International Review of the Red Cross (2026), 1–28.
doi:10.1017/S1816383125101033

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Mental health in conflict and post-conflict settings: An analysis of UN human rights treaty bodies' Concluding Observations

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Abstract

The continued applicability of international human rights law in situations of armed conflict entails that the right to mental health also applies. It is therefore crucial to examine how human rights supervisory mechanisms engage with this right in

* This paper was realized with the co-financing of the Next Generation EU PRIN 2022 project "Health Emergencies and Legal Preparedness – HELP: Global, Regional and National Approaches" (MUR 2022MYEW4J, CUP J53D23005710006).

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https://doi.org/10.1017/S1816383125101033 Published online by Cambridge University Press

such contexts. Building on this premise, the present paper investigates how United Nations treaty bodies address mental health in conflict and post-conflict settings in their Concluding Observations. The study is based on a textual analysis of these documents conducted through the Universal Human Rights Index database. The findings reveal that most recommendations contained in the Concluding Observations call for particular attention to the mental health of children, especially child combatants, and of women, particularly those who are victims of sexual and gender-based violence. In terms of action required, they emphasize the need to ensure the availability and accessibility of mental health and psychosocial support services to persons affected by conflict.

Keywords: mental health, psychosocial support, human rights treaty bodies, Concluding Observations, conflict.

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> – How can one die in Sarajevo?
> – You can be killed in many ways. You can be killed physically, in your body, which is the main way. But I think that many more people have been killed in their minds, in their souls.
>
> Bure, singer of the rock band Sikter, 1994[1]

Introduction

Armed conflicts not only kill bodies, but also kill minds, as claimed by Bure, singer of the rock band Sikter, which remained active during the Siege of Sarajevo (1992–96). During war, individuals often live in constant fear of being injured or dying and may witness the deaths of their loved ones. They can be forced to leave their homes and find themselves deprived of the means to sustain their livelihoods, and access to basic necessities such as food and water may be severely disrupted. Given these circumstances, it is unsurprising that one in five people living in situations of armed conflict suffers from a mental health condition,[2] and that more broadly, elevated

1 Interview between Bure and the documentarist Erik Gandini, Sarajevo, 1994. This quotation is a translation taken from the Italian podcast "Sikter" of the newspaper *Il Post* (second episode, minute 27, available at: www.ilpost.it/podcasts/sikter/). The original interview can be found in the 1995 documentary "Raja Sarajevo" by Erik Gandini.

2 Fiona Charlson *et al.*, "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis", *The Lancet*, Vol. 394, No. 10194, 2019, p. 245.

https://doi.org/10.1017/S1816383125101033 Published online by Cambridge University Press

levels of psychological distress are common among populations affected by armed conflict.[3] Furthermore, the detrimental effects of war on mental health can extend across generations, a phenomenon known as intergenerational trauma.[4]

In recent years, a small but growing number of legal experts have begun to engage with the often-overlooked issue of mental health in conflict and post-conflict settings. Notable contributors to this emerging field include Solomon,[5] Lieblich[6] and Lubell,[7] and the previous work of the present author can also be added to this list.[8] However, most existing studies address this subject primarily through the lenses of international humanitarian law (IHL) or international criminal law – for instance, some scholars have examined incidental mental harm within the framework of the IHL principle of proportionality,[9] while others have investigated how international criminal courts evaluate the psychological effects of armed conflict.[10] By contrast, perspectives grounded in international human rights law (IHRL) remain largely under-explored.[11]

In particular, scant attention has been devoted to the role that human rights supervisory bodies play in shaping States' obligations towards the mental health of the population in conflict and post-conflict contexts. Since it is now widely recognized that IHRL is applicable in situations of armed conflict, and since several human

3 Samantha Holmes, "Beyond Compliance Symposium: War Is Not Skin Deep – International Humanitarian Law and Mental Health", *Armed Groups and International Law*, 18 October 2024, available at: www.armedgroups-internationallaw.org/2024/10/15/beyond-compliance-symposium-war-is-not-skin-deep-international-humanitarian-law-and-mental-health/ (all internet references were accessed in January 2026).

4 Charlotte El-Khalil, Denisa Cuculidis Tudor and Catalin Nedelcea, "Impact of Intergenerational Trauma on Second-Generation Descendants: A Systematic Review", *BMC Psychology*, Vol. 1, No. 13, 2025, p. 668.

5 Solon Solomon, "The Psychological Impact of Military Operations on Civilians and the UN Human Rights Committee *Japalali* Decision: Exploring Mental Anguish under a Vida Digna, Right to Life Prism", *Journal of Conflict and Security Law*, Vol. 26, No. 2, 2021.

6 Eliav Lieblich, "Beyond Life and Limb: Exploring Incidental Mental Harm under International Humanitarian Law", in Derek Jinks, Jackson Maogoto and Solon Solomon (eds), *Applying International Humanitarian Law in Judicial and Quasi-Judicial Bodies: International and Domestic Aspects*, T. M. C. Asser Press, The Hague, 2014, pp. 188–193.

7 Noam Lubell and Amichai Cohen, "Strategic Proportionality: Limitations on the Use of Force in Modern Armed Conflicts", *International Law Studies*, Vol. 96, No. 159, 2020, p. 174.

8 Giulia Bosi, "The Protection of Mental Health under International Humanitarian Law", *Journal of International Humanitarian Legal Studies*, Advance Articles, 2025, available at: https://tinyurl.com/7kt2utd5. See also Giulia Bosi, "Six Ways IHL Protects Mental Health", *Humanitarian Law and Policy Blog*, 16 October 2025, available at: https://blogs.icrc.org/law-and-policy/category/special-themes/emerging-voices/.

9 See e.g. Isabel Robinson and Ellen Nohle, "Proportionality and Precautions in Attack: The Reverberating Effects of Using Explosive Weapons in Populated Areas", *International Review of the Red Cross*, Vol. 98, No. 1, 2016, p. 129; Jasmine Moussa, "A Closer Look at the Prohibition of Indiscriminate Attacks and Disproportionate Attacks", in Fausto Pocar and Gian Luca Beruto (eds), *The Additional Protocols 40 years later: New Conflicts, New Actors, New Perspectives*, International Institute of Humanitarian Law, 2017, p. 71.

10 See e.g. Solon Solomon, "International Criminal Courts and the Introduction of the Daubert Standard as a Mode of Assessing the Psychological Impact of Warfare on Civilians: A Comparative Perspective", doctoral thesis, King's College London, 2019.

11 A notable exception in this context is Lisa Laplante and Roxana Castellon, "Expanding the Definition of the Right to Mental Health: Attending to Victims of Political Violence and Armed Conflict in Their Communities of Origin", *Essex Human Rights Review*, Vol. 2, No. 1, 2008.

https://doi.org/10.1017/S1816383125101033 Published online by Cambridge University Press

rights instruments protect the right to health (including mental health), it is crucial to examine how these supervisory bodies engage with the issue of mental health during and after hostilities.

Building on this premise, the present paper seeks to answer the following research question: how do United Nations (UN) human rights treaty bodies address mental health in conflict and post-conflict settings in their Concluding Observations? UN human rights treaty bodies (hereinafter referred to simply as treaty bodies) are committees of independent experts responsible for overseeing the implementation of the core international human rights treaties. Concluding Observations are documents through which these bodies articulate their recommendations following the review of States' periodic reports.

Our analysis shows that most recommendations concerning mental health in conflict contained in the Concluding Observations call for particular attention to the mental health of children, especially child combatants, and women, particularly those who are victims of sexual and gender-based violence (SGBV). Regarding the thematic issues addressed, the recommendations emphasize the need to ensure the availability and accessibility of mental health and psychosocial support services (MHPSS). The Committee on the Rights of the Child (CRC Committee, the treaty body for the Convention on the Rights of the Child, CRC) is the treaty body that has adopted the largest number of recommendations, followed by the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee, the treaty body for the Convention on the Elimination of All Forms of Discrimination against Women, CEDAW) and the Committee on Economic, Social and Cultural Rights (CESCR, the treaty body for the International Covenant on Economic, Social and Cultural Rights, ICESCR), which have adopted the same number as each other. Overall, recommendations concerning the mental health of persons affected by conflict accounted for less than 0.1% of the total recommendations issued by treaty bodies present in the Universal Human Rights Index (UHRI) database.

This study is based on a textual analysis of the Concluding Observations conducted through the UHRI database, which was chosen for its advanced filtering capabilities.[12] The research combines elements of content and thematic analysis. Content analysis was employed to identify the most relevant recommendations contained in the Concluding Observations, followed by a thematic analysis to identify target groups and thematic issues. The analysis was carried out using Excel software and manual coding; this was possible because of the limited number of recommendations found (105). As observed by Lyons, studies examining Concluding

12 UHRI, "Welcome to the Universal Human Rights Index (UHRI)", 2025, available at: https://uhri.ohchr.org/en. The data was collected on 21 October 2025. According to the Geneva Academy website, the developers/administrators of the database are the UN Office of the High Commissioner for Human Rights (UN Human Rights), in partnership with the Danish Institute for Human Rights and HURIDOCS for machine learning/natural language processing (see: https://archives.geneva-academy.ch/geneva-humanrights-platform/tracking-tools/detail/7-universal-human-rights-index.html).

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Observations often lack methodological rigour[13] – to counter this tendency, the present study provides a detailed explanation of the methodology adopted.

After a brief preliminary section on definitions and terminology, this paper is structured in two main parts: theoretical and practical. The theoretical part examines the legal basis and core components of the right to mental health, the application of this right in situations of armed conflict and the role of treaty bodies' Concluding Observations in guiding States in the implementation of human rights conventions. The practical part investigates how mental health is addressed in the Concluding Observations – it outlines the study's methodology and limitations, presents the results and discusses them. The paper concludes with a summary of the findings, recommendations for future action, and a few final reflections.

Definitions and terminology

Before delving further into the topic, a few notes on concepts and terminology are necessary. While treaty bodies do not generally provide definitions of the mental health-related terms they use, we find it useful to provide the most common definitions of the key terms employed by this paper and adopted by the committees, such as "mental health", "mental disorder" and "psychosocial support". Given that the definitions provided below come from institutional sources within the UN system (such as the World Health Organization (WHO)) or closely connected to it (such as the International Red Cross and Red Crescent Movement), it is likely that treaty bodies had these definitions in mind when drafting their Concluding Observations.

"Mental health" is defined by WHO as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community".[14] WHO further explains that mental health is "an integral component of health and well-being and is more than the absence of mental disorders".[15] Although other definitions of mental health have been proposed in the literature,[16] WHO's formulation remains the most widely used and authoritative in the international legal arena, given the Organization's institutional leadership on global health issues.

A "mental disorder" is defined by WHO as a syndrome "characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour", which "is usually associated with distress or impairment in important areas of functioning".[17] The expression "mental health condition" is

13 Donna Lyons, "Human Rights Derogations: Sourcing and Analysing the Concluding Observations of the International Human Rights Treaty Bodies", *Irish Studies in International Affairs*, Vol. 32, No. 1, 2021, p. 163.

14 WHO, "Mental Health", 2025, available at: www.who.int/health-topics/mental-health#tab=tab_1.

15 WHO, *World Mental Health Report: Transforming Mental Health for All*, 2022, p. 8; Pan American Health Organization, "Mental Health", 2025, available at: www.paho.org/en/topics/mental-health.

16 Silvana Galderisi, Andreas Heinz, Marianne Kastrup, Julian Beezhold and Norman Sartorius, "Toward a New Definition of Mental Health", *World Psychiatry*, Vol. 14, No. 2, 2015, p. 231.

17 WHO, "Mental Disorders", 2025, available at: www.who.int/news-room/fact-sheets/detail/mental-disorders.

https://doi.org/10.1017/S1816383125101033 Published online by Cambridge University Press

often used as a synonym for "mental disorder", and is sometimes preferred over the latter because it is perceived as less paternalistic.[18] Mental disorders/mental health conditions include depression, bipolar disorders, schizophrenia, anxiety disorders, post-traumatic stress disorders and eating disorders. Within the human rights sphere, persons with mental health conditions are frequently referred to as "persons with psychosocial disabilities", an expression that emphasizes the barriers that hinder their full and effective participation in society.[19]

To explain the terms "psychosocial support", "psychological support" and "specialized mental health care", it is possible to rely on the MHPSS framework of the International Red Cross and Red Crescent Movement.[20] "Psychosocial support" concerns the promotion of mental health, resilience and social interaction within communities. It is generally directed at the wider population, but it may also target individuals and groups at risk. "Psychological support" encompasses prevention and treatment for persons experiencing more complex psychological distress, and includes activities such as counselling and psychotherapy. "Specialized mental health care" consists of clinical care and treatment for persons with mental health conditions and is commonly also referred to as "psychiatric care".[21]

The theory: The right to mental health, armed conflict, and Concluding Observations

The right to mental health

The first global recognition of health as a human right appeared in the WHO Constitution, the preamble of which declares that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".[22] Subsequently, the right to health was codified in several human rights instruments. The most relevant provision on this right is commonly considered to be Article 12 of the ICESCR.[23] Other international human rights conventions that safeguard

18 In this paper, the expressions "mental health condition" and "mental disorder" are used interchangeably.

19 Whereas the expression "persons with intellectual disabilities" is commonly used to refer to persons who experience problems in their intellectual functioning, such as people with Down syndrome. WHO Europe, *Mental Health, Human Rights and Standards of Care: Assessment of the Quality of Institutional Care for Adults with Psychosocial and Intellectual Disabilities in the WHO European Region*, 2018, p. vi.

20 International Federation of Red Cross and Red Crescent Societies, Psychosocial Centre, "The International Red Cross and Red Crescent Movement's Mental Health and Psychosocial Support Framework", available at: https://pscentre.org/wp-content/uploads/2021/06/mhpss-framework.pdf.

21 For a comprehensive overview on the use of mental health language and terminology by UN agencies and treaty bodies, see Giulia Bosi, "The Power of Language and the Right to Mental Health: Definitions, Terminology and Instrumentalization", *Italian Review of International and Comparative Law*, No. 2/2025, 2025, available at: www.iriclaw.com/Article/Archive/index_html?ida=40&idn=13&idi=-1&idu=-1.

22 Constitution of the World Health Organization, 14 UNTS 185, 22 July 1946 (entered into force 7 April 1948) (WHO Constitution), Preamble.

23 International Covenant on Economic, Social and Cultural Rights, 993 UNTS 3, 16 December 1966 (entered into force 3 January 1976) (ICESCR), Art. 12.

https://doi.org/10.1017/S1816383125101033 Published online by Cambridge University Press

the right to health include the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, with its corresponding treaty body, the Committee on the Elimination of All Forms of Racial Discrimination, CERD),[24] the CEDAW,[25] the CRC[26] and the Convention on the Rights of Persons with Disabilities (CRPD, with its corresponding treaty body, the CRPD Committee).[27] At the regional level, the right to health is recognized across all principal regional human rights systems – namely, the European, African and inter-American ones.[28]

The right to health encompasses both physical and mental health. While some instruments do not explicitly mention mental health in their provisions on the right to health, this right has constantly been interpreted to include the mental dimension. This interpretation likely stems from the fact that the ICESCR, which provides the most authoritative articulation of the right to health, expressly refers to mental health as an integral component of the right: this treaty recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical *and mental health*".[29] Similarly, the WHO Constitution offers a definition of health that includes mental health.[30]

The main features of the right to mental health, which can be derived from the CESCR's General Comment 14 on the right to health, are as follows.[31]

- **Access to mental health care and underlying determinants.** The right to mental health encompasses both the right to mental health care and the right to the underlying determinants of health. Therefore, it not only contains the right to receive treatment, but also extends to the determinants of health, such as "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment".[32]

24 International Convention on the Elimination of All Forms of Racial Discrimination, 660 UNTS 195, 21 December 1965 (entered into force 4 January 1969) (ICERD), Art. 5.

25 Convention on the Elimination of All Forms of Discrimination against Women, 1249 UNTS 13, 18 December 1979 (entered into force 3 September 1981) (CEDAW), Art. 12.

26 Convention on the Rights of the Child, 1377 UNTS 3, 20 November 1989 (entered into force 2 September 1990) (CRC), Art. 24.

27 Convention on the Rights of Persons with Disabilities, 2515 UNTS 3, 13 December 2006 (entered into force 3 May 2008) (CRPD), Art. 25.

28 European Social Charter, ETS 35, 18 October 1961 (entered into force 26 February 1965), Art. 11 (the European Social Charter was revised in 1996 – European Social Charter (Revised), ETS 16, 3 May 1996 (entered into force 1 July 1999) – but Article 11 is almost identical in both versions); African Charter on Human and Peoples' Rights (Banjul Charter), CAB/LEG/67/3 rev. 5, 21 ILM 58 (1982), 1 June 1981 (entered into force 21 October 1986), Art. 16; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), A-52, 17 November 1988 (entered into force 16 November 1999), Art. 10.

29 ICESCR, above note 23, Art. 12 (emphasis added).

30 The WHO Constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". WHO Constitution, above note 22, Preamble.

31 For a more detailed description of the key features of the right to mental health, see Giulia Bosi, "Neurotechnologies and the Right to Mental Health", *BioLaw Journal*, No. 1/2025, 2025, pp. 310–312.

32 CESCR, General Comment No. 14, "The Right to the Highest Attainable Standard of Health (Article 12)", UN Doc. E/C.12/2000/4, 11 August 2000, para. 4.

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- **AAAQ framework.** Mental health services, goods and facilities must be available, accessible, acceptable and of good quality (the "AAAQ framework").[33] Availability requires that health facilities, goods and services for mental health exist in sufficient quantity within the State. Accessibility encompasses several sub-dimensions: non-discrimination, physical accessibility and economic accessibility. Non-discrimination implies that mental health facilities, goods and services are accessible to all without discrimination, physical accessibility requires that persons with disabilities are able to access mental health facilities, and economic accessibility entails that mental health services are affordable. Acceptability requires that services, goods and facilities for mental health adhere to medical ethics and are culturally appropriate. Quality entails that mental health services, goods and facilities meet medical and scientific standards and are of good quality – for instance, by guaranteeing that mental health professionals are properly trained.
- **The principle of progressive realization.** Like other socio-economic rights, the right to mental health is subject to the principle of progressive realization.[34] Under this principle, States are required to take measures, to the maximum of their available resources, to progressively achieve the full realization of the right. Nevertheless, States are bound by certain core minimum obligations, meaning that minimum essential levels of the right to mental health must always be upheld. These core obligations include, for example, ensuring non-discriminatory access to mental health care and the provision of essential drugs.
- **Participation and accountability.** The realization of the right to mental health requires the participation of the population in decision-making related to mental health.[35] Participation can take different forms, such as democratic elections or public consultations on the development of mental health policies. In addition, States must be held accountable for their (in)action on the right to mental health.[36] Accountability may be administrative, political or judicial: administrative accountability includes mechanisms such as reviews of how public funds are spent, political accountability is obtained through democratic elections, and judicial accountability involves the adjudication of violations of the right to mental health in courts.

Along with General Comment 14, a range of other documents must be taken into account to fully grasp the scope and content of the right to mental health. These include several recent Human Rights Council resolutions,[37] reports from the UN

33 *Ibid.*, para. 12.

34 *Ibid.*, paras 30–31, 43–44.

35 *Ibid.*, para. 11.

36 *Ibid.*, para 59–62; UN Human Rights and WHO, "The Right to Health", Fact Sheet No. 31, 2008, pp. 31–33.

37 HRC Res. 52/12, 3 April 2023; HRC Res. 43/13, 19 June 2020; HRC Res. 36/13, 28 September 2017; HRC Res. 32/18, 1 July 2016.

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High Commissioner for Human Rights,[38] and the seminal guidance *Mental Health, Human Rights and Legislation*,[39] developed in 2023 by WHO and the UN Office of the High Commissioner for Human Rights (UN Human Rights). Collectively, these documents underscore that a modern understanding of mental health and human rights law entails a paradigm shift away from biomedical and coercive models and towards human rights-based, person-centred and community-anchored approaches. They also highlight the need to address the social and economic factors that impact mental health and the importance of realizing cross-sectoral interventions.

Finally, the right to mental health must be considered in connection with other human rights. First and foremost, this right is closely linked with other socio-economic rights such as the right to safe food and nutrition, the right to access safe and potable water and adequate sanitation, and the right to healthy occupational and environmental conditions, as noted above. In addition, the paradigm shift outlined in the previous paragraph emphasizes the necessary interaction between the right to mental health and several civil and political rights, including the rights to liberty and security of person, freedom from torture and ill-treatment, and freedom from discrimination. In this sense, the right to mental health is inextricably connected with the CRPD, which also protects persons with psychosocial disabilities.

The right to mental health in situations of armed conflict

For a long time, the application of IHRL (and thus, the right to mental health) to conflict settings was contested. It was commonly held that IHRL was the law applicable in times of peace, while IHL was the law applicable during conflict.[40] IHL, also known as the law of armed conflict, is the branch of international law that seeks to limit the effects of hostilities; it "protects persons who are no longer directly participating in the hostilities and restricts the means and methods of warfare".[41] IHL is codified in various treaties, primarily the Geneva Conventions of 1949 and their Additional Protocols of 1977.[42]

38 *Mental Health and Human Rights: Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/58/38*, 14 January 2025; *Mental Health and Human Rights: Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/39/36, 24 July 2018; *Mental Health and Human Rights: Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/34/32, 31 January 2017.

39 WHO and UN Human Rights, *Mental Health, Human Rights and Legislation: Guidance and Practice*, 2023.

40 Noam Lubell, "Challenges in Applying Human Rights Law to Armed Conflict", *International Review of the Red Cross*, Vol. 87, No. 860, 2005, p. 738.

41 International Committee of the Red Cross, "What Is International Humanitarian Law?", 2004, available at: www.icrc.org/sites/default/files/external/doc/en/assets/files/other/what_is_ihl.pdf.

42 Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950); Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea of 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950); Geneva Convention (III) relative to the Treatment of Prisoners of War of 12 August 1949, 75 UNTS 135 (entered into force 21 October 1950); Geneva Convention (IV) relative to the Protection of Civilian Persons in Time of War of 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950); Protocol Additional (I) to the Geneva Conventions of

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However, it is now widely recognized that IHRL continues to apply in situations of armed conflict – in other words, IHRL remains applicable at all times, both in peace and in war. This position has been definitively confirmed by the International Court of Justice (ICJ) in its 1996 Advisory Opinion on the *Legality of the Threat or Use of Nuclear Weapons* (Nuclear Weapons Advisory Opinion), its 2004 Advisory Opinion on the *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory* (Wall Advisory Opinion), and the 2005 *Case Concerning Armed Activities on the Territory of the Congo*, in which the Court notably affirmed the applicability of human rights treaties, including those protecting socio-economic rights, in conflict settings.[43] Human rights treaty bodies, as well as regional and domestic courts, have also reached this conclusion.[44] Even before these Advisory Opinions, several scholars had already argued in favour of the applicability of human rights during armed conflict.[45] As a result, situations of hostilities are governed by two main branches of international law: IHL and IHRL.[46]

The continued applicability of IHRL in situations of armed conflict entails that the right to health, including the right to mental health, also applies in such situations.[47] Nonetheless, a State engaged in a conflict may encounter significant challenges in fulfilling its obligations related to the right to mental health. IHRL generally recognizes that States may face difficulties in fully implementing human rights in certain situations and allows them to derogate from or limit human rights under specific circumstances. While the ICESCR (which, as seen above, is the reference treaty for the protection of the right to health) does not contain a derogation clause, its Article 4 permits the State to subject the rights enshrined in the Covenant to limitations.[48] In situations of hostilities, such limitations could be justified, for example,

12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1978); Protocol Additional (II) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609, 8 June 1977 (entered into force 7 December 1978).

43 ICJ, *Legality of the Threat or Use of Nuclear Weapons*, Advisory Opinion, 8 July 1996 (Nuclear Weapons Advisory Opinion), para. 25; ICJ, *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, 9 July 2004 (Wall Advisory Opinion), paras 102–113; ICJ, *Case Concerning Armed Activities on the Territory of the Congo (Democratic Republic of the Congo v. Uganda)*, Judgment, 19 December 2005, p. 168, para. 216.

44 See, for instance, CESCR, *Concluding Observations on the Additional Information Submitted by Israel*, UN Doc. E/C.12/1/Add.69, 31 August 2001, paras 12–19; European Court of Human Rights, *Loizidou v. Turkey*, Appl. No. 15318/89, 28 December 1996, para. 44; Supreme Court of Israel, *Public Committee against Torture in Israel et al. v. Government of Israel et al.*, Case No. 769/02, 14 December 2006, para. 18.

45 On this point, see Elizabeth Mottershaw, "Economic, Social and Cultural Rights in Armed Conflict: International Human Rights Law and International Humanitarian Law", *International Journal of Human Rights*, Vol. 12, No. 3, 2008, pp. 450–452.

46 For a detailed description of the relationship between IHL and IHRL in armed conflict, see Marco Sassòli, "International Humanitarian Law and International Human Rights Law", in Ben Saul and Dapo Akande (eds), *The Oxford Guide to International Humanitarian Law*, Oxford University Press, Oxford, 2020. Examining the relationship between IHRL and IHL falls outside the scope of this paper, as it is not directly relevant to the present analysis.

47 On the application of the right to health in armed conflict, see *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc. A/68/297, 9 August 2013.

48 ICESCR, above note 23, Art. 4.

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on grounds of national security.[49] For a limitation to be lawful, it must respect certain criteria: it must be determined by law, pursue the legitimate aim of promoting "the general welfare in a democratic society",[50] and be necessary and proportionate to reach this aim.[51] Thus, during armed conflict, States can limit the right to mental health.

Be that as it may, the principle of progressive realization remains a continuous obligation of the State even during hostilities. This principle "does not dilute certain immediate obligations of States, including taking concrete steps towards the full realization of the right to health", which encompasses measures to progressively provide mental health services.[52] Moreover, any retrogressive measure "would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources".[53] Retrogressive measures are those that, directly or indirectly, result in a decline in the enjoyment of human rights protected under the ICESCR. The mere existence of an armed conflict does not, by itself, justify the adoption of retrogressive measures.[54] Accordingly, even in situations of armed conflict, States must take deliberate and concrete steps toward the realization of the right to mental health.

Concluding Observations of UN treaty bodies

To better understand State obligations under the right to mental health in conflict and post-conflict settings, this paper examines how UN treaty bodies have addressed this right in their Concluding Observations. At the international level, the implementation of UN human rights treaties (including those protecting the right to health) is monitored by the UN treaty bodies. These bodies are composed of independent experts, who act in their individual capacity and not as representatives of the States of which they are nationals. Currently, there are ten UN human rights treaty bodies.[55] They perform several key functions, including issuing

49 Gauthier de Beco, "Taking Economic and Social Rights Earnestly: What Does International Human Rights Law Offer Persons with Disabilities in Situations of Armed Conflict?", *International Review of the Red Cross*, Vol. 115, No. 922, 2022, p. 319.

50 The notion of "general welfare" is associated with the economic and social well-being of individuals and the community.

51 Emanuele Sommario, "Limitation and Derogation Provisions in International Human Rights Law Treaties and Their Use in Disaster Settings", in Flavia Zorzi Giustiniani, Emanuele Sommario, Federico Casolari and Giulio Bartolini (eds), *Routledge Handbook of Human Rights and Disasters*, Routledge, London, 2018, pp. 99–101. See also Amrei Muller, "Limitations to and Derogations from Economic, Social and Cultural Rights", *Human Rights Law Review*, Vol. 9, No. 4, 2009, p. 570.

52 *Report of the Special Rapporteur*, above note 47, para. 10.

53 CESCR, General Comment No. 3, "The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)", UN Doc. E/1991/23, 14 December 1990, para. 9.

54 UN Human Rights, *Protection of Economic, Social and Cultural Rights in Conflict: Report of the United Nations High Commissioner for Human Rights*, 2015, p. 8, available at: www.ohchr.org/sites/default/files/Documents/Issues/ESCR/E-2015-59.pdf.

55 The list of all treaty bodies can be found at UN Human Rights, "Treaty Bodies", available at: www.ohchr.org/en/treaty-bodies.

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General Comments, reviewing State reports on treaty implementation, and publishing Concluding Observations. Most treaty bodies are allowed to consider individual complaints and to conduct inquiries.

This article focuses on Concluding Observations, which are documents in which a treaty body expresses its concerns, observations and recommendations in response to a State's periodic report on the implementation of the treaty. Human rights treaties typically require States Parties to submit such reports every four to five years, outlining the measures they have undertaken to fulfil their treaty obligations. Treaty bodies often also receive information on how the State is implementing the treaty from other sources, such as non-governmental organizations (NGOs), academic establishments and UN entities.[56] Taking all available information into account and engaging in a constructive dialogue with the State Party delegation, the treaty body reviews the report and subsequently issues its Concluding Observations. Concluding Observations are not legally binding and the entire process is non-adversarial and non-adjudicative in nature.[57]

Concluding Observations were chosen as the subject of this analysis for two main reasons. First, they contribute to defining human rights obligations. O'Flaherty notes that they are key instruments to interpreting international human rights conventions,[58] and similarly, Myer argues that they have helped elucidate the content of human rights.[59] Concluding Observations are particularly valuable due to their practical orientation – by highlighting specific concerns and requiring action in particular areas, they outline concrete measures that States should implement. One common criticism of IHRL is its abstraction and vagueness, and Concluding Observations help to address this by offering more tangible guidance, thereby substantiating States' obligations under human rights treaties.[60]

Second, Concluding Observations are widely regarded as authoritative, despite being non-binding. They are statements coming from independent experts appointed expressly to review treaty implementation. In addition, although Concluding Observations are not binding, they are based on legally binding treaty obligations. Zhang observes that their interpretation is typically deemed to be "of great value",[61] while Meier and Kim argue that Concluding Observations possess

56 For a detailed description of the work of the treaty bodies, see UN Human Rights, "What the Treaty Bodies Do", available at: www.ohchr.org/en/treaty-bodies/what-treaty-bodies-do.

57 Kerstin Mechlem, "Treaty Bodies and the Interpretation of Human Rights", *Vanderbilt Journal of Transnational Law*, Vol. 42, No. 3, 2009, p. 923.

58 Michael O'Flaherty, "The Concluding Observations of United Nations Human Rights Treaty Bodies", *Human Rights Law Review*, Vol. 6, No. 1, 2006, p. 51.

59 Sam Myer, "The Success and Legitimacy of UN Treaty Bodies and UN Special Procedures in Clarifying the Content of Human Rights", *Exeter Law Review*, Vol. 47, 2022, p. 63.

60 The importance of Concluding Observations in the context of the right to health has already been highlighted by leading global health scholars. See, for instance, Benjamin Mason Meier, Marlous De Miliiano, Averi Chakrabarti and Yuna Kim, "Accountability for the Human Right to Health through Treaty Monitoring: Human Rights Treaty Bodies and the Influence of Concluding Observations", *Global Public Health*, Vol. 13, No. 11, 2018, p. 2.

61 Xuelian Zhang, "On the Concluding Observations of the United Nations Human Rights Treaty Bodies", *Journal of Human Rights*, Vol. 18, No. 3, 2019, p. 352.

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the "legal authority" to clarify treaty provisions.[62] The relevance of these documents is evident even in the international legal jurisprudence. The ICJ took into account Concluding Observations issued by the Committee on Civil and Political Rights (CCPR, also known as the Human Rights Committee) and the CESCR when interpreting Israel's obligations in the 2004 Wall Advisory Opinion.[63] This authority also extends to the domestic level: the majority of States seem to "take the reporting procedure seriously",[64] and national courts have also relied on Concluding Observations in their judgments.[65] For instance, in 2012, the Supreme Court of Argentina considered the Concluding Observations of the CCPR and the CRC Committee in the landmark *F., A. L. s/ Medida Autosatisfactiva* case on legal abortion.[66]

For all these reasons, Concluding Observations constitute a good subject of analysis. At the same time, it should be recognized that focusing on these documents also presents certain shortcomings – for instance, treaty bodies rarely address complex matters, such as mental health, with conceptual sophistication. In addition, because Concluding Observations emerge from a process of constructive dialogue with the State, they may be shaped by political considerations and thus avoid being overly severe or overly specific on certain issues. Lastly, there might be a degree of inconsistency among the Concluding Observations issued by different treaty bodies.

The practice: Mental health in the Concluding Observations of UN treaty bodies

Methodology and limitations

This research is based on a textual analysis of Concluding Observations conducted through the UHRI database. The database allows the examination of the various paragraphs of the Concluding Observations that express concerns or observations, or require the State to take action. Throughout this paper, the general term "recommendations" is used to refer to all such paragraphs.[67] The database organizes recommendations according to treaty body, country, human rights theme, and the

62 Benjamin Mason Meier and Yuna Kim, "Human Rights Accountability through Treaty Bodies: Examining Human Rights Treaty Monitoring for Water and Sanitation", *Duke Journal of Comparative and International Law*, Vol. 26, No. 1, 2015, p. 146.

63 Nuclear Weapons Advisory Opinion, above note 43, paras 110, 112.

64 UN Human Rights, "The United Nations Human Rights Treaty System", Fact Sheet No. 30, Rev. 1, 2012, p. 29.

65 Machiko Kanetake, "Engagement of Domestic Courts with the Findings of United Nations Human Rights Treaty Monitoring Bodies", in André Nollkaemper, Yuval Shany, Antonios Tzanakopoulos (eds) and Eleni Methymaki (assistant ed.), *The Engagement of Domestic Courts with International Law: Comparative Perspectives*, Oxford University Press, Oxford, 2024, p. 308.

66 Supreme Court of Argentina, *F., A. L. s/ Medida Autosatisfactiva*, F 259 XLVI, 13 March 2012, paras 12–13, 26.

67 The database designates all these paragraphs as "recommendations" but, it also makes it possible to distinguish these "recommendations" into two subcategories: "concerns/observations" and "recommendations". This study does not differentiate between the two, as both are considered relevant in guiding the State on the areas where action is needed. For example, the analysis includes both paragraphs expressing concern

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persons or groups concerned. In addition, it includes a "text search" function that enables the retrieval of specific words or expressions. The UHRI database was chosen for its advanced filtering capabilities, which facilitate targeted searches.

The research aimed to identify recommendations regarding the protection of the mental health of persons affected by armed conflict within the sphere of the right to health, and to answer the following two questions:

1. Which target groups were most frequently addressed in the recommendations?
2. Which thematic issues were most frequently identified as areas of concern or as requiring action?

The data collected also made it possible to answer additional questions that help to better contextualize the analysis:

3. Which treaty bodies issued the greatest number of recommendations?
4. Which countries received the highest number of recommendations?
5. In which years were the largest numbers of recommendations issued?

The following UHRI filters were applied: *Country*: all countries; *Mechanism*: treaty bodies; *Human rights themes*: the right to health; and *Concerned persons*: persons affected by armed conflict. In the "text search" bar, the following keywords were entered: "mental health" (which also retrieved expressions such as "mental health condition(s)"); "mental healthcare"; "mental illness" (including the plural "mental illnesses"); "mental disorder" (including the plural "mental disorders"); "psychiatry"; "psychiatric"; "psychology"; "psychological"; "psychosocial"; and "intellectual" (which allowed us to look for expressions such as "psychosocial and intellectual disabilities"). It must be noted that the use of the preset UHRI filter "persons affected by armed conflict" also captured recommendations directed at countries where there is no armed conflict, but that are the destination of people fleeing war. Although these recommendations do not concern conflict or post-conflict settings, they were retained in the study because they still address the nexus between mental health and war and may be of great interest to receiving countries.

The recommendations resulting from the application of these filters underwent a preliminary screening, during which all recommendations deemed irrelevant to the analysis were excluded. The recommendations eliminated at this stage were: (a) those in which mental health-related terms were not explicitly connected to conflict/post-conflict situations; (b) those that mentioned persons with psychosocial

(e.g., "The Committee is concerned about reports of problems with the availability, accessibility and quality of mental health-care services, in particular for those who live close to conflict-affected areas": CESCR, *Concluding Observations on the Fourth Periodic Report of Armenia*, UN Doc. E/C.12/ARM/CO.4, 14 November 2023, para. 53) and those that explicitly call for action (e.g., "The Committee recommends that the State Party … improve the availability and accessibility of … mental health services for children, particularly those in vulnerable situations, such as children affected by conflict": CRC Committee, *Concluding Observations on the Combined Fifth and Sixth Periodic Reports of Iraq*, UN Doc. CRC/C/IRQ/CO/5-6, 18 July 2025, para. 39(a)).

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and intellectual disabilities yet did not refer to their mental health but rather referred to other rights, such as their right to education; (c) those that welcomed State policies without expressing concern or requesting States to take action; and (d) those that referred to previous paragraphs of the Concluding Observation without adding any substantive measures.

To answer the first two questions listed above, a set of classification labels was developed following an initial reading of the material (the full list of the labels can be found in the footnotes). These labels included, for instance, "women", "children" and "prisoners" for question 1 on target groups,[68] and "availability and accessibility of mental health and psychosocial support (MHPSS)", "quality of MHPSS" and "acceptability of MHPSS" for question 2 on thematic issues.[69] Under question 1, a series of sub-classification labels was created for the two most frequently recurring target groups, namely women and children. The label "children" included sub-labels such as "child soldiers" and "children with disabilities",[70] while "women" included "women victims of SGBV", "pregnant women" etc.[71] A single recommendation could be associated with multiple labels.[72] To answer questions 3, 4 and 5 listed above, classification labels were not required, as the relevant data (countries concerned, recommending bodies and year of publication) came directly from the database and only needed to be analyzed.

The methodology adopted for this study presents some limitations. First, the UHRI database only includes Concluding Observations issued from 2007 onwards;[73] moreover, recommendations made by human rights mechanisms typically appear in the database six to twelve months after publication, and consequently, the analysis might not cover the most recent documents. Nonetheless, this study

68 The classification labels for research question 1 were "children, "women", "prisoners", "persons with disabilities", "internally displaced persons" and "war veterans". Classification labels were developed on the basis of the first preliminary reading. Target groups not mentioned in the recommendations were not taken into account (for example, the potential classification label "migrant workers" was not created because this target group was not present in the recommendations).

69 The classification labels for research question 2 were "availability and accessibility of MHPSS", "quality of MHPSS", "acceptability of MHPSS", "cooperation with international organizations", "mental health awareness raising", "stigmatization of persons with mental health conditions", "collection of mental health data", "adoption of a mental health policy", "negative impact of conflict on mental health", "generic request to take measures" and "lack of information provided to the committee". The term "MHPSS" has been used instead of "mental health care" as several recommendations also referred to psychological/psychosocial support. It must also be noted that recommendations which referred, in general terms, to the need to provide MHPSS were considered to fall under the label "availability and accessibility of MHPSS".

70 The classification labels within the category "children" were "child soldiers", "child victims of SGBV", "asylum-seeking children", "children in prison", "internally displaced children", "children with disabilities", "children with mental health conditions" and "child victims of child marriage". The label "asylum-seeking children" also included refugee and migrant children.

71 The classification labels within the category "women" were "women victims of SGBV", "women with disabilities" and "pregnant women". It should be pointed out that categories such as "women/children with disabilities" were counted only under "women" or "children", not also under "persons with disabilities", as this analysis focused on the primary group(s) targeted by each recommendation.

72 For instance, one recommendation could be associated with the labels "women", "women victims of SGBV", "children" and "child soldiers" (target groups); and "quality of MHPSS" and "acceptability of MHPSS" (thematic issues).

73 See D. Lyons, above note 13, p. 162.

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covers recommendations from 2008 to 2025, representing a broad temporal scope for examining such materials. Second, only recommendations employing expressions related to the semantic field of mental health were identified, and as a result, some recommendations concerning mental health, but not employing this terminology, have been omitted. To reduce this limitation, not only "mental health" but a range of related expressions were used, such as "psychological" and "psychosocial", as described above. Third, since this study incorporates elements of thematic analysis, it inherently entails a degree of subjectivity. The process of identifying themes (i.e., the "classification labels") and linking them to the recommendations was inevitably influenced by the researcher's perspective.

Results

A total of 105 recommendations were identified through the application of the UHRI database filters described above. Following the exclusion of recommendations deemed not relevant, the final dataset comprised eighty-four recommendations. As of 7 November 2025, the total number of recommendations coming from treaty bodies present in the database amounted to 116,633. This indicates that the recommendations referring to mental health in relation to persons affected by armed conflict represented less than 0.1% of the total.

The most frequently mentioned target group was children, with nearly 70% of all recommendations (fifty-nine recommendations) dedicated to them (see Figure 1).[74] Many of these recommendations regarding children referred to specific subgroups of children in particularly vulnerable conditions (see Figure 2).

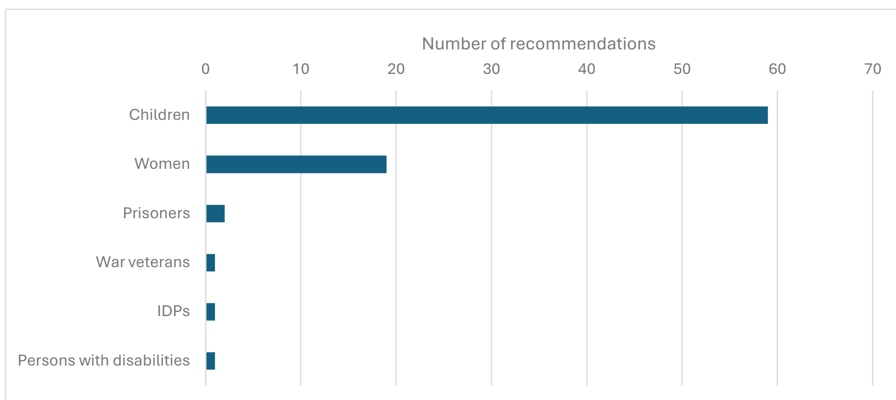

Figure 1. Target groups.

74 Since it is not possible to include all recommendations due to space limitations, the following footnotes include one illustrative example for each finding. For instance, regarding recommendations targeting children, see CRC Committee, above note 67, para. 39: "The Committee recommends that the State Party: (a) Improve the availability and accessibility of age- and development-appropriate mental health services for children, particularly those in vulnerable situations, such as children affected by conflict."

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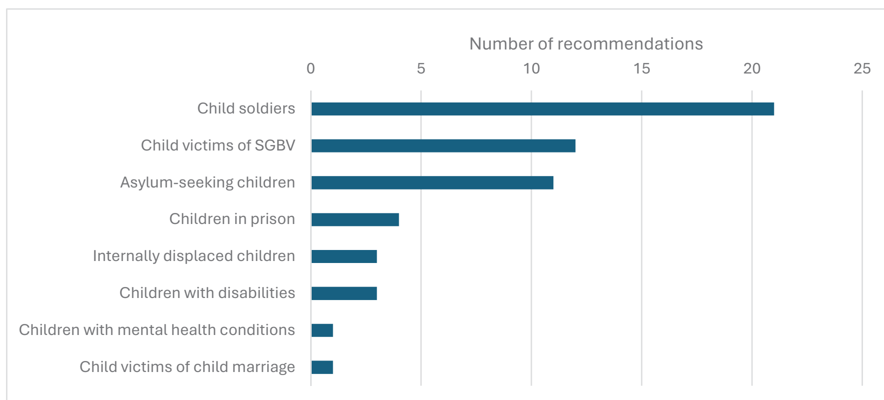

Figure 2. Target subgroups: Children.

Approximately one third of the recommendations concerning children mentioned child soldiers (twenty-one recommendations),[75] while other frequently cited subgroups were child victims of SGBV (twelve recommendations)[76] and asylum-seeking children (eleven recommendations).[77] The second most frequently mentioned target group was women, appearing in 22% of the recommendations (nineteen recommendations).[78] Within this group, the most common subgroup cited was women victims of SGBV (twelve recommendations).[79] Other groups, such as prisoners and war veterans, were rarely mentioned.

75 See e.g. CRC Committee, *Concluding Observations on the Combined Third to Fifth Periodic Reports of Cameroon*, UN Doc. CRC/C/CMR/CO/3-5, 6 July 2017, para. 41: "[T]he Committee recommends that the State Party: … (c) Establish and adequately resource community-based support structures to reintegrate children associated with armed groups, including vigilante groups, promoting their physical and psychological recovery and social reintegration."

76 See e.g. CRC Committee, *Concluding Observations on the Combined Third to Fifth Reports of the Democratic Republic of the Congo*, UN Doc. CRC/C/COD/CO/3-5, 28 February 2017, para. 25: "[T]he Committee expresses its deep concern that: … (b) Rape and other types of sexual violence against women and children are used as weapons of war in conflict-affected areas of the country; (c) Children surviving sexual violence receive little access to health care, psychological support and compensation."

77 See e.g. CRC Committee, *Concluding Observations on the Combined Fifth and Sixth Periodic Reports of the Republic of Korea*, UN Doc. CRC/C/KOR/CO/5-6, 24 October 2019, para. 49: "The Committee recommends … that the State party: … (b) Establish mechanisms for the early identification of asylum-seeking children from conflict areas, … and strengthen the physical and psychological support provided to them."

78 See e.g. CEDAW Committee, *Concluding Observations on the Report of Myanmar Submitted under the Exceptional Reporting Procedure*, UN Doc. CEDAW/C/MMR/CO/EP/1, 18 March 2019, para. 60: "The Committee, bearing in mind the large number of Rohingya women and girls who are victims of conflict-related violence and that in most cases such violence leads to disabilities, both visible, such as physical or sensory disabilities, and invisible conditions, such as psychosocial disabilities, as a result of mental illness, including post-traumatic disorder, is concerned about the lack of information on the measures taken by the State party to identify cases of acquired disability among Rohingya women and girls and to ensure their rehabilitation."

79 See e.g. CEDAW Committee, *Concluding Observations on the Initial Report of South Sudan*, UN Doc. CEDAW/C/SSD/CO/1, 23 November 2021, para. 23: "[T]he Committee recommends that the State party: (a) Implement the standard operating procedures for prevention of, protection against and response to gender-based violence of 2014, to ensure access for victims of conflict-related sexual violence to shelters and legal, psychosocial and medical assistance."

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Regarding thematic issues, the most recurrent area of concern or required action was the availability and accessibility of MHPSS, which featured in almost 80% of the recommendations (sixty-six recommendations) (see Figure 3).[80] Other issues were mentioned with considerably lower frequency; among these, the most common were the recognition by treaty bodies of the negative impact of conflict on mental health (eight recommendations)[81] and the quality of mental health services (seven recommendations).[82] Additional issues raised included complaints about the lack of information on mental health provided to the treaty body,[83] the need to adopt a mental health policy,[84] and the acceptability of MHPSS.[85]

More than 50% of the recommendations were issued by the CRC Committee, which produced thirty-one recommendations under the CRC and fourteen under the Optional Protocol to the CRC on the Involvement of Children in Armed Conflict (OPAC) (see Figure 4).[86] The CEDAW Committee and the CESCR followed, each issuing 20% of the total recommendations (seventeen recommendations each). Other committees that made occasional references to mental health in this context included the Committee against Torture (CAT, the treaty body for the Convention against Torture) (two recommendations) and the CCPR (one recommendation).

The Democratic Republic of the Congo (DRC) received the highest number of recommendations related to mental health (seven recommendations),[87]

80 See e.g. CESCR, *Concluding Observations on the Fifth Periodic Report of Sri Lanka*, UN Doc. E/C.12/LKA/CO/5, 4 August 2017, para. 59: "The Committee is concerned that, despite measures taken, the mental health-care system is inadequate and insufficiently available and accessible, while the need for mental health and psychosocial services is acute for many, in particular those in conflict-affected areas who suffer from conflict-related post-traumatic disorders (art. 12)."

81 See e.g. CRC Committee, *Concluding Observations on the Combined Fifth and Sixth Periodic Reports of Israel*, UN Doc. CRC/C/ISR/CO/5-6, 16 September 2024, para. 37: "The Committee is deeply concerned about: (a) The negative impact of the attack of 7 October 2023 and the ongoing armed conflict on the mental health and well-being of children."

82 See e.g. CESCR, *Concluding Observations on the Fourth Periodic Report of Armenia*, UN Doc. E/C.12/ARM/CO/4, 14 November 2023, para. 54: "The Committee urges the State party to intensify its efforts to … guarantee the quality of professional mental health-care services, especially for conflict-affected populations, in particular through the provision of adequate training for mental health professionals."

83 See e.g. CESCR, *Concluding Observations of the CESCR: Nepal*, UN Doc. E/C.12/NPL/CO/2, 16 January 2008, para. 25: "The Committee is … concerned about the lack of information on the extent of mental health problems, particularly in relation to persons affected by the conflict."

84 See e.g. CESCR, *Concluding Observations of the CESCR: Angola*, UN Doc. E/C.12/AGO/CO/3, 1 December 2008, para. 36: "The Committee recommends that the State party should step up its efforts in the area of health and requests it to adopt a global health policy that includes … policies targeted to individuals who suffer from war post-traumatic mental disorders."

85 See e.g. CRC-OPAC Committee, *Concluding Observations on the Report Submitted by Georgia under Article 8(1) of the OPAC*, UN Doc. CRC/C/OPAC/GEO/CO/1, 30 October 2019, para. 32: "The Committee recommends that the State party: … (c) Provide immediate, culturally responsive … assistance to ensure that such children [children who may have been recruited to serve in armed conflict] are supported in their physical and psychological recovery."

86 Optional Protocol on the Involvement of Children in Armed Conflict, 2173 UNTS 222, 25 May 2000 (entered into force 12 February 2002) (OPAC).

87 See e.g. CESCR, *Concluding Observations on the Sixth Periodic Report of the Democratic Republic of the Congo*, UN Doc. E/C.12/COD/CO/6, 28 March 2022, para. 33.

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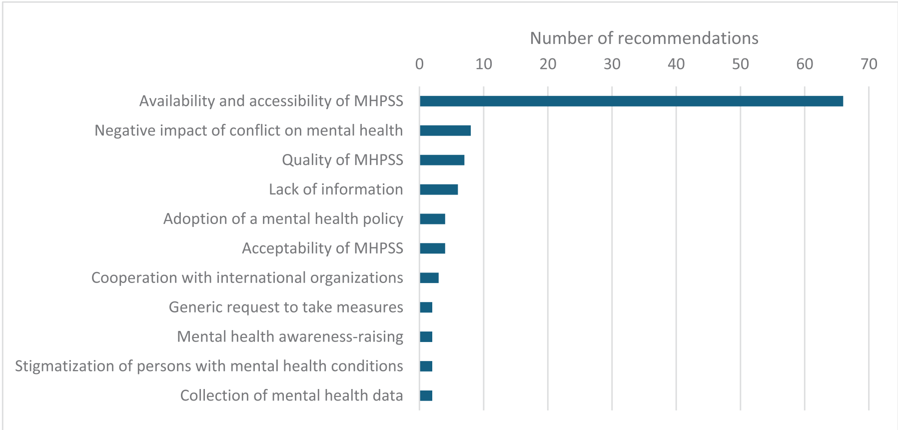

Figure 3. Thematic issues.

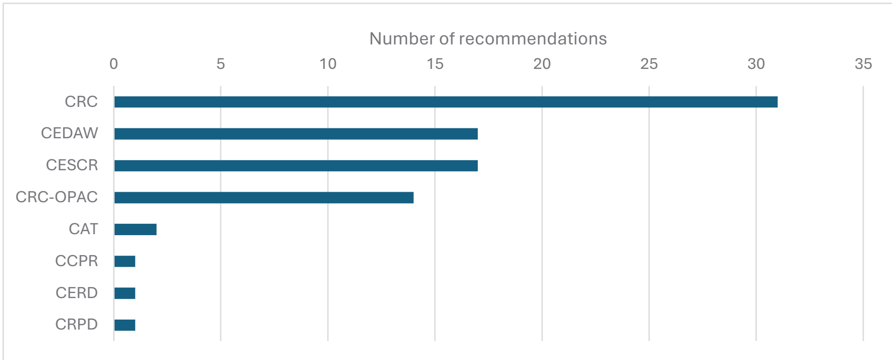

Figure 4. Recommending bodies.

followed by Ukraine (six),[88] Afghanistan (five),[89] Iraq (five),[90] Sri Lanka (five),[91] Angola (four),[92] the Central African Republic (CAR) (four)[93] and Israel (four)

88 See e.g. CRC Committee, *Concluding Observations on the Combined Fifth and Sixth Periodic Reports of Ukraine*, UN Doc. CRC/C/UKR/CO/5-6, 27 October 2022, para. 31.

89 See e.g. CRC, *Concluding Observations: Afghanistan*, UN Doc. CRC/C/AFG/CO/1, 8 April 2011, paras 51(e), 52(e).

90 See e.g. CESCR, *Concluding Observations on the Fifth Periodic Report of Iraq*, UN Doc. E/C.12/IRQ/CO/5, 14 March 2024, para. 46.

91 See e.g. CESCR, above note 80, para. 59.

92 See e.g. CRC-OPAC Committee, *Concluding Observations on the Report Submitted by Angola under Article 8(1) of the OPAC*, UN Doc. CRC/C/OPAC/AGO/CO/1, 29 June 2018, para. 29(a).

93 See e.g. CRC Committee, *Concluding Observations on the Second Periodic Report of the Central African Republic*, UN Doc. CRC/C/CAF/CO/2, 8 March 2017, para. 65(b).

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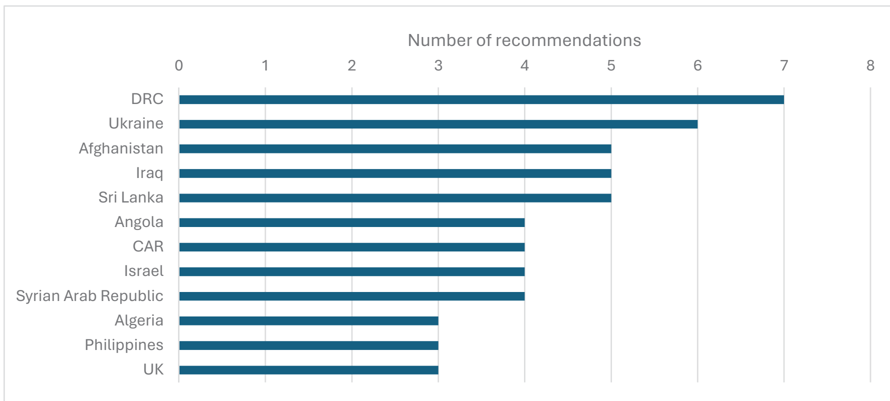

Figure 5. Countries concerned (first 12 out of 34).

(see Figure 5).[94] Several other countries received recommendations in smaller numbers, including Algeria (three),[95] the Philippines (three),[96] the United Kingdom (three),[97] Armenia (two),[98] Colombia (two),[99] Cote d'Ivoire (two),[100] Ethiopia (two),[101] Georgia (two)[102] and Nepal (two).[103] Overall, the eighty-four recommendations were addressed to thirty-four countries, covering all continents.

In terms of publication date, four periods can be distinguished in order to better identify trends: (a) 2008–16, (b) 2017–19, (c) 2020–21 and (d) 2022–25. The first period (2008–16) is the one with the fewest recommendations, representing 27% of the total, with an average of 2.5 recommendations per year (see Figure 6). The highest number of recommendations was issued during the second period (2017–19), accounting for 39% of the total in just three years. The number of

94 See e.g. CESCR, *Concluding Observations of the CESCR: Israel*, UN Doc. E/C.12/ISR/CO/3, 16 December 2011, para. 32.

95 See e.g. CRC-OPAC Committee, *Concluding Observations on the Report Submitted by Algeria under Article 8(1) of the OPAC*, UN Doc. CRC/C/OPAC/DZA/CO/1, 22 June 2018, para. 35.

96 See e.g. CRC Committee, *Concluding Observations on the Combined Fifth and Sixth Periodic Reports of the Philippines*, UN Doc. CRC/C/PHL/CO/5-6, 26 October 2022, para. 43(c).

97 See e.g. CRC Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, UN Doc. CRC/C/GBR/CO/4, 20 October 2008, para. 57.

98 See e.g. CESCR, above note 82, paras 53–54.

99 See e.g. CAT, *Concluding Observations on the Sixth Periodic Report of Colombia*, UN Doc. CAT/C/COL/CO/6*, 7 June 2023, para. 23.

100 See e.g. CEDAW, *Concluding Observations on the Fourth Periodic Report of Côte d'Ivoire*, UN Doc. CEDAW/C/CIV/CO/4, 30 July 2019, para. 10(d).

101 See e.g. CCPR, *Concluding Observations on the Second Periodic Report of Ethiopia*, UN Doc. CCPR/C/ETH/CO/2, 7 December 2022, para. 27.

102 See e.g. CRC-OPAC Committee, above note 85, paras 31–32.

103 See e.g. CESCR, above note 83, para. 45.

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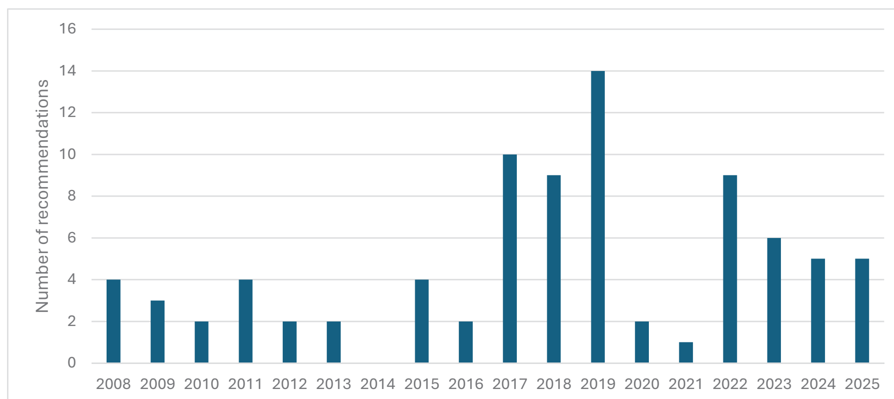

Figure 6. Recommendation publication year.

recommendations dropped sharply in 2020–21 (to 4% of the total), before increasing again between 2022 and 2025, when almost 30% of all recommendations were issued.

Discussion

The data presented above reveal a clear predominance of recommendations dedicated to the mental health of children and women affected by conflict. These results are unsurprising and in line with studies suggesting that children and women are categories that have received "colossal attention" from treaty bodies.[104] IHRL's attention to children is particularly well established, and the CRC remains one of the most widely ratified treaties, with 196 States Parties. Moreover, the protection of children during hostilities has been the subject of numerous international instruments and initiatives over the past three decades. Among these, it is worth recalling the creation of the mandate of the Special Representative for Children in Armed Conflict by the UN General Assembly in 1997;[105] Security Council Resolution 1261 of 1999, which identified six grave violations affecting children the most during the hostilities and requested the Secretary-General to report on them;[106] and the OPAC, adopted in 2000 and entered into force in 2002, which currently has 172 States Parties.[107]

More specifically, several recommendations emphasized the need to provide MHPSS to child soldiers. The conscription and use of minors remain widespread in

104 Anganile Willie Mwenifumbo and Harumi Fuentes Furuya, "In the Pursuit of Justice for Women and Children and the Right to Development: A Review of Concluding Observations of the United Nations Human Rights Treaty Bodies", in Helmut Kury, Stavomir Redo and Evelyn Shea (eds), *Women and Children as Victims and Offenders: Background, Prevention, Reintegration*, Springer, Cham, 2016, p. 69.

105 UNGA Res. 51/77, 20 February 1997.

106 UNSC Res. 1261, 30 August 1999.

107 OPAC, above note 86.

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various conflict settings, and the consequences for their mental health are well documented.[108] Child soldiers are exposed to violence, death and sexual abuse and are coerced into perpetrating violence themselves. Similar considerations apply to child victims of SGBV, the other most prominent subgroup identified: SGBV continues to be used as a "strategic weapon of war" in several conflicts, taking a heavy toll on mental health.[109] It is also noteworthy that the recruitment and use of children as soldiers and sexual violence against children constitute two of the six grave violations identified by Security Council Resolution 1261. It can thus be argued that the "six violations" framework established by that resolution has significantly influenced the treaty bodies' work.

Another point emerging from the analysis is the presence of recommendations concerning asylum-seeking children. These recommendations seem to reflect States' obligations not only under Article 24 of the CRC (right to health), but also under its Article 39, which requires States Parties to take all appropriate measures to promote the physical and psychological recovery of child victims of armed conflict. As observed by Tobin and Marshall, this obligation "arises irrespective of whether a state is responsible for, involved with, or contributed to the harmful treatment experienced by a child".[110] The presence of asylum-seeking children as a target group is particularly interesting, as the States concerned are typically the so-called "countries of destination" rather than those where the conflict occurs. This shows that States' obligations to protect the mental health of children affected by armed conflict extend beyond the countries directly impacted by the hostilities.

The second-most frequently cited group was women, especially those who are victims of SGBV. This focus likewise reflects a significant number of international initiatives addressing sexual violence in conflict over the past thirty years. Among these, the 1995 Beijing Declaration and Platform for Action makes references to the phenomenon of sexual abuse during hostilities,[111] and Security Council Resolution 1888 of 2009 establishes the Office of the Special Representative on Sexual Violence in Conflict.[112] Since then, a report of the Secretary-General on conflict-related sexual violence has been issued every year, further institutionalizing attention to this matter. Overall, the emphasis on women and children as groups whose mental health requires special protection corresponds to a high interest in the impact of conflict on these populations in the global policy agenda.

108 Rochelle L. Frounfelker *et al.*, "Living through War: Mental Health of Children and Youth in Conflict-Affected Areas", *International Review of the Red Cross*, Vol. 101, No. 911, 2019, p. 485.

109 Elena Cherepanov, "Sexual and Gender-Based Violence as Warfare", in Robert Geffner *et al.* (eds), *Handbook of Interpersonal Violence and Abuse Across the Lifespan: A Project of the National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV)*, Springer, Cham, 2022.

110 John Tobin and Chelsea Marshall, "Article 39: The Right to Reintegration and Recovery", in John Tobin (ed.), *The UN Convention on the Rights of the Child: A Commentary*, Oxford University Press, Oxford, 2019, p. 1562.

111 Beijing Declaration and Platform for Action, adopted at the Fourth World Conference on Women, 27 October 1995, paras 133–136.

112 UNSC Res. 1888, 30 September 2009. Other relevant resolutions in this context include UNSC Res. 1960, 16 December 2010, and UNSC Res. 2106, 24 June 2013.

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Regarding thematic issues, most recommendations concerned the availability and accessibility of MHPSS for persons affected by conflict. This focus demonstrates a strong recognition by treaty bodies of the acute need for MHPSS in conflict and post-conflict contexts. By contrast, comparatively less attention was paid to the two other elements of the AAAQ framework – that is, acceptability and quality of mental health services and facilities. The treaty bodies seem to take a pragmatic approach in this regard: they prioritize the provision of MHPSS services while giving less prominence to considerations such as their cultural appropriateness (acceptability) or the need to have properly trained staff (quality). In conflict settings, typically characterized by severe resource constraints, this emphasis on access over other elements may be understandable. Nevertheless, the cultural acceptability of MHPSS interventions should not be underestimated: the risk, especially if NGOs or international organizations provide such services, is often that a Western conception of mental health will be imposed, which could undermine the effectiveness of the interventions.

Another issue that deserves attention is that although some recommendations refer to mental health-care services or psychiatric care,[113] several others adopt a broader approach by referring to psychological and/or psychosocial support.[114] In many instances, the recommendations mention mental health and psychological/psychosocial support services together.[115] This linguistic choice reflects the awareness of treaty bodies that conflict affects the mental health of the entire population, and not only that of those who have or develop mental health conditions. Consequently, the services that the State should put in place during and after hostilities encompass not only clinical interventions aimed at treating mental health conditions (psychiatric care) but also measures to alleviate mental distress that does not necessarily reach this threshold (psychosocial and psychological support). In sum, these recommendations highlight the need for a multi-layered approach to mental health, including psychosocial support, psychological support and specialized mental health care. This finding suggests that the right to mental health entails State obligations not only in relation to treatment but also in relation to mental health prevention and promotion.

The other thematic issues identified in the recommendations also warrant discussion. In conflict settings, the shortage of financial and human resources often constitutes one of the main obstacles to implementing human rights, including the right to (mental) health. The principle of progressive realization does not, in itself,

113 For example, CESCR, above note 82, para. 53 mentions "mental health-care services".

114 For example, CESCR, above note 87, para. 33 mentions "access to health care and psychological support"; and CEDAW Committee, *Concluding Observations on the Combined Third and Fourth Periodic Reports of Saudi Arabia*, UN Doc. CEDAW/C/SAU/CO/3-4, 14 March 2018, para. 18(e) mentions "psychological assistance". This is also the reason why this study has adopted the term "MHPSS" instead of "mental health care" in the classification labels.

115 For example, CESCR, *Concluding Observations on the Seventh Periodic Report of Ukraine*, UN Doc. E/C.12/UKR/CO/7, 2 April 2020, para. 40 mentions "mental health care and psychological support"; CRC Committee, *Concluding Observations on the Combined Fifth and Sixth Periodic Reports of Norway*, UN Doc. CRC/C/NOR/CO/5-6, 4 July 2018, para. 37(d) mentions "psychological and psychiatric care"; and CESCR, above note 80, para. 59 mentions "mental health and psychosocial services".

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resolve the question of how to allocate resources, and for this reason, even the less frequently cited issues in the recommendations may serve as useful indicators of areas for prioritization. These issues include the quality of MHPSS services; the adoption of a mental health policy; the acceptability of MHPSS services; cooperation with international organizations providing such services; mental health awareness-raising; the fight against the stigmatization of persons with mental health conditions; and the collection of mental health data.

It is noteworthy that the recommendations did not address one essential feature of the right to (mental) health: participation. This absence was not unexpected, as participation remains one of the most neglected components of the right to health.[116] In the context of armed conflict, the operationalization of participatory processes is even more challenging. Nevertheless, designing mental health policies that respond to people's needs, rather than adopting a top-down approach, would not only constitute respect for one key dimension of the right to health, but would also likely enhance the success of the measures. In practical terms, treaty bodies could recommend following the Inter-Agency Standing Committee's (IASC) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, which provide useful guidance on participatory approaches.[117] For example, the *Guidelines* emphasize that "[t]he affected population should … be involved in defining well-being and distress".[118] The element of accountability was likewise largely absent from the recommendations, though this omission is perhaps more understandable given that administrative, political and judicial mechanisms are often severely disrupted during conflict.

The finding that the most active treaty body was the CRC Committee is consistent with the parallel finding that the majority of the recommendations focused on children. Similar reasoning applies to the CEDAW Committee, which ranked second, as women were the second-most frequently cited target group. The finding that the CESCR issued several recommendations (it shared the second position with the CEDAW Committee) is coherent with previous work by Schmid, who has underlined that mental health has become one of the key substantive areas of attention in the CESCR's consideration of conflict-related issues.[119] In contrast, treaty bodies associated with the civil and political rights sphere, such as the CCPR, have rarely issued recommendations on mental health. This finding demonstrates that mental

116 Kwanele Asante, "The Right to Participate: An Under-Utilised Component of the Right to the Highest Attainable Standard Health", *The BMJ Opinion*, 16 February 2021, available at: https://blogs.bmj.com/bmj/2021/02/16/the-right-to-participate-an-under-utilised-component-of-the-right-to-the-highest-attainable-standard-health/.

117 IASC, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, 2007, pp. 38–49. The IASC is the humanitarian coordination forum of the UN system, and it also includes some non-UN organizations. The target audience of the *Guidelines* includes, together with international organizations and NGOs, "government authorities" (p. 6).

118 *Ibid.*, p. 41.

119 Evelyne Schmid, "Socio-Economic and Cultural Rights and Wrongs after Armed Conflicts: Using the State Reporting Procedure before the United Nations Committee on Economic, Social and Cultural Rights More Effectively", *Netherlands Quarterly of Human Rights*, Vol. 31, No. 3, 2013, p. 256.

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health continues (understandably) to be conceptualized predominantly within the framework of socio-economic rights.

The analysis of countries addressed by the recommendations shows, as expected, that the highest numbers of recommendations were directed to States involved in situations of international or non-international armed conflict, such as the DRC, Ukraine, Afghanistan and Iraq. However, more than thirty different countries in total were addressed by the recommendations, showing that an interest in the protection of the mental health of persons affected by conflict is not limited to certain geographical regions or particular conflicts. Moreover, as anticipated above, not all countries receiving the recommendations were countries impacted by conflict – some were countries of destination, where persons affected by hostilities seek asylum.

Finally, the temporal distribution of the recommendations reveals a net increase in attention to the topic between 2015 and 2019. One possible explanation is that during this period, the UN Special Rapporteur for the Right to Health was Dainius Pūras (2014–20), a professor of child psychiatry and public mental health who dedicated significant consideration to the protection of the right to mental health. Pūras advocated against overmedicalization and gave prominence to mental health prevention and promotion,[120] and it is plausible that his reports informed and inspired the treaty bodies' work.

Conversely, the sharp decline in recommendations between 2020 and 2021 may be linked to the COVID-19 pandemic. During those years, the mental health needs of persons affected by conflict may have been overshadowed by other right-to-health concerns, such as access to vaccines. In addition, fewer Concluding Observations were issued in that period due to the deferral of sessions and the holding of sessions online. It is also worth mentioning that, especially after the COVID-19 pandemic, UN Human Rights is undergoing a significant financial crisis that is impacting the work of the treaty bodies.[121] By way of illustration, in 2025, six treaty bodies had to cancel one of their annual sessions, leading to the postponement of several State Party reviews and related Concluding Observations.[122]

120 *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc. A/HRC/35/21, 28 March 2017; *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc. A/HRC/41/34, 12 April 2019.

121 International Service for Human Rights, "Urgent Support Needed for the UN Treaty Bodies", 2025, available at: https://ishr.ch/latest-updates/urgent-support-needed-for-the-un-treaty-bodies/; CCPR, "The UN Budget Crisis and Its Deepening Impact on the Human Rights Committee and Civil Society Participation", 2025, available at: https://ccprcentre.org/ccprpages/the-un-budget-crisis-and-its-deepening-impact-on-the-human-rights-committee-and-civil-society-participation.

122 *Report of the Chairs of the Human Rights Treaty Bodies on Their Thirty-Seventh Annual Meeting*, UN Doc. A/80/294, 31 July 2025, para. 40.

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Conclusions

> I went onstage to check how things were going and was stunned to see how many young people managed to come even though they had to evade mortar and sniper fire coming from the surrounding hills. The hunger for a normal life prevailed. So many people were ready to risk their lives for two hours of any music whatsoever.[123]

With these words, Nebojša Šerić Šoba, another member of the rock band Sikter, described one of the band's concerts in besieged Sarajevo. His reflection reminds us that our minds need nourishment and protection just as much as our bodies do.

IHRL recognizes the importance of mental health through the corresponding human right: the right to mental health. The main features of this right include the requirements that mental health services, goods and facilities be available, accessible, acceptable and of good quality; its subjection to the principle of progressive realization; and the participation of the population in the development of mental health policies. Since IHRL continues to apply in situations of armed conflict, the right to mental health remains relevant even in such contexts. Although this right cannot be implemented during hostilities in the same way as in peacetime, IHRL nonetheless requires States to take concrete steps towards its realization even in conflict settings.

To better understand State obligations under the right to mental health in situations of armed conflict, this paper has examined how UN treaty bodies have addressed this right in their Concluding Observations. The findings reveal that the vast majority of the recommendations concerned children, especially child soldiers, and women, especially those who are victims of SGBV. These results reflect the strong focus on the impact of conflict on these two groups in the broader global policy framework. Relevant initiatives in this context include the establishment of the Special Representative of the Secretary-General for Children in Armed Conflict and the Special Representative of the Secretary-General on Sexual Violence in Conflict. Notably, various recommendations also addressed child victims of armed conflict seeking asylum, demonstrating that even countries of destination bear obligations to promote the psychological recovery of these children.

In terms of thematic issues, treaty bodies concentrated primarily on the need to provide MHPSS to persons affected by conflict. Recommendations commonly referred to both psychiatric care and psychological/psychosocial support, revealing an awareness of the importance of addressing mental health at multiple levels. Other issues mentioned included the quality and acceptability of MHPSS, the adoption of a national mental health policy and the collection of mental health data. One aspect that might have warranted greater attention is participation; in conflict settings, developing mental health policies through bottom-up approaches not

123 Nebojša Šerić Šoba, "Just Another Day in a Besieged City", *Kosovo 2.0*, 6 April 2022, available at: https://kosovotwopointzero.com/en/just-another-day-in-a-besieged-city/.

https://doi.org/10.1017/S1816383125101033 Published online by Cambridge University Press

only constitutes respect for the right to mental health but also likely enhances the effectiveness of interventions.

Directions for future action flowing from this study's findings include the following:

- **For States:** States should continue submitting reports to treaty bodies, as Concluding Observations have proven to be a valuable tool for clarifying human rights obligations and identifying areas of concern. Adequate funding for treaty bodies is also essential, given that current budgetary constraints are significantly affecting their work. As far as the right to mental health is concerned, States should be aware that they should take concrete steps towards its realization even in situations of armed conflict. While implementing this right during hostilities can be particularly challenging, some measures do not require substantial resources, such as collaborating with international organizations that provide MHPSS services.
- **For treaty bodies:** Treaty bodies should keep addressing the mental health of persons affected by armed conflict in their Concluding Observations, given the growing societal and political importance of mental health and the well-documented adverse effects of hostilities on the mental health of populations. They should be as specific as possible in their recommendations and avoid generic requests to "take measures". With respect to thematic issues, they could pay more attention to the importance of participatory models in developing mental health policies. Furthermore, the CRC Committee, CEDAW Committee and CESCR – the treaty bodies that issued the majority of recommendations on mental health issues – could coordinate to develop a common approach on mental health. Providing States with consistent feedback on priority areas could enhance the overall impact of the recommendations.

Through its empirical analysis, this paper hopes to support States in implementing their obligations towards the mental health of persons affected by armed conflict, demonstrating how an abstract human right can be translated into more practical and concrete steps. This study may also serve as a useful resource for treaty bodies, increasing awareness of how they have addressed mental health in situations of armed conflict to date and identifying areas for potential improvement. The insights provided by this paper may inform the drafting not only of future Concluding Observations but also of future General Comments. For instance, this analysis could provide valuable input for the drafting process of the CESCR's new General Comment on the application of the ICESCR in situations of armed conflict.[124]

The issues explored in this study are particularly relevant today and will likely remain so in the years to come, as modern warfare tactics, like cyber-attacks and psychological warfare, and potential future military developments, such as the

124 *Committee on Economic, Social and Cultural Rights: Report on the Seventy-First and Seventy-Second Sessions*, UN Doc. E/2023/22, E/C.12/2022/3, 22 February 2023, para. 96.

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use of neurotechnologies, continue to have a profound effect on mental health[125] – indeed, it has unsurprisingly been claimed that "[t]he human brain is the battlefield of the 21st century".[126] Future research could examine whether, and to what extent, the Concluding Observations analyzed in this study have had a tangible impact on the countries concerned. It could also explore what participatory approaches have proven particularly effective in situations of armed conflict.

All of this being said, the importance of providing MHPSS in conflict and post-conflict contexts should not obscure the social and political factors that give rise to mental distress in the first place. For instance, it has been observed that there is "a tendency to depict all Palestinians as traumatized and suffering from mental health issues while simultaneously disregarding the context that creates these mental health issues".[127] For this reason, it remains of the utmost importance not to decontextualize mental distress, and above all, to ask those affected by armed conflict what their needs are.

125 On these issues, see Ryan Shandler, Michael L. Gross and Daphna Canetti, "Cyberattacks, Psychological Distress, and Military Escalation: An Internal Meta-Analysis", *Journal of Global Security Studies*, Vol. 8, No. 1, 2023; Evariste E. Sebahutu, "The Conceptualization of Psychocide and Psychoethnicide: Psychological Warfare's Impact on Rwandan's [*sic*] Mental Health", *International Journal of Child Development and Mental Health*, Vol. 12, No. 2, 2024; Federico Mantellassi and Edward Madziwa, *Neurotechnologies in the Military Domain: A Primer*, UN Institute for Disarmament Research, 2025.

126 This 2018 quotation from James Giordano of the Institute for National Strategic Studies is taken from NATO and Science and Technology Organization, *Cognitive Warfare: The Future of Cognitive Dominance*, 2022, p. 1-1.

127 Maria Helbich and Samah Jabr, "Mental Health under Occupation: An Analysis of the De-Politicization of the Mental Health Discourse in Palestine and a Call for a Human Rights Approach", *International Journal of Human Rights in Healthcare*, Vol. 15, No. 1, 2022, p. 4. For a wider discussion on this point, see also G. Bosi, above note 21.

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