilities, art. 25 (d).

Advance edited version

and free and informed consent.[44] In some contexts, diversion into custodial or institutional settings replaces community-based support, restricts rights and fails to address underlying needs. The Committee has emphasized that institutionalization and other segregated settings may result in isolation, loss of autonomy and control over daily life and exclusion from the community.[45] Such barriers can also adversely affect young people's mental health, trust in institutions and social inclusion.

50. Young people are also affected by stigma-based discrimination in recruitment and workplace practices, grounded in assumptions about competence or reliability. Disrupted education-to-employment pathways can further compound exclusion. Precarious employment deepens financial insecurity, compounding stress and psychosocial harm.

51. Discrimination in housing and heightened risks of homelessness are also concerns for young people. The impact can be compounded by punitive legal approaches to poverty-related behaviours, undermining independent living and community inclusion and contributing to delayed autonomy and continued dependence on family structures.[46] The impact on these rights is further exacerbated by intersecting forms of discrimination, with LGBTIQ+ young people, among others, facing disproportionate homelessness levels, with serious and compounding negative effects on mental health.[47]

52. Stigma, unmet support needs and inflexible, unsafe educational environments undermine access, continuity and equal opportunity in education. Young people experiencing distress are overrepresented among those not in education, employment or training. Discriminatory requirements, such as mental health certifications, may restrict their access and may be compounded by disruptions linked to crisis episodes or coercive interventions. Over time, disengagement may become entrenched, reinforcing long-term socioeconomic exclusion and limiting employment and independence.

53. Young people are frequently excluded from meaningful participation in relevant decision-making processes, an approach that weakens the accountability, responsiveness and legitimacy of mental health-related laws, policies and programmes. These dynamics may also limit the effective exercise of freedoms of expression and information, further constraining agency, trust and participation.

54. The right to privacy can be undermined through intrusive data collection and data processing practices and the unauthorized disclosure of mental health information, enabling microtargeting, discrimination in education, employment and housing and creating a chilling effect on seeking support. Surveillance, data-sharing and profiling practices further undermine privacy, reinforce discrimination, restrict self-expression and agency and deter young people from seeking support, exacerbating distress.

C. Barriers to the enjoyment of the right to mental health

55. States worldwide have adopted mental health laws, policies, strategies and action plans.[48] However, youth-specific provisions are often limited, addressed indirectly within general frameworks or completely absent. Consequently, the legal and policy architecture is often insufficient to ensure effective realization of young people's human rights.

56. Shortcomings in applying legal safeguards, especially consent, confidentiality, respect for legal capacity and access to support persons, independent oversight and effective remedies, constitute significant barriers to rights-based mental healthcare and may result in preventable harm, affecting young people. Continued reliance on institutional and coercive models over community-based services undermines autonomy and dignity, entrenching stigma and exclusion and creating structural barriers to access and trust for young people.

[44] See CRPD/C/5.

[45] CRPD/C/5, paras. 89 and 90; and Committee on the Rights of Persons with Disabilities, general comment No. 5 (2017) on living independently and being included in the community, paras. 46–49.

[46] See, for example, https://desapublications.un.org/publications/world-youth-report-youth-mental-health-and-well-being, p.76; A/HRC/56/61/Add.3; and submissions.

[47] See https://www.unfe.org/en/know-the-facts/challenges-solutions/youth-homelessness.

[48] See https://www.who.int/publications/i/item/9789240114487.

Advance edited version

The Committee on the Rights of Persons with Disabilities has emphasized the rights to autonomy, legal capacity, integrity, independent living and free and informed consent and has called for a shift from institutional and coercive practices towards community-based support.[49]

57. In addition, deaths by suicide and suicide attempts remain criminal offences in at least 23 countries.[50] The criminalization of death by suicide and suicide attempts may deter young people experiencing suicidal ideation from seeking help or emergency, mental health or psychosocial assistance, due to fear of legal repercussions, stigma or other negative consequences. For young people, among whom suicide is the third leading cause of death globally, such barriers may delay access to support during periods of acute distress. Criminalization can affect reporting and data collection, as individuals, families and health professionals may be reluctant to report suicide attempts or deaths by suicide.[51] It may also weaken prevention efforts and evidence-based responses. Limited availability, accessibility, affordability and quality of mental health and psychosocial services, as well as broader social and cultural stigma, may also prevent young people from obtaining support when needed.[52]

58. Young people's right to mental health is undermined by systemic gaps in the availability, accessibility, acceptability and quality of care. Many systems remain crisis-led and institution-centred, with insufficient investment in prevention, early intervention and community-based support. Youth-specific services remain scarce, unevenly distributed and underresourced, reflecting workforce shortages, limited multidisciplinary capacity and weak service integration. These gaps contribute to long waiting times, disrupted care continuity and delayed support, disproportionately affecting marginalized young people, including those in rural or remote areas and institutional or custodial settings.

59. Access is further constrained by financial, geographical and administrative barriers. Out-of-pocket costs, limited or no insurance coverage, including exemptions for mental health services, and indirect costs, including transport and time away from employment, disproportionately affect young people, including those in poverty. The urban concentration of service centres and unreliable transport disrupt education, employment, support networks and healthcare continuity. Complex bureaucratic requirements and referral pathways, restrictive eligibility criteria, documentation requirements, lack of accessibility, language barriers and digital exclusion can exclude or deter young people and create "drop-off" points before treatment, particularly for migrants, undocumented young people and those in the justice system.

60. Services that are not acceptable, youth-friendly or of sufficient quality can undermine youth mental health and violate the rights to non-discrimination, privacy and informed consent. Stigma, distrust, limited cultural adaptation, confidentiality concerns and fear of repercussions in education, work, social or family settings discourage engagement. Negative experiences, coercion or punishment can delay care. Marginalized young people, particularly Indigenous, migrant and LGBTIQ+ young people, may experience some services as culturally or socially unsafe, insensitive or punitive. In some contexts, practices aimed at suppressing sexual orientation or gender identity persist and may amount to torture.[53]

[49] Convention on the Rights of Persons with Disabilities, arts. 3 (a), 12, 17, 19 and 25 (d); Committee on the Rights of Persons with Disabilities, general comment No. 5 (2017); the Committee's guidelines on the implementation of article 14 of the Convention; and https://www.ohchr.org/sites/default/files/documents/publications/WHO-OHCHR-Mental-health-human-rights-and-legislation_web.pdf.

[50] See https://www.who.int/publications/i/item/9789240078796.

[51] See https://iris.who.int/server/api/core/bitstreams/f5e481d9-fd9c-4d39-a438-3ddbd229942d/content.

[52] See https://iris.who.int/server/api/core/bitstreams/40e5a13a-fe50-4efa-b56d-6e8cf00d5bfa/content, pp. 65 and 66.

[53] See A/HRC/44/53.

Advance edited version

61. Quality services can be undermined due to limited trauma-informed, culturally grounded and youth-centred approaches. In some contexts, inconsistent standards and coercive practices undermine trust. Despite increased policy attention through national frameworks, education-based programmes and community initiatives,[54] fragmentation and weak cross-sector coordination across health, social care, education and justice services weaken accountability, implementation and care continuity. This includes the transition from child to adult and for young people transitioning between community and custodial settings, leaving needs unmet and increasing the risk of escalation.

62. Outdated or inconsistently applied clinical guidance, insufficient training, staff shortages, overcrowding and scarce youth-friendly, evidence-based interventions mean that assessment and treatment are often not adapted to developmental needs. This reduces effectiveness and contributes to poorer outcomes and repeat crises. Biomedical approaches and weak safeguards can lead to restrictive or unsafe care, distrust and reduced engagement. Under pressure, services may rely on unsuitable placements or restrictive practices, rather than community-based care and support.

63. A key structural gap is discontinuity between child and adult services. In many contexts, services are structured around age thresholds, triggering abrupt changes in eligibility and care pathways, including loss of support and changes in referral and clinical thresholds, providers and coordination. Where transitional support is absent, care plans may not follow young people, interrupting treatment. Systems do not adequately recognize that young people's needs are continuous and evolving, contributing to worsening mental health outcomes. These gaps undermine the availability of appropriate and continuous care services.[55]

64. Constraints on young people's autonomy, including rules and practices that maintain dependence, such as parental notification or authorization requirements, can restrict access to confidential advice or support. Coercive practices, including treatment without free and informed consent, can discourage engagement. Such barriers are inconsistent with States' obligations and deter young people from seeking help, delay access and increase crisis-driven contact. They undermine agency during transitions to independence and shape whether services are experienced as supportive or as mechanisms of control.

65. An important gap is the absence of disaggregated data relating to mental health expenditures on young people. In the absence of such data, this limits the ring-fencing of resources, assessing alignment with youth needs and comparing prevention and early intervention and crisis allocations. It weakens the prioritization of youth-appropriate services and the evaluation of whether resources match rising demand.

66. Across all regions, gaps in mental healthcare for young people reflect and are compounded by underinvestment in the sector as a whole: mental health generally receives less than 2 per cent of health budgets and sometimes less than 0.5 per cent in low-income settings.[56] This constrains workforce capacity, community-based services and crisis support. Even where overall investment increases, youth targeting is often partial, and capacity does not scale proportionately. Austerity measures and reliance on donor- or project-based funding contribute to uneven coverage, "stop-start" services and persistent geographical inequities, affecting sustainability and equity.[57]

67. Many States lack high-quality, disaggregated data on youth mental health and comprehensive monitoring and evaluation systems. This is particularly relevant concerning social determinants, especially in low- and middle-income countries.[58] Reliance on partial or

[54] See submissions from the Council of Europe, the Oman Human Rights Commission and the National Human Rights Committee of the State of Qatar .

[55] International Covenant on Economic, Social and Cultural Rights, art. 12; and submission from Estonia.

[56] See https://iris.who.int/server/api/core/bitstreams/31714489-1345-4439-8b37-6cbdc52e15ca/content; and https://iris.who.int/server/api/core/bitstreams/5897b3c7-2848-47a7-ba22-0a7902342a81/content.

[57] See submissions from Bosnia and Herzegovina, Guatemala, Spain, the Defensoría de los Derechos de las Niñas, Niños y Adolescentes de la República Argentina and the Human Rights Centre (Finland).

[58] See https://desapublications.un.org/publications/world-youth-report-youth-mental-health-and-well-being, p. 13.

Advance edited version

outdated data hinders the identification of needs, can exacerbate service gaps and priority risks and contribute to misplaced resource allocation. The absence of robust indicators disaggregated by age, disability and other relevant characteristics limits the tracking of unmet needs, outcomes or inequities, reinforcing crisis-driven responses leaving the most marginalized young people less visible.

68. Youth participation in the design, implementation and monitoring of services related to youth mental health remains uneven. Although some States report engagement through large-scale consultations and youth councils, [59] participation is often limited, not systematically embedded in decision-making, and lacking in sustained, adequately resourced implementation. Young persons with psychosocial disabilities are frequently excluded. These gaps in turn undercut the effectiveness of mental health services, as absent youth input, services are less likely to be accepted by young people, can be improperly focused and may fail to fully consider and address human rights impacts.

69. Young people may face barriers to effective accountability for rights violations and remedies for violations related to mental health.[60] Weak or absent independent monitoring, oversight and youth-responsive, accessible and confidential complaint mechanisms, particularly in institutional settings or regarding informed consent, confidentiality and restrictive practices can expose young people to harm and leave violations unaddressed. Power imbalances with service providers, educational institutions, employers, families or authorities, fear of stigma or retaliation, limited resources, lack of accessible information about rights and remedies and uncertainty regarding legal capacity, consent and confidentiality may prevent young people from reporting violations or seeking redress. Unclear or lengthy complaint and appeals processes may delay access to support, compound distress, undermine trust in services and impede youth autonomy, participation and the equal enjoyment of rights.

V. Youth-rights based approach to mental health

70. A comprehensive rights-based approach to youth mental health integrates rights-respecting mental health services, support for youth development and agency and action on social determinants. This requires a shift from fragmented, reactive, institution-centric responses towards integrated systems prioritizing early intervention, community-based approaches and empowerment. While systems should be adapted to specific social, economic, cultural and political contexts, the core elements of a youth rights-based approach apply to all States and settings.

A. Enabling legal and policy environment

71. Comprehensive legal and policy frameworks are essential to ensuring that systems related to youth mental health are grounded in human rights, effectively implemented and address their distinct needs and rights. Non-discrimination and equality should guide implementation, ensuring that young people in all their diversity can enjoy their rights. Frameworks should reflect obligations concerning legal capacity, mental integrity, freedom from coercion and ill-treatment and free and informed consent without requiring parental authorization or consent.

72. Approaches should shift towards rights-based, long-term community-based approaches that respect autonomy, dignity and inclusion. States should repeal laws that criminalize suicide and suicide attempts and adopt rights-based responses grounded in care and prevention.

[59] See submissions from Ecuador, Estonia, Spain and Monitoringausschuss (Independent Monitoring Committee of Austria).

[60] Based on analysis of stakeholder submissions, including submissions from the Public Defender of Rights and Defender of Children's Rights of the Czech Republic, the National Human Rights Committee of the State of Qatar and the Scottish Human Rights Commission.

Advance edited version

B. Integrated rights-based systems

73. States should adopt a whole-of-government multidisciplinary approach to youth mental health, bringing together the health, education, finance, labour, child protection, social protection, social welfare, justice, environmental and digital sectors. Such systems require coherent rights-based frameworks, sustained financing, effective governance, multisectoral collaboration, rights-compliant data-sharing and strengthened mental health literacy across sectors to deliver timely, equitable, high-quality and youth-friendly services.

74. States should ensure the continuity of care across services, settings and life stages, including child-adult service transitions, and avoid age-based thresholds that interrupt support. States should establish a comprehensive, adequately resourced continuum of services, including prevention, early intervention, crisis care and long-term support, through community-based, multidisciplinary and rights-respecting models, including youth hubs[61] and integrated service platforms, local centres and mobile outreach.[62]

75. States should ensure that services are non-discriminatory and accessible, through reduced waiting times, simplified referral pathways and confidential, autonomous access. Clear standards should guarantee timely, youth-centred, stigma-free support, including through community platforms, complemented by digital and tele-mental health services, mobile and in-person services where appropriate.[63] Digital delivery must address quality, literacy, inequality, privacy and data protection safeguards.

76. To ensure acceptability, States should provide culturally appropriate, gender-responsive services grounded in dignity, autonomy and non-discrimination, including by addressing gender-specific risks and barriers and ensuring safe, inclusive support.

77. Youth-friendly, rights-compliant services include confidentiality, autonomous or self-referral access where appropriate, accessible formats and reasonable accommodation for young persons with disabilities. This requires eliminating coercive and discriminatory practices and providing care and support based on free and informed consent.

78. States should ensure quality through rights-compliant standards of care. As an essential element of such care, States should invest in a trained, diverse and geographically distributed mental health workforce, with youth-specific competencies. Updated curricula, continuous professional development, effective governance and robust oversight should support trauma-informed, youth-responsive approaches across primary care, education and community services.[64]

C. Addressing social determinants

79. Youth mental health cannot be addressed solely through the provision of health services. A rights-based response to youth mental health must also address the social determinants that shape young people's enjoyment of their rights.

80. Prevention requires sustained, coordinated rights-based action to transform social and structural conditions affecting mental health before harm occurs. This includes reducing poverty and inequality, preventing violence and discrimination, including gender-based violence, ensuring safe, inclusive education, community and digital spaces, strengthening social protection, housing, food security and access to decent work, promoting social connection and enabling meaningful youth participation.

81. Young people's mental health is particularly affected by crises and uncertainty, such as due to the multiple planetary crises and in times of conflict and displacement, including climate related displacement. To respond effectively, States should offer accessible, rights-based mental health and psychosocial support, adapting service delivery to young people,

[61] See examples in Australia and Singapore in the submission from the United Nations Children's Fund.
[62] See the submissions from Colombia, Guatemala, Portugal and Slovenia.
[63] See the submissions from El Salvador and the National Council for Human Rights (Egypt).
[64] See submissions from Bosnia and Herzegovina and Italy.

Advance edited version

while ensuring that such services are fully compatible with international human rights law and standards and delivered with respect for young people's dignity.

D. Enabling environments

82. Strong social connections across education, employment, recreational and community settings are critical for youth mental health. Arts, cultural, sports, youth, spiritual and other community spaces can strengthen belonging, dignity, participation and resilience.[65] To realize these connections requires investment in accessible, inclusive, youth-centred spaces and support for local organizations connected to young people and their communities.

83. Strengthening the capacity of the family, community leaders, trusted adults and professionals across relevant sectors is essential. To do so, investment in mental health literacy, training and resources is required to enable these actors to play a role in early identification, effective responses and appropriate support and referral. Measures should include developing and disseminating accessible, evidence-based and current rights-based guidance, regular training and tools.

E. Financing youth mental health

84. Adequate, equitable and sustained financing is crucial for realizing young people's mental health. States should ensure sufficient, progressive and equitable budget allocations in sectors related to youth mental health, including ring-fenced investment. Prioritizing prevention, early intervention and community-based services is essential. Transparent, disaggregated budget data are critical for monitoring and accountability, including youth-focused analyses.

85. A human rights economy approach to youth mental health requires investments that address structural inequalities, strengthen public systems and are centred on young people's needs. In contexts of fiscal constraints or reduced donor support, States should prioritize essential services, protect minimum core entitlements and prevent any disproportionate impact on young people. Budget decisions should be efficient, equitable, non-discriminatory and transparent. They should address chronic underinvestment, reduce reliance on short-term or donor-dependent financing, where possible, and high-quality, transparent, disaggregated data on budgets and outcomes across relevant sectors should be made publicly available.

F. Facilitating meaningful participation and agency

86. Meaningful youth participation is a cornerstone of a human rights-based approach and forms part of States' human rights obligations. Youth engagement at the national and international levels is essential,[66] brings long-term economic, political and social benefits and strengthens social cohesion and trust.[67] Designing them jointly and taking peer- and youth-led approaches contribute to improved acceptability, uptake, responsiveness and alignment with youth needs, including enhanced accessibility and choice. The design, implementation, monitoring and evaluation of legislation, policies and programmes related to mental health should reflect young people's lived experiences, needs and recommendations.

87. Meaningful, inclusive and safe youth participation requires a safe, enabling environment ensuring participation and respect for the freedoms of opinion, expression, information and peaceful assembly and association. Barriers to participation for all young people must be removed, establishing well-resourced, permanent participation structures within legislative, policy and budgetary processes and providing capacity-building and financial, material and institutional support to strengthen youth organizations. Efforts should ensure the inclusion of marginalized young people, especially those with psychosocial

[65] Submissions from Guatemala, the United Nations Youth Office and the Kinderrechtencommissariat (Flemish Children's Rights Commissioner).
[66] General Assembly resolution 79/1, para. 58.
[67] A/75/982, para. 44.

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disabilities, drawing on the policy brief of the Secretary-General on meaningful youth engagement and the core principles for meaningful youth participation.[68]

G. Accountability, data and oversight

88. Accountability is essential to upholding youth rights related to mental health and to address human rights violations and abuses. It requires transparent governance, effective oversight and accessible remedies, including effective corrective and remedial measures. Effective and accessible complaint, judicial and non-judicial appeal and redress mechanisms, alongside independent oversight bodies,[69] are necessary. National human rights institutions and independent monitoring bodies play a critical role in assessing compliance and gaps, alongside national human rights treaty monitoring frameworks.

89. Timely, high-quality, transparent and disaggregated data on young people, covering all grounds of discrimination, is fundamental for accountability. Comprehensive and transparent monitoring and evaluation mechanisms are required to assess systems, identify gaps and inform evidence-based legislation and policymaking, and youth rights impact assessments and evaluations must be included in legislative, policy and programme design.

90. A youth rights-based approach requires assessing care continuity, particularly during transitions, and whether systems prevent exclusion, discrimination and gaps in service provision. Strengthened monitoring and evaluation frameworks support evidence-based policymaking and progressive realization. Such measures are critical to preventing violations, assessing compliance and ensuring that legal and policy commitments translate into tangible improvement in rights.

VI. Conclusions and recommendations

91. The world is facing challenges in youth mental health, driven by rising needs that outpace response capacity, structural determinants and persistent service gaps.[70] Recent crises, including the COVID-19 pandemic, have exacerbated these challenges, exposing long-term underinvestment and fragmentation. Contributing factors include poverty and insecurity, discrimination and exclusion, violence and trauma, digital harm, conflict and the multiple planetary crises. While drivers differ within and between countries, the result for young people is clear: they experience poorer educational, employment, health and social outcomes and diminished enjoyment of their rights.

92. Sustained cross-sectoral investment in services and programmes relevant to youth mental health is needed, focusing on prevention, early intervention and community-based responses. Mental health services should be youth-responsive, non-discriminatory, available, accessible, acceptable and of high quality. It is essential that care providers respect autonomy and privacy ensure free and informed consent and that delivery is free from coercion.

93. **Recognizing the urgency to address youth mental health, and ensuring a youth-centred human rights-based approach, the United Nations High Commissioner for Human Rights invites States to:**

(a) **Review and, where necessary, amend, enact, adopt and implement legal and policy frameworks, anchored in human rights, to establish a whole-of-government cross-sectoral approach to youth mental health, including by addressing the direct and indirect impact and repealing laws criminalizing suicide and suicide attempts;**

[68] See https://www.un.org/sites/un2.un.org/files/our-common-agenda-policy-brief-youth-engagement-en.pdf; and https://www.un.org/youthaffairs/en/core-principles-meaningful-youth-participation.

[69] Universal Declaration of Human Rights, art. 8; and see https://www.ohchr.org/sites/default/files/documents/publications/WHO-OHCHR-Mental-health-human-rights-and-legislation_web.pdf.

[70] See https://desapublications.un.org/publications/world-youth-report-youth-mental-health-and-well-being.

Advance edited version

(b) **Eliminate coercive and restrictive practices in mental health settings by strengthening legal safeguards, including free and informed consent, supported decision-making, independent oversight and effective remedies, in accordance with international human rights law, including by ensuring continuity and quality of care and safe transitions across services and settings, including between age-based services and community and custodial or institutional settings, while prioritizing diversion, where possible;**

(c) **Adopt a multisectoral integrated approach aiming at universal, high-quality and accessible mental health services for young people and ensure that they are adequately resourced and available and prepared to respond to crises;**

(d) **Address discrimination through intersectional, gender-responsive and disability-inclusive approaches, address the social determinants of youth mental health through coordinated, rights-based action to reduce poverty and inequality, prevent violence, ensure safe and inclusive educational and community environments and address discrimination, social exclusion and digital harm, with particular attention to young people in situations of vulnerability;**

(e) **Ensure meaningful and inclusive youth participation in the design, implementation and evaluation of relevant legislation, policies, budgets, programmes and strategies, including concerning mental health;**

(f) **Ensure accessible information on mental health services and complaint pathways for all young people, apply a youth rights lens to mental health budgeting, publish transparent, disaggregated data across sectors related to youth mental health, access and outcomes and ensure access to effective remedies, including independent, accessible complaint and redress mechanisms;**

(g) **Consider concrete steps to address, in particular, gaps in care arising during the period of transition from child to adult care, challenges arising from the implications of digital technologies, gender inequality and unequal power relations, adequate standard of living, mental health provision in conflict, humanitarian and displacement settings and safeguards for meaningful participation and supported decision-making;**

(h) **Take steps, including through international cooperation, to the maximum of their available resources, with a view to achieving progressively the full realization of the right to health, including the mental health of young people;**

(i) **Integrate youth mental health as cross-cutting issue in the monitoring, reporting, investigation and follow-up activities of national human rights mechanisms.**

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