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STUDY GUIDE

WORLD HEALTH ASSEMBLY

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World mental health report

Transforming mental health for all

World Health Organization

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Chapter 1. Introduction

A world report to inspire and inform change.

Twenty years after WHO published its landmark *The world health report 2001: mental health – new understanding, new hope*, the recommendations made then remain valid today.

Yet many advances have been made. Interest in and understanding of mental health has increased. Many countries have established, updated and strengthened mental health policies or plans. Advocacy movements have amplified the voices of people with lived experience of mental health conditions. Informed by research, the field has advanced technically. Numerous practical, evidence-based mental health guidelines, manuals and other tools are now available for implementation.

WHO Member States adopted the *Comprehensive mental health action plan 2013–2030.* They committed to meet global targets for improved mental health. These were focused on strengthening leadership and governance, community-based care, promotion and prevention, and information systems and research.

But WHO's latest analysis of country performance against the action plan shows that progress has been slow. For most of the world, the approach to mental health care remains very much business as usual. The result? Mental health conditions continue to exact a heavy toll on people's lives, while mental health systems and services remain ill-equipped to meet people's needs.

In the meantime, global threats to mental health are ever present. Growing social and economic inequalities, protracted conflicts, violence and public health emergencies threaten progress towards improved well-being. Now, more than ever, business as usual for mental health simply will not do.

This report is designed to inspire and inform the indisputable and urgent transformation required to ensure better mental health for all. While promoting a multisectoral approach, this report is especially written for decision-makers in the health sector. This includes ministries of health and other partners in the health sector who are generally tasked with developing mental health policy and delivering mental health systems and services.

Business as usual for mental health simply will not do.

Summary: Chapter 1

The introduction sets the tone for the rest of the report. It details the history of the comprehensive mental health action plan 2013-2030 and the status quo of mental health legislation worldwide.

3 Did you know that...

The 66th Session of the World Health Assembly adopted the WHO's comprehensive mental health action plan 2013 - 2020 in May 2013 that emphasizes the essential role of mental health in achieving health for all people. The plan has 4 objectives: 1) Make mental health a top priority for governments by ensuring strong leadership and support for mental health programs, policies, and services; 2) Improve access to mental health care by integrating it into general healthcare systems, making services more available, affordable, and community-based; 3) Create initiatives to prevent mental health problems by reducing stigma, raising awareness, and addressing risks like poverty, violence, and discrimination; and, 4) Increase understanding of mental health issues by collecting reliable data, conducting research, and sharing knowledge to improve policies and care.
This plan was extended until 2030 with updates added in 2021.

4 Something to think about

Why has progress been so slow? Are there specific factors limiting the implementation of comprehensive mental healthcare initiatives in the country you have been assigned to represent? WHO's Mental Health Gap Action Programme (mhGAP) provides tools for scaling up care, particularly in low-resource settings.

Chapter 2. Principles and drivers in public mental health

Mental health is critically important for everyone, everywhere.

Mental health is an integral part of our general health and well-being and a basic human right. Having good mental health means we are better able to connect, function, cope and thrive. Mental health exists on a complex continuum, with experiences ranging from an optimal state of well-being to debilitating states of great suffering and emotional pain. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case.

At any one time, a diverse set of individual, family, community and structural factors may combine to protect or undermine our mental health and shift our position on the mental health continuum. Although most people are remarkably resilient, people who are exposed to unfavourable circumstances – including poverty, violence and inequality – are at higher risk of experiencing mental health conditions. Risks can manifest themselves at all stages of life, but those that occur during developmentally sensitive periods, especially early childhood, are particularly detrimental. Protective factors similarly occur throughout our lives and serve to strengthen resilience. They include our individual social and emotional skills and attributes as well as positive social interactions, quality education, decent work, safe neighbourhoods and community cohesion, among others.

Because the factors determining mental health are multisectoral, interventions to promote and protect mental health should also be delivered across multiple sectors. And when it comes to providing care, a multisectoral approach is similarly needed because people with mental health conditions often require services and support that extend beyond clinical treatment.

Mental health risks and protective factors can be found in society at different scales. Local threats heighten risk for individuals, families and communities. Global threats heighten risk for whole populations and can slow worldwide progress towards improved well-being. In this context, key threats today include: economic downturns and social polarization; public health emergencies; widespread humanitarian emergencies and forced displacement; and the growing climate crisis.

Among its many impacts, the COVID-19 pandemic has created a global crisis for mental health, fuelling short- and long-term stresses and undermining the mental health of millions. For example, estimates put the rise in both anxiety and depressive disorders at more than 25% during the first year of the pandemic. At the same time, mental health services have been severely disrupted and the treatment gap for mental health conditions has widened.

Mental health is an integral part of our general health and well-being and a basic human right.

Summary: Chapter 2

This chapter focuses on a number of factors that impact mental health as well as local threats that heighten risk for individuals, families and communities and global threats that heighten risk for whole populations.

1 Did you know that...

The WHO constitution defines health as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. This implies that mental health is more than just the absence of mental disorders or disabilities. It is an integral part of health, determined by a range of socioeconomic, biological and environmental factors.
Mental health thus refers to a state of well-being in which an individual realizes their own abilities, can cope with normal stresses of life, can work productively and is able to contribute to their community (WHO, 2024).

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4 Did you know that...

According to the WHO 2012 background paper ("RISKS TO MENTAL HEALTH: AN OVERVIEW OF VULNERABILITIES AND RISK FACTORS BACKGROUND PAPER BY WHO SECRETARIAT FOR THE DEVELOPMENT OF A COMPREHENSIVE MENTAL HEALTH ACTION PLAN") discussing vulnerabilities and risk factors to mental health, these can include:
Individual attributes - low self-esteem, cognitive/ emotional immaturity, medical illness, substance abuse
Social circumstances - bereavement, neglect, exposure to violence, abuse, low income and poverty, work stress, unemployment
Environmental factors - limited access to basic services, social injustice and discrimination, gender inequalities, exposure to war, civil unrest or natural calamity.

Protective factors in mental health in these three categories include:
Individual attributes - high self-esteem, ability to solve problems and manage stress or adversity, communication skills physical health and fitness
Social circumstances - social support of family & friends, good parenting / family interaction, economic security, and scholastic achievement
Environmental factors - equality of access to basic services, social and gender equality, physical security and safety

Unfavorable circumstances during childhood and adolescence may be detrimental to the development of protective factors in childhood and adolescence.

5 Something to think about

The WHO 2022 World Mental Health Report discusses impacts of the COVID-19 pandemic on mental health. How did the global pandemic affect your state of mental well-being, and the mental health of youth in the country you have been assigned to represent?

Chapter 3. World mental health today

Mental health needs are high but responses are insufficient and inadequate.

In all countries, mental health conditions are highly prevalent. About one in eight people in the world live with a mental disorder. The prevalence of different mental disorders varies with sex and age. In both males and females, anxiety disorders and depressive disorders are the most common.

Suicide affects people and their families from all countries and contexts, and at all ages. Globally, there may be 20 suicide attempts to every one death, and yet suicide accounts for more than one in every 100 deaths. It is a major cause of death among young people.

Mental disorders are the leading cause of years lived with disability (YLDs), accounting for one in every six YLDs globally. Schizophrenia, which occurs in approximately 1 in 200 adults, is a primary concern: in its acute states it is the most impairing of all health conditions. People with schizophrenia or other severe mental health conditions die on average 10 to 20 years earlier than the general population, often of preventable physical diseases.

Overall, the economic consequences of mental health conditions are enormous. Productivity losses and other indirect costs to society often far outstrip health care costs. Economically, schizophrenia is the most costly mental disorder per person to society. Depressive and anxiety disorders are much less costly per person; but they are more prevalent, and so majorly contribute to overall national costs.

In addition to being pervasive and costly, mental health conditions are also severely underserved. Mental health systems all over the world are marked by major gaps and imbalances in information and research, governance, resources and services. Other health conditions are often prioritized over mental health, and within mental health budgets, community-based mental health care is consistently underfunded. On average, countries dedicate less than 2% of their health care budgets to mental health. More than 70% of mental health expenditure in middle-income countries still goes towards psychiatric hospitals. Around half the world's population lives in countries where there is just one psychiatrist to serve 200 000 or more people. And the availability of affordable essential psychotropic medicines is limited, especially in low-income countries. Most people with diagnosed mental health conditions go completely untreated. In all countries, gaps in service coverage are compounded by variability in quality of care.

Several factors stop people from seeking help for mental health conditions, including poor quality of services, low levels of health literacy in mental health, and stigma and discrimination. In many places, formal mental health services do not exist. Even when they are available, they are often inaccessible or unaffordable. People will often choose to suffer mental distress without relief rather than risk the discrimination and ostracization that comes with accessing mental health services.

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Summary: Chapter 3

This chapter centers on the state of mental health today and highlights the most common mental health conditions worldwide that include depressive and anxiety disorders. Chapter 3 also details the economic consequences of mental health and provides an overview of the major gaps and imbalances in information, research and funding resources when compared to other health conditions that are considered a higher priority. It emphasizes the need to acknowledge mental health conditions as significant comorbidities and to recognize factors that are preventing young people from seeking help - health illiteracy, societal stigma and discrimination.
Definition:
Comorbidities are the presence of one or more additional medical conditions or diseases occurring alongside a primary condition. For example, someone with diabetes who also has high blood pressure and obesity has comorbidities. These conditions can interact and affect the treatment or progression of each other. Mental health can be a comorbidity to other diseases when psychological conditions like depression, anxiety, or stress coexist with physical health conditions, such as diabetes, heart disease, or cancer. Living with a chronic physical illness can increase the risk of developing mental health issues due to stress, lifestyle changes, or the burden of managing the disease. At the same time, mental health conditions can worsen physical illnesses. For example, depression may reduce adherence to medical treatments or healthy behaviors, exacerbating the physical condition and anxiety can increase stress hormones, which may negatively affect conditions like hypertension or asthma.

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1 Did you know that...

The WHO International Classification of Diseases defines anxiety disorders as conditions characterized by excessive fear and anxiety, related to behavioral disturbances, with symptoms severe enough to result in significant distress or impairment in functioning. This broad cluster of disorders can include specific phobias, or related to episodes of intense panic attacks (see ICD-11 CDDR for mental, behavioral and neurodevelopmental disorders, 2024).

Depressive disorders are characterized by depressive mood or loss of pleasure accompanied by other cognitive, behavioral or neurovegetative symptoms that significantly impair the individual's ability to function. They should not be confused psychological states, which may point to the presence of bipolar disorder (see ICD-11 CDDR for mental, behavioral and neurodevelopmental disorders, 2024). The Diagnostic and Statistical Manual for Mental Disorders 5th ed. further specifies that symptoms must be experienced for at least 6 months or longer for a diagnosis to be made (DSM-5, 2013).

Globally, about 14% of adolescents (10-19 years old) experience mental health disorders, including anxiety, depression, and behavioral conditions.

2 Interesting facts...

Suicide is the fourth leading cause of death among adolescents aged 15–19 globally.

Find out the mortality statistics of youth in the country you have been assigned to represent. How many have been attributed to mental health conditions? Is there under-reporting of such cases in the country you have been assigned to represent? If such data do not exist, what measures can be taken to collect reliable data?

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4 Something to think about

Have there been any studies that demonstrate productivity losses due to mental health conditions in the labor force of the country you have been assigned to represent? Are they demonstrably greater than the associated healthcare costs?

6 Something to think about

What can be done to reduce the stigma and societal perceptions associated with seeking mental healthcare services?

Did you know?

In many cultures, discussing mental health is taboo, preventing youth from seeking help or discussing their feelings openly. In low- and middle-income countries, up to 90% of adolescents with mental health conditions receive no treatment due to stigma and lack of resources. In high-income countries, the treatment gap remains at 30-50%, showing that this is a global issue.

Definition:

Mental health services: The means by which effective interventions for mental health are delivered. The way these services are organized has an important bearing on their effectiveness. Typically, mental health services include outpatient facilities, mental health day treatment facilities, psychiatric wards in a general hospital, community mental health teams, supported housing in the community, and mental hospitals. Expanding mental health services to the education sector is seen as one way of making the delivery of services more effective, efficient and equitable.

Chapter 4. Benefits of change

Committing to mental health is an investment towards a better life and future for all.

There are three main reasons to invest in mental health: public health, human rights and socioeconomic development.

Investing in mental health for all advances public health. It can greatly reduce suffering and improve the health, quality of life, functioning and life expectancy of people with mental health conditions. Enhanced coverage and increased financial protection are fundamental steps towards closing the vast care gap and reducing inequities in mental health. To that end, including mental health in universal health coverage packages of essential services is vital. So too is integrating mental and physical health care, which improves accessibility, reduces fragmentation and duplication of resources and better meets people's health needs.

Investing in mental health is needed to stop human rights violations. Around the world, people with mental health conditions are frequently excluded from community life and denied basic rights. For example, they are not only discrim- inated against in employment, education and housing, but also do not enjoy equal recognition before the law. And too often they are subjected to human rights abuses by some of the very health services responsible for their care. By implementing internationally agreed human rights conventions, such as the Convention for the Rights of People with Disabilities, major advances can be made in human rights. Anti-stigma interventions – particularly social contact strategies through which people with lived experience help to shift attitudes and actions – can also reduce stigma and discrimination in the community.

Investing in mental health can enable social and economic development. Poor mental health puts a brake on development by reducing productivity, straining social relationships and compounding cycles of poverty and disadvantage. Conversely, when people are mentally healthy and live in supportive environments, they can learn and work well and contribute to their communities, to the benefit of all.

Accumulated evidence shows that there is a core set of cost–effective interventions for priority conditions that are feasible, affordable and appropriate. These include school-based social and emotional learning programmes and regulatory bans on highly hazardous pesticides (to prevent suicides), as well as a range of clinical interventions as listed in the WHO UHC Compendium.

> Scaling up treatment for depression and anxiety provides a **benefit–cost ratio of 5 to 1**

4 Something to think about

What occupational safeguards for people with mental disorders might you ask for in your draft resolution?

Chapter 5. Foundations for change

Transforming mental health starts with building the foundations for well-functioning mental health systems and services.

In many ways, health system strengthening provides the foundations for change in mental health. It enables reorganization and scaling up of services and support. Key areas for action include: governance and leadership; finance; public awareness; and competencies for mental health care.

Global and national frameworks are critical to guide action on mental health and provide an enabling context for transformation. Legislation that complies with international human rights instruments is needed to protect and promote human rights. Given that the causes and needs of mental health cross sectors, it is essential that laws and policies aimed at improved mental health address all sectors.

Three types of political commitment – expressed, institutional and budgetary – are needed to drive the mental health agenda forward. Advocacy, evidence and political context can be hugely influential in fostering commitment and leadership. Humanitarian and public health emergencies in particular represent an obligation and opportunity for countries to invest in mental health. They offer unparalleled platforms for change. Strong public interest and understanding also drive improvement. People with lived experience are important agents of change to improve public awareness of mental health and acceptance of people with mental health conditions.

To transform mental health services, commitment must be translated into action through appropriate financing. In practice, this means policy-makers and planners need to devote more funds to mental health. This is achieved either by getting additional resources from the state treasury or external funders, or by redistributing resources towards mental health, both within the health budget as well as across government.

A competent and motivated workforce is a vital component of a well-functioning health system. All countries need to expand their specialized workforce for mental health, while simultaneously building mental health care competencies of other care providers and individuals. In particular, primary care staff and a wide range of community providers – including community workers and peers – need to be equipped with new skills to detect mental health conditions, provide basic interventions and support, refer people where necessary, and follow-up.

Beyond the mental health workforce, each of us can strengthen our individual skills and competencies in understanding and looking after our own mental health. Everyone in the community and the care system needs to support social inclusion for people living with mental health conditions, and to promote rights-based, person-centred, recovery-oriented care and support.

In many settings, digital technologies offer promising tools, and can strengthen mental health systems by providing ways to inform and educate the public, train and support health care workers, deliver remote care, and enable self-help.

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4 Did you know that...

Only 36% of countries have mental health policies specific to children and adolescents. Even where policies exist, enforcement is often weak due to funding and infrastructure challenges.

Find out how healthcare funding is distributed in the country you have been assigned to represent. This is usually detailed in the annual department of health budget. Is the funding devoted to mental healthcare adequate? How is it allocated?

Mental health legislation, or mental health provisions integrated into other laws cover a broad array of issues such as access to mental health care, anti-discrimination, general health, disability, employment, social welfare, education, housing, and other areas.

5 Something to think about

There is less than 1 child psychiatrist per 100,000 children in most low-income countries. Mental health expenditures are less than 1% of total health budgets in many nations, making access to services inequitable. Telehealth and digital tools like mental health apps are becoming critical in addressing gaps in access. However, digital divides between regions limit their reach.

How are mental healthcare practitioners/psychiatrists/psychotherapists licensed in the country you have been assigned to represent? What is the provider to patient ratio? How can the specialized workforce be expanded?

Chapter 6. Promotion and prevention for change

Transforming mental health means strengthening multisectoral promotion and prevention for all.

At all stages of life, promotion and prevention are required to enhance mental well-being and resilience, prevent the onset and impact of mental health conditions, and drive down the need for mental health care. There is increasing evidence that promotion and prevention can be cost–effective. Promotion and prevention interventions work by identifying the individual, social and structural determinants of mental health, and then intervening to reduce risks, build resilience and establish supportive environments for mental health. Interventions can be designed for individuals, specific groups or whole populations.

Reshaping the determinants of mental health often requires action beyond the health sector, which makes effective promotion and prevention a multi-sectoral venture. The health sector can contribute significantly by embedding promotion and prevention efforts within health services; and by advocating, initiating and, where appropriate, facili- tating multisectoral collaboration and coordination.

Suicide prevention is an international priority, with a Sustainable Development Goal (SDG) target to reduce the suicide mortality rate by one third by 2030. To help countries reach this target, WHO has developed the LIVE LIFE approach to suicide prevention, which prioritizes four interventions with proven efficacy: limiting access to the means of suicide; interacting with the media for responsible reporting on suicide; fostering social and emotional life skills in adolescents; and early intervention for anyone affected by suicidal behaviours. Banning highly hazardous pesticides is a particularly inexpensive and cost–effective intervention. In countries with a high burden of pesticide self-poisonings, bans can lead to an immediate and clear drop in overall suicide rates, without agricultural loss.

Infancy, childhood and adolescence are ages of both vulnerability and opportunity in mental health. Nurturing, caregiving and supportive learning environments can be hugely protective of future mental health. On the other hand, adverse childhood experiences increase the risk of experiencing mental health conditions. Four key strategies for reducing risks and boosting protective factors include: developing and enforcing policies and laws that promote and protect mental health; supporting caregivers to provide nurturing care; implementing school-based programmes, including anti-bullying interven- tions; and improving the quality of environments in communities and digital spaces. School-based social and emotional learning programmes are among the most effective promotion strategies for countries at all income levels.

Like schools, workplaces can be places of both opportunity and risk for mental health. Employers and governments have a responsibility to create more work opportunities for people with mental health conditions, and to promote and protect all people's mental health at work. For governments, that means implementing supportive legislation and regulations in human rights, labour and occupational health. For employers, WHO guidelines emphasize the importance of organizational interventions, manager mental health training and interventions for workers.

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1 Did you know that...

What promotion and prevention strategies detailed in the 2022 World Mental Health Report are being implemented in the country you have been assigned to represent?

3 Did you know that...

PPublished in 2021, LIVE LIFE is WHO's contribution towards the creation of comprehensive national suicide prevention strategies. The multipurpose guide can be used by countries with or without an existing suicide prevention strategy as well as by national or local centres and community stakeholders involved in suicide prevention, mental health and addiction counseling (WHO, 2021).

3 Did you know that...

What are the rates of pesticide self-poisonings in the country you have been assigned to represent? Are they easily accessible? Do any consumer/regulation policies exist that restrict access to these toxic chemicals?

4 Something to think about

How effective are anti-bullying interventions in schools? Are there cyberspace protections for minors in your country? How can digital spaces be made safer?

Cyberbullying impacts about 37% of young people worldwide, contributing to mental health struggles.

Chapter 7. Restructuring and scaling up care for impact

Transforming mental health means strengthening community-based care for all in need.

At the heart of mental health reform lies a major reorganization of mental health services. This must shift the locus of care for severe mental health conditions away from psychiatric hospitals towards community-based mental health services , closing long-stay psychiatric hospitals once there are adequate community alternatives. At the same time, care for common conditions such as depression and anxiety must be scaled up. Both strategies are critical to improve coverage and quality for mental health care. Community-based mental health care is more accessible and acceptable than institutional care and delivers better outcomes for people with mental health conditions. People-centred, recovery-oriented and human rights-based care is essential.

Community-based mental health care comprises a network of interconnected services that includes: mental health services integrated in general health care; community mental health services; and services that deliver mental health care in non-health settings and support access to key social services. Social and informal support delivered by community providers (e.g. community workers, peers) complement formal services and help ensure enabling environments for people with mental health conditions. Overall, there is no single model for organizing community-based mental health services that applies to all country contexts. Yet every country, no matter its resource constraints, can take steps to restructure and scale up mental health care for impact.

Integrating mental health into general health services typically involves task-sharing with non-specialist health care providers or adding dedicated mental health staff and resources to primary and secondary health care. Task-sharing with primary health care providers has been shown to help reduce the treatment gap and increase coverage for priority mental health conditions. Task-sharing within disease-specific services such as HIV/AIDS or TB programmes can improve both physical and mental health outcomes.

General hospitals and community mental health centres or teams provide secondary mental health care. They are often the cornerstone of community-based networks of services. They typically cater for a range of mental health conditions in adults, adolescents and children and blend clinical services with psychosocial rehabilitation and activities to promote social inclusion and participation in community life. Supported living services offer a valuable alternative to institutional care; and can include a mix of facilities with varying levels of support for different levels of dependency.

At all levels of health care, peer support services provide an additional layer of support in which people use their own experiences to help each other – by sharing knowledge, providing emotional support, creating opportunities for social interaction, offering practical help or engaging in advocacy and awareness raising.

The responsibility for delivering community-based mental health care straddles multiple sectors. Complementing health interventions with key social services, including child protection and access to education, employment and social protection, is essential to enable people with mental health conditions achieve their recovery goals and live a more satisfying and meaningful life.

1 Something to think about

As detailed in this report, psychiatric institutions are associated with stigma and negative societal perceptions. This is an obstacle that gets in the way of seeking help with mental health problems and an uptrend in untreated mental health disorders despite existing therapeutic interventions. Community-based mental health clinics and integration of mental healthcare services into general practice and educational settings can greatly influence this negative trend.

Mental health conditions comprise a broad range of problems, with different symptoms. They are generally characterized, however, by some combination of disturbed thoughts, emotions, behavior and relationships with others.

Chapter 8. Conclusion

Deepen commitment, reshape environments, and strengthen care to transform mental health.

This report argues for a worldwide transformation towards better mental health for all. The WHO *Comprehensive mental health action plan 2013–2030* represents a commitment from all countries to improve mental health and mental health care and provides a blueprint for action. No country is expected to fulfil every implementation option in the global action plan. And many countries do not have the resources to implement every action described in this report. But every country has ample opportunities to make meaningful progress towards better mental health for its population. Choosing what to focus on first will depend on country contexts, local mental health needs, other priorities and the existing state and structure of each mental health system.

The evidence, experience and expertise presented in this report point to three key paths to transformation that can accelerate progress against the global action plan. These focus on shifting attitudes to mental health, addressing risks to mental health in our environment and strengthening systems that care for mental health.

First, we must **deepen the value and commitment** we give to mental health as individuals, communities and governments; and match that value with more commitment, engagement and investment by all stakeholders, across all sectors.

Second, we must **reshape the physical, social and economic characteristics of environments** – in homes, schools, workplaces and the wider community – to better protect mental health and prevent mental health conditions. These environments need to give everyone an equal opportunity to thrive and reach the highest attainable level of mental health and well-being.

Third, we must **strengthen mental health care** so that the full spectrum of mental health needs is met through a community-based network of accessible, affordable and quality services and support.

Each path to transformation is a path towards better mental health for all. Together, they will lead us closer to a world in which mental health is valued, promoted and protected; where everyone has an equal opportunity to enjoy mental health and to exercise their human rights; and where everyone can access the mental health care they need.

Individuals, governments, care providers, nongovernmental organizations, academics, employers, civil society and other stakeholders all have a part to play. It will take the combined efforts of us all to transform mental health.

Just over twenty years ago WHO published its landmark *World health report 2001 Mental health: new understanding, new hope (1)*. Building on earlier global reports and using insights from science, epidemiology and real-world experience, the 2001 report shone a light on mental health's critical role in the well-being of individuals, communities and countries. It laid bare the enormous public health and socioeconomic impacts of mental ill-health and exposed a huge gap between people's need for, and receipt of, care or treatment.

The international health community had already been advocating for mental health action for decades *(2)*. But the 2001 report marked a watershed moment in global awareness of mental health's importance, the prevalence and impact of mental health conditions, and the need for a public health approach. Through its ten recommendations, the report provided one of the earliest and clearest global frameworks for action on mental health. It called on countries to: provide treatment in primary care; make psychotropic medicines available; provide care in the community; educate the public; involve communities, families and consumers; establish national policies, programmes and legislation; develop human resources; link with other sectors; monitor community mental health; and support more research.

1.1 Twenty years on

Twenty years later, all of these recommendations remain valid. Yet progress has been made. In many countries political leaders, professionals across sectors, and people in the general population increasingly recognize the importance of mental health.

Recommendations made in 2001 remain valid, yet there has been progress.

Since the 2001 report, countries around the world have formally adopted international frameworks that guide them to act for mental health. Most notably, WHO Member States have adopted the *Comprehensive mental health action plan 2013–2030* committing them to meet ten global targets for improved mental health *(3)*. These are structured around leadership and governance, community-based care, promotion and prevention, and information systems and research (see Fig. 1.1). Historic conventions and global goals, such as the Convention on the Rights of Persons with Disabilities (CRPD), the Sustainable Development Goals (SDGs) and universal health coverage (UHC), have given countries further critical impetus to transform and improve mental health.

Since 2001, many countries have also established their own national policies and programmes on mental health. International research on mental health is advancing, with relevant and high-quality research continuously disseminated through the world's leading public health journals. And mental health is also increasingly integrated in public health training programmes.

Advocacy movements that include, and may be led by, people with lived experience have gained much greater prominence over the past two decades. This has helped many people to become more knowledgeable and understanding of mental health. Mental health issues and experiences are now more frequently discussed and shared in broadcast and social media, particularly following the COVID-19 pandemic, and especially among young people. Such coverage not only helps destigmatize mental ill-health but also increases

3 Something to think about

What progress has the country you have been assigned to represent made in mental healthcare in the past decade? Has there been significant growth in terms of policy or the expansion of mental health services to children and adolescents?
Paragraph 4
'Sustainable Development Goals'

Addressing mental health in youth impacts SDG 4 (Quality Education) and SDG 10 (Reduced Inequalities) by ensuring equitable access to care and education. Mental health is also directly tied to achieving SDG target 3.4, which calls for reducing premature mortality from non-communicable diseases by promoting mental health and well-being.

5 Did you know that...

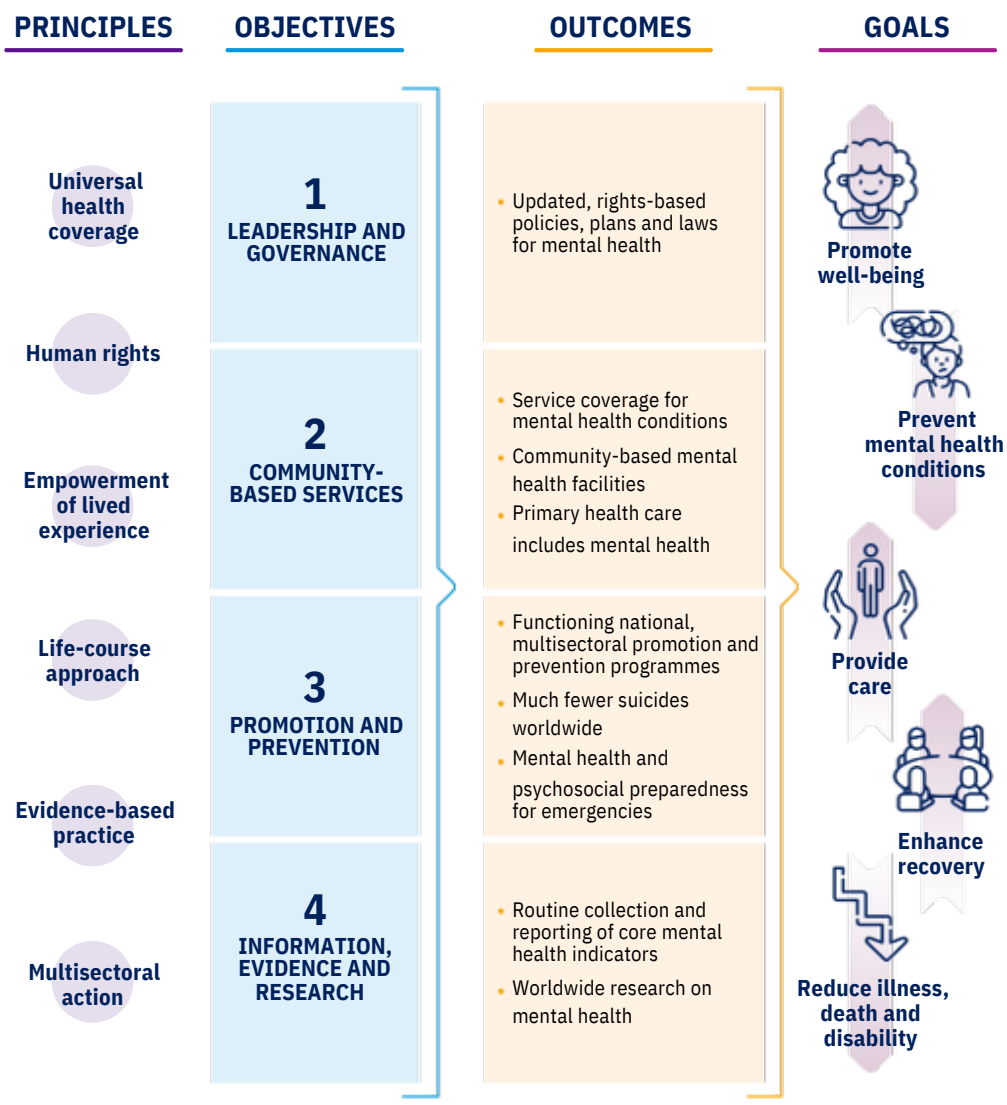
How is mental health incorporated into medical school and specialty training curriculums in the country you have been assigned to represent?

6 Did you know that...

While social media can foster connections and provide mental health information, excessive use correlates with increased anxiety, depression, and body image concerns.

FIG. 1.1

A visual summary of the *Comprehensive mental health action plan 2013–2030*



Source: WHO, 2021 (*3*).

the value given to the voices, priorities and expertise of people with lived experience.

International agencies are also increasingly interested in mental health and have had a key role in raising its profile as a relevant issue, including through their flagship publications such as UNICEF's 2021 *State of the world's children* report on mental health *(4)*.

Although in 2001 mental disorders were already known to be common, much more is known today about their epidemiology including their early onset, high prevalence and interacting determinants. Informed by further research, the field has also advanced technically. Task-sharing between specialist and non-specialist mental health care providers has been widely demonstrated to be effective, including for psychological interventions, and is now more frequently implemented. The number of practical, evidence-based mental health guidelines, manuals and other tools has also vastly expanded.

The mental health needs of people affected by conflicts, disasters and disease outbreaks have become widely recognized, and mental health is frequently, though not always, addressed as part of crisis responses.

4

3 Did you know that...

Organizations like the World Health Organization (WHO), UNICEF, and UNESCO are leading efforts to integrate mental health into school systems and develop youth-friendly mental health services.

3 Did you know that...

Ascertain whether there is integration of mental healthcare with general healthcare in the country you have been assigned to represent, and to what level task-sharing is performed between specialist and non-specialist providers in community-based settings.

Task-sharing in mental health refers to a collaborative approach where certain mental health care responsibilities are shared between specialist and non-specialist providers. This approach is often used in settings where access to trained mental health specialists is limited, helping to expand care to underserved populations.

Specialist providers (e.g., psychiatrists, psychologists, and other mental health professionals) focus on more complex cases, provide training, and offer supervision to non-specialists. They ensure that non-specialists are equipped with the necessary skills and knowledge.

4 Something to think about

Is mental healthcare part of the crisis response to those affected by natural disasters and civil conflict in the country you have been assigned to represent? Is it provided on a long term basis (i.e. for those affected by PTSD)?

1.2 Time for change

Despite this progress, for most countries and communities, mental health conditions continue to exact a heavy toll on people's lives, while mental health systems and services remain ill-equipped to meet people's needs.

Nearly a billion people around the world live with a diagnosable mental disorder. Most people with mental health conditions do not have access to effective care because services and supports are not available, lack capacity, cannot be accessed or are unaffordable; or because widespread stigma stops people from seeking help. Different belief systems, language and idiomatic expressions around mental health across cultures influence whether, how and where people seek help. They also influence whether people recognize problems or experiences – their own and those of others – as concerning mental health.

Financial and human resources for mental health are still scarce in most countries and are unevenly distributed. All over the world mental health receives just a tiny fraction of health budgets. In many countries most of these few and wholly inadequate resources go straight to psychiatric hospitals, which rarely provide the care people need, and are often located far from where most people live. As a result of extreme underinvestment, universal mental health coverage remains far out of reach. In some countries, the treatment gap for severe mental health conditions is a staggering 90%.

Too many people living with mental health conditions are not getting the care they need and deserve.

For people with mental health conditions that are detected, the care and treatment they get is all too often inadequate or improper.

Human rights violations continue to pervade institutions and communities around the world, including health services. Moreover, even when services try to address mental health conditions, most overlook affected people's physical health and wider social needs.

Both the 2001 report and the *Comprehensive mental health action plan 2013–2030* emphasized the need for accessible community-based mental health services. These should adopt a biopsychosocial approach to care and should be developed and delivered in close collaboration with multiple sectors and stakeholders to address the full range of needs that people living with mental health conditions may have.

But the global shift towards care in the community has been very slow and truly multisectoral initiatives remain few and far between. The truth is that two decades after the landmark 2001 report, and nearly a decade after the world committed to the action plan, the countries and communities that have seen real innovation and advances remain islands of good practice in a sea of need and neglect.

For most of the world, the approach to mental health care remains very much business as usual. And the result is that all over the world too many people living with mental health conditions are not getting the care they need and deserve.

The latest analysis by WHO's *Mental Health Atlas* of country performance against the action plan confirms that progress has been slow *(5)*. For example, in 2013 45% of countries reported having mental health policies and plans that were aligned with human rights instruments. The action plan set a target to increase that figure to 80% by 2020 (later this was extended to

5 **Did you know that...**

Find out if human rights violations in psychiatric institutions or community-based settings have been documented or reported in the country you have been assigned to represent.

6 **Did you know that...**

Originally conceived by George Engel in 1977, the biopsychosocial model observes healthcare under a multi-system lens, building upon the construct that illness and health are a result of interactions between biological, psychological and social factors.

2030); but nearly halfway into the plan the figure had only risen to 51% *(5)*. Coverage for care of psychosis worldwide is estimated to be as low as 29%. Some areas have had more success: the global age-standardized suicide mortality rate for 2019 had dropped 10% since 2013. But this is far short of the 33% reduction target for 2030. Overall, there is still a long way to go before the world meets the targets set out in the *Comprehensive mental health action plan 2013–2030*.

In the meantime, global threats to mental health are ever present. Growing social and economic inequalities, protracted conflicts and public health emergencies affect whole populations, threatening progress towards improved well-being. Most recently, the COVID-19 pandemic has affected the mental health and well-being of so many, both with and without pre-existing conditions, and has exacerbated social inequalities as well as systemic weaknesses in services.

And while anyone at any time can be affected by poor mental health, the risks are far from equal. Globally, women and young people have borne the brunt of the pandemic's social and economic fallout *(6)*. Some people – such as prisoners, forcibly displaced people, residents in long-term care homes and survivors of domestic violence – tend to be particularly vulnerable as pre-existing failures in human rights, legal or social protection may have worsened during the pandemic *(7)*. New demands for mental health care are adding to the strain on already overstretched health systems everywhere and are interacting with inequalities in ways that put mental health care out of reach for those who need it most.

Now, more than ever, business as usual for mental health care simply will not do. The need for wide-ranging transformation towards mental health for all is indisputable and urgent.

Countries everywhere need to step up their commitment and action to achieve a transformation that can change the course for mental health worldwide. The end goal is clear: the *Comprehensive mental health action plan 2013–2030* envisions a world where mental health is valued, promoted and protected; where high quality, culturally appropriate, acceptable and affordable community-based mental health care is available to everyone and anyone who needs it; and where people living with mental health conditions can participate fully in society free from stigma, discrimination or abuse.

Building on what has been achieved over the past 20 years, we must all strive to turn that vision into reality. We must strengthen our collective commitment to mental health and give it meaning, value and parity of esteem as individuals, communities and countries. We must intensify our collective actions to reform mental health systems towards comprehensive community-based networks of support. And we must change our collective actions to promote and protect mental health and reduce disparities so that everyone has an equal opportunity to flourish.

In 2021, WHO Member States recommitted themselves to the *Comprehensive mental health action plan 2013–2030*, updating it with new targets and implementation options that build on lessons learned over the past decade *(3)*. The updated plan provides a roadmap for action by all stakeholders. Every country, no matter its resource constraints, can do something substantial to support change towards better mental health.

Business as usual for mental health care simply will not do.

1.3 About this report

This report is designed to support the global transformation we need. It aims to strengthen how we value and commit to mental health as a critical contributor to population health, social well-being and economic development. And it aims to inspire a step-change in attitudes, actions and approaches towards better mental health for all.

Drawing on the latest evidence available, showcasing examples of good practice from around the world, and giving voice to people with lived experience, this report highlights why and where change is needed and how it can be achieved on the ground.

While acknowledging the need for a multisectoral approach and the relevance of this report to numerous stakeholders, this report is especially written for decision-makers in the health sector. This includes ministries of health and other partners in the health sector that are generally tasked with developing mental health policy and delivering mental health systems and services.

1.3.1 Scope

This report focuses specifically on mental health and people with mental health conditions (see Box 1.1 Mental health terms).

At times, the report also refers to neurological disorders, substance use disorders and cognitive and intellectual disabilities. While these conditions are not the main focus, this report acknowl- edges that all of them can be, and often are, closely linked with mental health conditions. About one third of all people who experience a substance use condition also experience a mental health condition, and people with a mental health condition are also more likely to develop a substance use condition. Both types of condition increase the risk of suicide *(8)*. And one in every four people who develop epilepsy will also develop depression or anxiety *(9)*. In many countries, services for different mental health, neurological and substance use conditions are all combined at the point of care.

As an organization made up of 194 Member States and as a specialized agency of the United Nations with lead responsibility for health, WHO promotes and adopts a set of universal values and rights, both in its work on norms and standards as well as in country support. While these global values and normative standards are fully reflected in this report, each region, country and setting is unique and requires a culturally sensitive and contextually relevant approach to mental health promotion, protection and care.

This report is designed to support the global transformation we need.

2.1 Concepts in mental health

2.1.1 Mental health has intrinsic and instrumental value

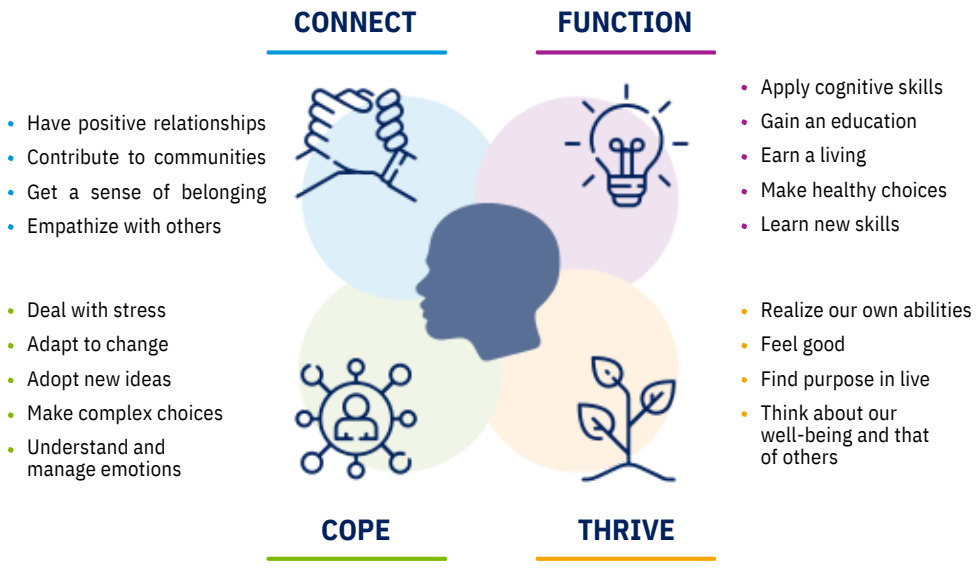
Mental health is intrinsic and instrumental to the lives of all people. It influences how we think, feel and act. It underpins our ability to make decisions, build relationships and shape the world we live in. Mental health is also a basic human right. And it is crucial to personal, community and socio-economic development. It is a part of us, all the time, even when we are not thinking about it.

Our mental health is as important as our physical health. When we have mental health we can cope with the stresses of life, realize our own abilities, learn and work well and contribute actively to our communities (see Box 1.1 Mental health terms). Having mental health means we are better able to connect, function, cope and thrive (see Fig. 2.1).

Conversely, when our mental health is impaired, and we lack access to appropriate support, our well-being can worsen. A wide range of mental health conditions can disturb our thoughts and feelings, change our behaviours, compromise our physical health and disrupt our relationships, education or livelihoods.

FIG. 2.1

Mental health has intrinsic and instrumental value, helping us to connect, function, cope and thrive



2.1.2 Mental health exists on a continuum

Diagnostic categories in clinical practice (and health statistics) describe discrete and specific mental disorders (see section 5.1.3 Evidence to inform policy and practice). This is true even though psychopathology falls along multiple dimensions such as anxiety, mood, perception, and social interaction *(14)*.

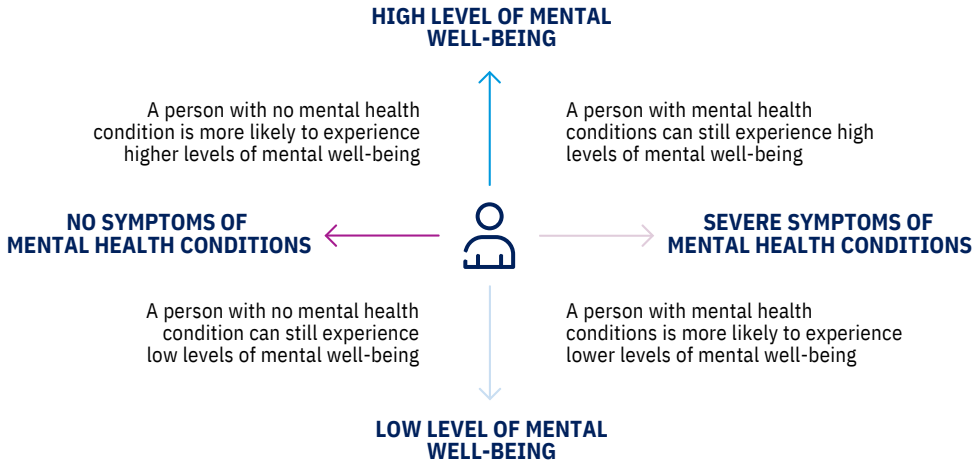
Mental health is not a binary state: we are not either mentally healthy or mentally ill. Rather, mental health exists on a complex continuum with experiences ranging from an optimal state of well-being to debilitating states of great suffering and emotional pain *(15)*. So mental health is not defined by the presence or absence of mental disorder.

Even though people with mental health conditions are more likely to experience lower levels of mental well-being, this is not always the case. Just as someone can have a physical health condition and still be physically fit, so people can live with a mental health condition and still have high levels of mental well-being (see Fig. 2.2). This may be true even in the face of a diagnosis of a severe mental health condition (read Charlene's experience).

Along the different dimensions of the continuum, mental health issues and challenges present in different ways and are experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes. Depression and anxiety, for example, can manifest as a short period of mild or moderate distress that lasts a few hours, days or weeks. But it can also manifest as a severe condition that endures over months or years *(16)*.

FIG. 2.2

The relationship between mental well-being and symptoms of mental health conditions



Source: Tudor, 1996 *(17)*.

NARRATIVE

Every step I take is a sign of progress

Joanna's experience

Living with a mental disorder is not synonymous with limitation. Society forces us to believe, perhaps unintentionally, that we are not capable of having responsibilities because of the crises we sometimes face. I have often tried to erase that idea from my mind but only now do I know that I too can move forward, even as the battle within me continues. My recovery is ongoing. I know I may still face obstacles but now I have tools to overcome them.

I don't remember how old I was when my inner emotional conflict arose but it was a long time ago. In 2014 I had the first of several crises and so began numerous visits to psychiatrists and psychologists. I had to drop out of school because of excessive anxiety and delusions that never left me alone. My medication numbed me and I couldn't concentrate. I lost a scholarship at a major university. I walked away from friends and family thinking they would be disappointed in me. I locked myself in, I hardly went out, I cried every day, and I didn't have the strength to get out of bed. The idea of a successful future had vanished.

This is the third time I've tried to start over from scratch. I think I am not so bad at it. I set myself the goal of going back to school and I have achieved it. I am 25 years old and in my second semester of linguistics, pursuing a career that I am really passionate about.

I have more goals to meet and challenges to overcome but I think the important thing is not to give up. Every step I take, even the small ones, is a sign of progress. I used to wonder what the reasons were for continuing this journey called life; thanks to the support of my family, my friends, and the mental health specialists that care for me I have found the answer. What I mean to say is that, although it may not seem like it, it is possible to find a way out and there will be people willing to help you.

Joanna Lovón, Peru

right to the highest attainable standard of mental health. This includes:

- the right to be protected from mental health risks;
- the right to available, accessible, acceptable and good quality care; and
- the right to liberty, independence and inclusion in the community.

Having a mental health condition should never be a reason to deprive a person of their human rights or to exclude them from decisions about their own health. Yet all over the world, people

1 Did you know that...

Mental health disorders can lead to concentration issues, absenteeism, and underachievement, impacting long-term career prospects. Students with untreated mental health challenges are twice as likely to drop out of school.

NARRATIVE

To be in the open air is to be happy

Regina's experience

My first hospitalization was in the children's unit at the state asylum, aged 14 years. When I was 18 years old I ran away by jumping over the wall. Over time I got to know all the psychiatric hospitals and every one was terrifying. I wouldn't wish that terror on anyone.

Now, thank God, I live in the community and I am free to be in the open air. For everyone, to be in the open air is to be happy. When my mind is empty I go out to the street – to see people and talk to them. Even if I've never seen them before in my life I stop and talk. It is worthwhile to live in a supported home. It has given me many good things – a house, a bed. In my life I have been freezing, I have starved, I have lived like a beggar. I can tell you it's horrible. I thank God for having found out about the supported living service, otherwise I wouldn't be here, in this wonderful house.

Regina Célia Freire da Silva, Brazil

with mental health conditions experience a wide range of human rights violations *(22)*. Many are excluded from community life, discriminated against, denied basic rights such as food and shelter, and prohibited from voting or getting married (see section 4.2.1 Action against stigma and discrimination).

Many more cannot access the mental health care they need, or can only access care that violates their human rights. In many places, lack of community-based services means that the main setting for mental health care is long-stay psychiatric hospitals or institutions, which are often associated with human rights violations.

Improving access to quality mental health care is inherent to, and indivisible from, a better life for self and a better life for all (read Regina's experience). A rights-based approach to mental health services protects those at risk of human rights violations, supports those living with mental health conditions, and promotes mental health for all *(23)*. The UN Convention on the Rights of Persons with Disabilities (CRPD) needs to be implemented across the world.

2.1.5 Mental health is everyone's business

The health sector has multiple roles in supporting the population's mental health (see Box 2.1 Four roles for the health sector). But so too do a broad range of other sectors and stakeholders.

Because the underlying determinants of mental health are multisectoral in nature (see section 2.2 Determinants of mental health), interventions to promote and protect mental health

INSIGHT

BOX 2.1

Four roles for the health sector

The health sector has four key roles in supporting mental health for all.

Provide care. The health sector can provide a range of equitable and rights-based services, irrespective of age, gender, socioeconomic status, race, ethnicity, disability or sexual orientation. These services are most useful when they are delivered at community levels, by practitioners best suited to provide effective care within the constraints of available human and financial resources (see Chapter 7 Restructuring and scaling up care for impact).

Promote and prevent. The health sector can advocate for and provide promotion and prevention programmes, in collaboration with other sectors. Such programmes can build awareness and understanding of mental health, end stigma and discrimination, and lessen the need for treatment and recovery services (see Chapter 6 Promotion and prevention for change).

Work in partnership. The health sector can partner with all stakeholders – in government, civil society, the private sector and especially among people with lived experience – to ensure multisectoral, inclusive and people-centred support for people with mental health conditions.

Support related initiatives. The health sector can advocate for and help address the structural risks and protective factors influencing mental health – the conditions in which people are born and live. This can promote and contribute to a whole-of-government and all-of-society approach to mental health.

should also be delivered in multiple sectors, including health, social care, education, child and youth services, business, housing, criminal justice, the voluntary sector, the private sector and humanitarian assistance.

When it comes to delivering care, a similarly multi-sectoral and collaborative approach is needed. This is because effectively supporting people with mental health conditions often extends beyond appropriate clinical care (usually given through the health sector) to also include, for example:

- financial support (through the social sector);
- a place to stay (through the housing sector);
- a job (through the employment sector);
- educational support (through the education sector);
- community support (through the social affairs sector); and
- various legal protections (through the judicial sector).

Just as multiple government sectors are needed, many other stakeholders – from policy-makers to professionals to people with lived experience and their families – need to be involved in promoting, protecting and supporting people's mental health. Nongovernmental organizations, peer networks,

wfuna
World Federation of United Nations Associations

3 Did you know that...

Programs like mental health education, counseling services, and peer support groups have been shown to reduce stigma and improve students' well-being. Yet, fewer than 25% of schools worldwide include mental health as part of their health curricula. 'youth services'

Some of these services are led by groups like Mental Health Youth Action that are pushing for policy change and awareness campaigns, proving that young voices are critical in driving progress.

traditional practitioners, faith-based organizations and others have a crucial part to play. Depending on circumstances and objectives, these stakeholders' roles may range from advocacy and activism to service provision and support. Working in partnership across public and private sectors can be an effective way of increasing the reach and resources of collaborative programmes.

People with lived experience are crucial stakeholders in mental health. Their participation is vital to improve mental health systems, services and outcomes *(24)*. Such participation includes full empowerment and involvement in mental health advocacy, policy, planning, legislation, programme design, service provision, monitoring, research and evaluation *(25)*. (For more information on the role of people with lived experience, see Chapter 4, In focus: Engaging and empowering people with lived experience.)

2.2 Determinants of mental health

Our mental health differs greatly depending on the circumstances in which we are born, raised and live our lives *(26)*. This is because mental health is determined by a complex interplay of individual, family, community and structural factors that vary over time and space and that are experienced differently from person to person *(27)*. Mental health conditions result from the interaction between an individu- al's vulnerability and the stress caused by life events and chronic stressors (see Fig. 2.3) *(28)*.

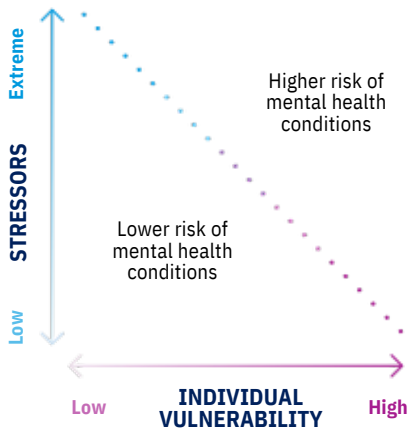
2.2.1 Spheres of influence

Individual psychological and biological factors relate to individuals' intrinsic and learned abilities and habits for dealing with emotions and engaging in relationships, activities, and responsibilities. A person's vulnerability to mental health problems is influenced by psychological factors (for example, cognitive and interpersonal factors) and biological factors. Biological vulnerabilities include genetics, but also, for example, high potency cannabis use, substance use by the mother, and oxygen deprivation at birth. Brain health is an important determinant because many of the risk or protective factors impacting mental health are mediated through brain structure and function *(29)*. A person's mental health also depends on the stressors in their life, which are influenced by family, community and structural factors in the environment.

Family and community comprise a person's immediate surroundings, including their opportunities to engage with partners, family, friends or colleagues, opportunities to earn a living and engage in meaningful activity, and also the social and economic circumstances in which they find themselves. Parenting behaviours and attitudes are particularly influential, especially from infancy through adolescence, as is parental mental health. Harsh parenting and physical punishment are known to undermine child mental health, often leading to behaviour problems *(30)*. And bullying has been identified as the leading risk factor for mental health problems in the Global Burden of Diseases, Injuries and Risk Factors Study 2019 *(31)*. Local social arrangements and institutions, such as access to preschool, quality schools, and jobs, significantly increase or reduce the opportunities that, in turn, empower each person to choose their own course in life. Restricted or lost opportunities can be detrimental to mental health.

FIG. 2.3

When individual vulnerabilities interact with stressors they can lead to mental health conditions



Structural factors relate to people's broader sociocultural, geopolitical and environmental surroundings, such as infrastructure, inequality, social stability and environmental quality. These shape the conditions of daily life. Access to basic services and commodities, including food, water, shelter, health and the rule of law, is important for mental health. So too are national social and economic policies: restrictions imposed during the COVID-19 pandemic for example had significant mental health consequences for many, including stress, anxiety or depression stemming from social isolation, disconnectedness and uncertainty about the future (see In focus: COVID-19 and mental health). Security and safety are important structural factors. And prevailing beliefs, norms and values – especially in relation to gender, race and sexuality – can also be hugely influential. Historical legacies of colonialism influence multiple structural factors in numerous countries, as do climate and ecological crises (see section 2.3.4 Climate crisis).

Together, individual, family, community and structural factors determine our mental health. Importantly, these determinants interact with each other in a dynamic way. For example, a person's sense of self-worth can be enhanced or diminished depending on their social support and economic security at the household level, which may in turn rely on political stability, social justice and economic growth in a country.

> *Mental health is determined by a complex interplay of individual, family and community, and structural factors.*

Even though the biological and social determinants of mental health are hugely influential, people are more than just their biology and the external environment. Individual psychological factors, as described above, also play a role, and people have choices and some agency over their existence, even if such choices can be very limited for people living in extreme adversity *(32)*.

Notably, each single determinant has only limited predictive strength *(33)*. Most at-risk people will not develop mental health conditions and many people with no known risk factor still develop a mental health condition. Nonetheless, across all these spheres of influence, the interacting determinants of mental health can serve to enhance or undermine mental health (see Fig. 2.4).

2.2.2 Risks undermine mental health

Although most people are remarkably resilient, people who are more exposed to unfavourable circumstances are at higher risk of experiencing mental health conditions *(34)*. In this context, conflict, disease outbreaks, social injustice, discrimination, and disadvantage are all macro-risks that can result in new mental health conditions for many and exacerbate

FIG. 2.4

Examples of risks and protective factors that determine mental health

	INDIVIDUAL	FAMILY AND COMMUNITY	STRUCTURAL
PROTECTIVE FACTORS Enhance mental health	• Genetic factors • Social and emotional skills • Sense of self-worth and mastery • Good physical health • Physical activity	• Good perinatal nutrition • Good parenting • Physical security and safety • Positive social networks, social capital and social supports • Green spaces	• Economic security • Good quality infrastructure • Equal access to services • Quality natural environment • Social justice and integration • Income and social protection • Social and gender equality
RISKS Undermine mental health	• Genetic factors • Low education • Alcohol and drug use • Unhealthy diet • Obesity and other metabolic risks • Chronic disease • Vitamin D deficiency • Body dissatisfaction • Sleep disturbances • Obstetric complications at birth	• Sexual abuse and violence • Emotional and physical abuse and neglect • Substance use by mother during pregnancy • Bullying • Intimate partner violence • Being a war veteran • Sudden loss of a loved one • Job strain • Job loss and unemployment • Urban living • Being from an ethnic minority	• Climate crisis, pollution or environmental degradation • Poor quality infrastructure • Poor access to services • Injustice, discrimination and social exclusion • Social, economic and gender inequalities • Conflict and forced displacement • Health emergencies

Sources: WHO, 2012 (*35*); Arango et al, 2021 (*36*).

existing mental health conditions for others (see section 2.3 Global threats to mental health).

Adversity is one of the most influential and detrimental risks to mental health

Individual, family and community, and structural risks can manifest themselves at all stages of life, but those that occur during developmentally sensitive periods of life are particularly detrimental, often continuing to affect mental health for years or even decades afterwards (see section 2.1.3 Mental health is experienced over the life-course).

Children with mental health problems and cognitive impairments are four times more likely to become a victim of violence than others *(37)*. Globally, more than half of all children aged 2–17 (around a billion individuals) experienced emotional, physical or sexual violence in the previous year *(38)*. Adverse childhood experiences, including exposure to violence, increase the risk of developing a wide range of behavioural problems and mental health conditions, from substance use and aggression to depression, anxiety and post-traumatic stress disorder (PTSD) *(39, 40)*.

Indeed, at all ages and stages of life, adversity – including poverty, violence, inequality and environmental deprivation – is a risk to mental health. Populations who live in adverse conditions, such as war zones, experience more mental health conditions than people who do not *(41)*.

In many countries, the lack of secure tenure for indigenous peoples makes them particularly vulnerable to land acquisitions and resource exploitation, creating social, economic and environmental adversities that heighten risks to mental health *(42)*.

Living in areas where the natural environment has been compromised – for example, through climate change, biodiversity and habitat loss, exploitation or pollution – can also undermine mental health. For example, growing evidence suggests that exposure to air pollution is likely to adversely affect the brain and increase the risk, severity and duration of mental health conditions at all stages of life *(43, 44)*.

Our gender, ethnic grouping and place of residence can affect our chances of developing a mental health condition. Women tend to be more socioeconomically disadvantaged than men and are also more likely to be exposed to intimate partner violence and sexual violence in the community, which are strong risk factors for a range of mental health conditions, especially PTSD (read Lion's experience) *(45)*. Racism or discrimination against a particular group in society increases the risk of social exclusion and economic adversity, both of which undermine mental health *(46)*.

Socially marginalised groups – including the long-term unemployed, sex workers, homeless people and refugees – tend to have higher rates of mental disorder than the general population but can have difficulties in accessing health care *(47)*. Other marginalized groups, including sexual minorities and indigenous peoples, are similarly at greater risk of depression, anxiety, suicide attempts or suicides, and substance-related problems *(48)*. They too can find it difficult to access the mental health services they need (read Kat's experience in Chapter 4).

The vicious cycle of disadvantage

Mental ill-health is closely linked to poverty in a vicious cycle of disadvantage. This disadvantage starts before birth and accumulates throughout life *(36)*. People living in poverty can lack the financial resources to maintain basic living standards; they have fewer educational and employment opportunities; they are more exposed to adverse living environments; and they are less able to access quality health care. These

daily stresses put people living in poverty at greater risk of experiencing mental health conditions.

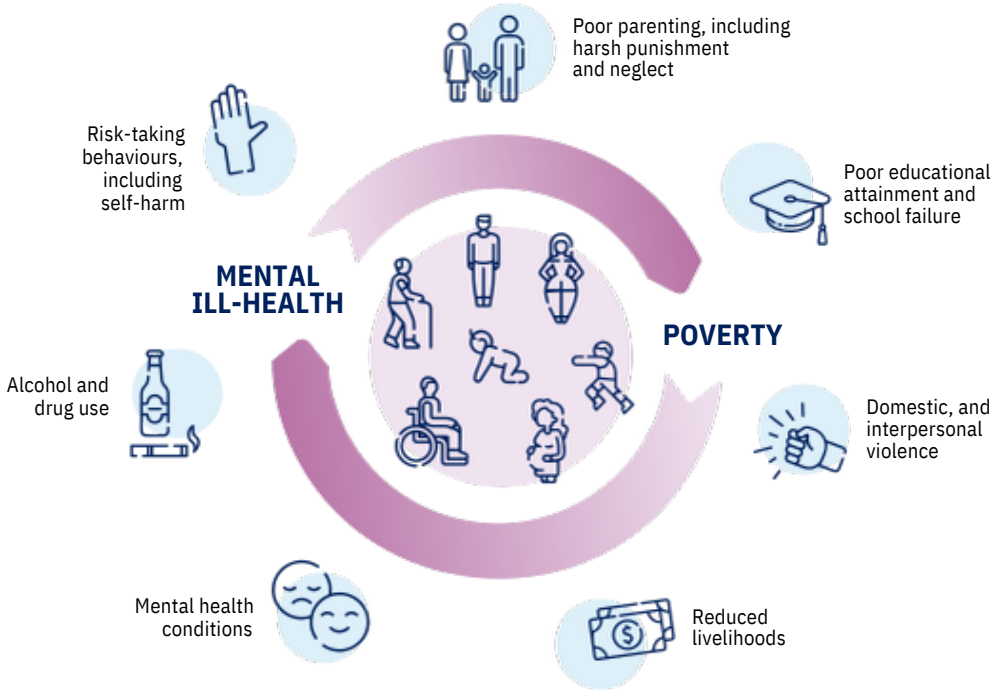
Similarly, people experiencing severe mental health conditions are more likely to fall into poverty through loss of employment and increased health expenditures. Stigma and discrimination may also undermine their social support structures. They are vulnerable to a downward spiral of lost resources and social exclusion that can worsen existing mental health conditions and increase the risk of substance use, poor parenting or failure at school. This then reinforces the vicious cycle between poverty and mental ill-health (see Fig. 2.5).

Whether or not someone develops mental health problems or moves into poverty, how long this lasts, and whether or not they can secure a route out, can in part be influenced by their access to quality social protection and health services *(49)*. Embedding mental health in universal health coverage – so that all people can receive the mental health services they need without suffering financial hardship – is critical (see section 5.3 Financing for mental health).

More than 80% of all people with mental disorders live in low- and middle-income countries (LMICs), where the vicious cycle between mental health and poverty is particularly prevalent because of a lack of welfare safety nets and poor accessibility to effective treatment *(50, 51)*.

FIG. 2.5

The vicious cycle between poverty and mental ill-health exacerbates mental health conditions



2.2.3 Protective factors build resilience

Just as the risks to mental health span multiple spheres of life, so too do the protective factors.

Our social and emotional skills, attributes and habits – which are established during our formative years – are critical to enabling us to deal with the stresses and daily choices of life. As such, they are key protective factors for mental health.

Family and community factors can also be influential in supporting mental health. Protective factors at these levels include positive family interactions, quality education, decent work conditions, safe neighbourhoods, community cohesion and shared cultural meaning and identity *(52)*.

Nurturing and supportive parenting can help protect people against developing mental health conditions *(18)*. Supportive families and carers are important at any age and can be real enablers of recovery for people living with mental health conditions (read Eleni's experience in Chapter 7).

> *Protective factors include positive parenting, quality education and employment, safe neighbourhoods and community cohesion.*

Throughout adulthood, employment under decent working conditions is particularly important for mental health. For people living with schizophrenia or bipolar disorder, employment can be an enormous source of stress, but it can also promote recovery and is associated with improved self-esteem, better social functioning and a higher quality of life *(53, 54)*. Employment has also been shown to reduce symptoms of depression and anxiety, while unemployment is a known risk factor for suicide attempts *(19)*.

Local built and natural environments are important. Safe neighbourhoods that are walkable and offer leisure opportunities are associated with fewer cases of depression and alcohol abuse *(52)*. And access to green and blue spaces – including city parks, forests, playgrounds, waterways and beaches – is also linked with better mental health, with beneficial effects on perceived stress, severity of symptoms and short- and long-term restorative outcomes *(55)*.

Across the world, there is noteworthy progress in reshaping structural factors that protect mental health. For example, formal global mandates for health and human rights should work as protective structural factors. Likewise, greater democracy and equal access to justice, reductions in poverty and greater acceptance of diversity are all important global trends that work towards better mental health. WHO's World Mental Health Survey found that gender differences in rates of depression were narrowing in countries as the roles of women and men became more equal *(56)*.

At all levels, from individual to structural, protective factors improve people's resilience. They can be a means to promote and protect mental health, both within and beyond the health sector (see Chapter 6 Promotion and prevention for change).

184 countries
have ratified the CRPD.

2.3 Global threats to mental health

Global threats to mental health are major structural stressors with the potential to slow worldwide progress towards improved well-being. They affect whole populations and so can undermine the mental health of huge numbers of people *(42)*.

Key threats today include: economic downturns and social polarization; public health emergencies; widespread humanitarian emergencies and forced displacement; and the growing climate crisis.

Some current global threats have emerged very quickly and recently, such as the COVID-19 pandemic (see In focus: COVID-19 and mental health). Others have gained importance more slowly.

Like other structural determinants, many of the global threats to mental health interact with each other. For example, the climate crisis can prompt a humanitarian emergency that in turn displaces many people. Similarly, humanitarian emergencies can create an economic downturn that forces displacement, in turn fuelling more social polarization.

Together, global threats heighten the risk and compound the burden of mental health conditions worldwide.

2.3.1 Economic and social inequalities

Economic downturns are associated with increases in suicide rates *(57)*. They also increase the risk of depression, anxiety and alcohol use, probably through their damaging effects on employment, income, security and social networks *(52)*.

Countries with greater income inequalities and social polarization have been found to have a higher prevalence of schizophrenia, depression, anxiety and substance use *(52)*. In all cases, it is the poorest groups that are hit the hardest.

Economic downturns are associated with increased suicide.

In the United States, after the 2008 economic crisis, “deaths of despair” rose among the working age population. Suicide and substance-use related mortality accounted for many of these deaths, which have been explained by lost hope due to unemployment, rising inequality and declining community support *(58)*.

The COVID-19 pandemic has amplified existing inequalities and steepening the social gradient of mental health in many countries (see In focus: COVID-19 and mental health).

2.3.2 Public health emergencies

Public health emergencies can have profound and long-lasting impacts on people’s mental health, both exacerbating pre-existing conditions and inducing new ones. They can also impact key infrastructure, disrupting basic services and supplies and making it difficult to provide affected people with formal mental health care. The COVID-19 pandemic is the most prominent global example and has severely impacted people’s mental health all over the world (see In focus: COVID-19 and mental health).

Research on the 2013–2016 Ebola epidemic in West Africa shows that many people have experienced acute and long-term mental health and psychosocial effects *(59)*.

- Fear of the virus can cause acute anxiety and distress.
- The grief of losing loved ones to the virus can last a long time.
- Survivors and their health care workers often face extreme stigma and discrimination.
- Physical isolation of exposed individuals and communities heightens the risk of psychosocial impacts.
- Outbreaks, and the response to them, can break local support systems, depleting people's coping resources, fracturing communities and undermining trust in health services.
- Many survivors develop mental health conditions, such as anxiety and mood disorders.

Some infectious diseases are associated with neurological complications that impact people's mental health. For example, Zika virus can lead to congenital Zika virus syndrome and Guillain-Barré syndrome *(60)*. COVID-19 is also associated with a range of neurological manifestations *(61)*.

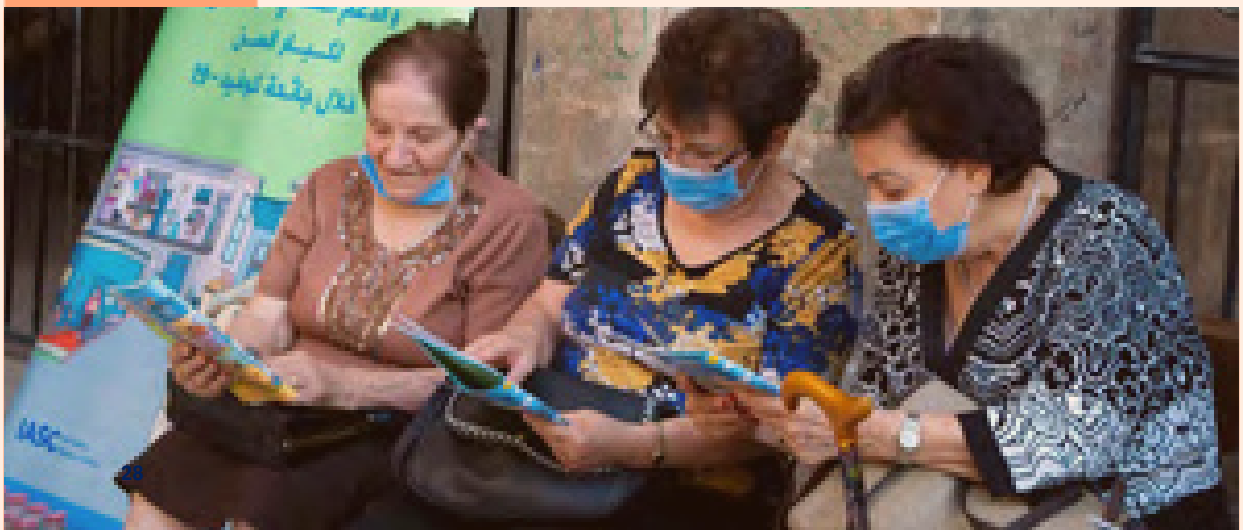
COVID-19 and mental health

The COVID-19 pandemic quickly became one of the biggest global crises in generations. It has had severe and far-reaching repercussions for health systems, economies and societies. Countless people have died, or lost their livelihoods. Families and communities have been strained and separated. Children and young people in every country have missed out on learning and socializing. Businesses have gone bankrupt. Millions people have fallen below the poverty line *(62)*.

Mental health has been widely affected. Plenty of us became more anxious during various waves of COVID-19; but for some the pandemic has sparked or amplified much more serious mental health problems.

At the same time, mental health services have been severely disrupted, especially in the first year of the pandemic. Staff and resources were often redeployed to COVID-19 relief. Social measures frequently prevented people from accessing care, and in many cases fear of the virus stopped people from seeking help. By early 2022 there were fewer disruptions, but too many people still could not get the mental health support they needed.
Of course, people in some places and circumstances have been more affected than others. And as the pandemic evolved, national public health measures changed, as did mental health stressors and impacts. Impacts during the early stages, when huge uncertainty and high death rates fuelled widespread fear and distress, were quite different from those seen during later stages, when isolation and fatigue became bigger threats to well-being.

The sections below describe the pandemic's impact on mental health and mental health services and summarize recommendations for response.



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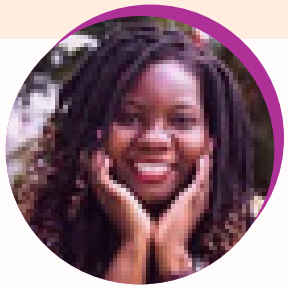


The impact of COVID-19 on mental health cannot be made light of

Esenam's experience

I live with bipolar disorder in Ghana, where the COVID-19 pandemic has been an unprecedented stressor to the mental health of many individuals. I have many friends who had relapses in their mental health because of the increased levels of fear and panic. It was almost as if fear was contagious.

In Ghana, a great many people – including health care workers, people with COVID-19, children, women, youth and older adults – are experiencing psychological distress and mental health symptoms as a result of the pandemic.

Most people are afraid to seek help because they think that if they visit the hospital, they might end up getting infected with COVID-19 because of the virus' subtle mode of transmission and contraction. I myself did not go to the clinic for therapy for an entire year partly because of this fear. I was also unemployed at the time and did not have the funds for treatment. But my pensioner parents managed to make sure my medications were always refilled.

I have been privileged to have a good system of support. But it is not the same for others. Some people could not afford treatment. It was and still is a very difficult time for a lot of people. The impact of COVID-19 on mental health cannot be underestimated. It cannot be made light of.

Esenam Abra Drah, Ghana

Mental health stressors

The COVID-19 pandemic has created several short- or long-term stressors for mental health *(63)*.

Stress from the potential health impacts of the virus. For some people, and especially during the early months – when little was known about the virus and there were strict public health and social measures – the fear of infection and death (both for oneself and for loved ones) was distressing (read Esenam's experience). At that time, bereavement could be particularly distressing because normal grieving processes and funeral rites were disrupted *(64)*. Throughout the pandemic some people experienced major adversities: getting very ill; experiencing post-COVID condition; or witnessing suffering and death, which, like any adversity, can impact on mental health.

Stress from public health and social measures. National and localized quarantines and physical distancing rules, imposed to protect people's health, also reduce the social connections and day-to-day

support that contribute to mental health. These measures made many people isolated, lonely, bored or helpless. They strained relationships or affected family functioning, leading to anger and aggression against children, partners and family members *(65)*. For some people – especially older adults, children and people with learning or developmental disabilities – losing or changing routines has been very stressful. Similarly, disruptions to mental health services have distressed people who need treatment and support.

Stress from unemployment and financial insecurity. Unemployment, poverty and adversity are known risk factors for mental health conditions (see section 2.2.2 Risks undermine mental health). In early 2020, an acute global recession left millions of people jobless and prompted an unprecedented rise in extreme poverty *(62)*. Recovery has been slow. In 2022 (at time of writing), the pandemic continued to affect labour markets, the increase in poverty lingered and global unemployment remained above pre-pandemic levels *(63)*.

Stress from false information and uncertainty. At the start of the pandemic, poor knowledge, rumours and misinformation about the virus fuelled fears and worries. Extensive media coverage of illness, death and misfortune have further contributed to population distress. The COVID-19 "infodemic" has continued to spread incorrect information, including intentional disinformation, with the potential to undermine both physical and mental health *(66)*.

Widespread distress

Many people have proved resilient to the new stresses and vulnerabilities created by COVID-19. They have reported healthy coping mechanisms, for example linked to outdoor activities and green spaces or to regular contact with friends and family and informal community-based support *(67)*.

But just as there has been extensive resilience, a great number of people have reported mental health problems since the pandemic began, including psychological distress and symptoms of depression, anxiety or post-traumatic stress. People may resort to negative coping measures, including using alcohol, drugs, tobacco, and spending more time on addictive behaviours, such as gambling or online gaming. All these compound the risks to mental health *(63)*.

As part of the Global Burden of Diseases, Injuries and Risk Factors Study 2020 (GBD 2020), researchers estimated a 25–27% rise in the prevalence of depression and anxiety in the first year of the pandemic (see Box 3.2 Depression and anxiety in times of COVID-19) *(68)*. A recent WHO umbrella review confirmed a significant rise in these conditions, especially during the initial months of the pandemic *(69)*.

From the start there was concern that suicide rates would also rise as risk factors increased, and due to the well-recognized link between suicidal behaviours and economic hardship. But initial reports have been mixed: some studies showed a rise, others showed a fall *(69)*. There is however usually a significant delay between collecting and releasing national suicide statistics, so early data showing stable rates does not confirm that suicidal behaviour is not an issue.

Indeed, there have been worrying signs of more widespread suicidal thoughts and behaviours. For example, there are indications of increased self-harm among adolescent girls and increased suicidal thoughts among health care workers *(69)*. The rise in suicidal thoughts and behaviours was driven by low social support, physical and mental exhaustion, poor physical health, sleep disturbances, isolation, loneliness and mental health difficulties.

Variable vulnerabilities

The mental health impacts of the pandemic are felt unequally across society, with some groups of people affected much more than others. And the pandemic has exacerbated many health and social inequalities. Vulnerability varies by context, but groups that have often been at greater risk of

adverse mental health outcomes include young people, women, people with pre-existing conditions, those from minority ethnic communities, and the socioeconomically disadvantaged. Many of these characteristics can overlap.

Studies show that younger people have been more affected than older adults *(69)*. Extended school and university closures interrupted routines and social connections, meaning that young people missed out on learning and experiences expected for healthy development. Disruption and isolation can fuel feelings of anxiety, uncertainty and loneliness, and can lead to affective and behavioural problems *(70)*. For some children and adolescents, being made to stay at home is likely to have increased the risk of family stress or abuse, which are known risk factors for mental health problems.

Studies also show women have been more affected than men *(68)*. They were, and continue to be, more likely to be financially disadvantaged due to lower salaries, fewer savings, and less secure employment than their male counterparts. Women have also borne a large brunt of the stress in the home, especially when they provided most of the additional informal care required by school closures. A rapid assessment concluded that violence against women and girls intensified in the first year of the pandemic, with 45% of women reporting they had experienced some form of violence, either directly or indirectly *(65)*.

Another vulnerable group has been people with pre-existing mental health conditions. They are not more susceptible to COVID-19 infection, but when infected, they have been more likely to get severely ill, be hospitalized, or die *(69)*. There can be many reasons for this health inequity. Social determinants, including economic deprivation, poor access to health care and lower health literacy, may play a part. Other clinical risk factors for severe COVID-19, including noncommunicable diseases and immunological disturbances, are also more prevalent among people living with mental health conditions.

Service disruptions

Before the pandemic, decades of chronic neglect and underinvestment meant there was limited access to quality, affordable mental health care in many countries. In early 2021, as COVID-19 rapidly spread across the globe, almost all mental health services were disrupted or suspended as staff and infrastructure were diverted to support the response.

Services and supports delivered through community providers were greatly disrupted, with local groups and drop-in centres closed or cancelled for several months. School-based mental health programmes have been particularly badly affected.

More than two years into the pandemic, health systems, including mental health services, continue to experience heavy pressure. COVID-19 continues to disrupt essential health services everywhere and widen the treatment gap for mental and other health conditions. In early 2022, 44% of countries responding to a WHO survey reported one or more disruptions to mental health care, including prevention and promotion programmes, diagnosis, treatment and life-saving emergency care *(71)*.

Since the beginning, mental health service providers have been working to mitigate service disruptions, for example by delivering care via alternative routes when public health and social measures were in place. This has included providing more home-based services, offering more tele-mental health support (see Chapter 5, In focus: Harnessing digital technologies for mental health). Still, there have been significant barriers to delivering and accessing digital solutions, particularly in countries with limited infrastructure, pre-existing inequalities or low levels of technological literacy.

Community-based initiatives were often faster to adapt, finding innovative ways to provide psychosocial support, including through digital technologies and informal supports.

Many countries have made efforts to develop or adapt psychological interventions to treat or prevent pandemic-related mental health conditions and to improve resilience, especially among health care workers and people with COVID-19. This includes, for example, relaxation training, digital interventions, and guided crisis interventions.

Within the first six months of the pandemic most countries surveyed by WHO – including half of all low-income countries – had built mental health and psychosocial support (MHPSS) into their national COVID-19 response plans *(72)*. And by early 2021, the number of country-level multisectoral MHPSS coordination groups in humanitarian settings had doubled *(73)*. But by the end of 2021, more than a third of countries surveyed by WHO had still not allocated any additional funding to deliver MHPSS *(71)*.

Recommendations for response

Throughout the pandemic, WHO has worked with partners within the Inter-Agency Standing Committee (IASC) to develop and disseminate multi-lingual and multi-format guidance, tools and resources to support responders, public health planners and the general public *(74, 75)*. In January 2021 the WHO Executive Board emphasized the need to integrate MHPSS within all aspects of preparedness and response for all public health emergencies *(76)*. In order to minimize the mental health consequences of the COVID-19 pandemic, the Executive Board also urged Member States to:

- **Apply a whole of society approach to promote, protect and care for mental health.** This means, among other things: including MHPSS in national responses; protecting people from harmful activities such as domestic violence or impoverishment (for example through social and financial protection measures); and communicating widely about COVID-19 to promote mental health.
- **Ensure widespread availability of mental health and psychosocial support.** This includes, for example: scaling up access to remote support such as self-help; supporting community action that promotes social cohesion (for example befriending initiatives); including mental health and social care in essential services to ensure uninterrupted in-person care; and protecting the human rights of people with mental health conditions, especially in any emergency legislation.
- **Support recovery from COVID-19 by building mental health services for the future**. This is about building back better and using the pandemic as an opportunity to advocate for a reorganization and scaling up of mental health services and systems. In particular, it is about implementing the updated *Comprehensive mental health action plan 2013–2030*, which was approved by the Seventy-fourth World Health Assembly in 2021.

2.3.3 Humanitarian emergencies and forced displacement

In 2022, 274 million people were estimated to need humanitarian assistance, marking a significant rise from the previous year, which was already by far the highest figure in decades *(77)*.

People with severe mental health conditions are extremely vulnerable during and after emergencies *(78)*. Inevitable disruptions to all health services during an emergency means people with severe mental health conditions struggle to access the services and support they need. And whether they are living in communities or institutions, anybody with mental health conditions is at increased risk of human rights violations during humanitarian emergencies *(79)*.

Risks to mental health, such as violence and loss, as well as poverty, discrimination, overcrowding, food insecurity and the breakdown of social networks are also widespread in humanitarian emergencies. For example, malnutrition is common during war and is associated with developmental delays and mental health conditions *(80)*.

Almost all people affected by emergencies will experience psychological distress. For most people, this improves over time. But for others, the impacts on mental health can endure.

> On average
> **1 in 5 people**
> in settings affected by conflict have a mental disorder.

One in five people living in settings affected by conflict in the preceding ten years is estimated to have a mental disorder *(81)*. Mental disorders are also estimated to be very common among survivors of natural disasters *(82)*. Experiencing a disaster increases the risk of problematic substance use, especially among people with pre-existing problems *(82)*. Frontline responders, such as emergency care providers and relief workers, are at particular risk of mental health problems, both in the short and long term.

Estimates suggest 84 million people worldwide were forcibly displaced during 2021. These include refugees, asylum seekers and internally displaced persons who have been forcibly displaced from their homes by conflict *(83)*. Mental health conditions such as depression, anxiety, PTSD and psychosis are much more prevalent among refugees than among host populations *(84)*.

Various stresses can affect the mental health and well-being of people who are forcibly displaced, both before and during their flight, including any stay in displacement settings such as refugee camps *(85)*. This includes exposure to challenging and life-threatening conditions such as violence, detention or lack of access to basic services. When settling in a new place, people who have been forcibly displaced often find it difficult to access mental health care and may face poor living conditions, adverse socioeconomic conditions, discrimination, isolation, strained family and support networks, uncertainty around work permits and legal status (asylum application), and in some cases immigration detention.

Overall, armed conflict is extremely damaging to societies, creating grievances, hatred and social divisions that not only impact mental health but can also heighten the risk of further violence. Addressing the social and mental health

impacts of emergencies is thus not only part of humanitarian emergency preparedness, response and recovery but also of peacebuilding *(86)*.

2.3.4 Climate crisis

The risks that the growing climate crisis pose to people's physical health have long been established *(87)*. Evidence is now accumulating to show the climate crisis can also impact mental health, through stresses and risks imposed by extreme weather events as well as through longer-term environmental change such as rising temperatures, rising sea levels, air pollution, prolonged droughts and gradual spread of climate-sensitive diseases.

Both extreme weather events and incremental change can also lead to conflict and forced migration, which present significant risks to mental health.

Extreme weather events – including tropical storms, floods, mudslides, heatwaves, and wildfires – have increased by at least 46% since 2000 *(88)*. They can result in depression, anxiety, PTSD and other stress-related conditions for many of those affected *(81, 89)*.

> *Higher ambient temperatures are linked with higher risk of hospitalization, suicidal behaviour and death for people with mental health conditions.*

Incremental environmental change can also be devastating. It can upset food and water supplies, alter growing conditions, reshape natural habitats and landscapes and weaken infrastructure. It can cause people to lose their homes and force communities to disperse. It can result in financial and social stress, and increase the risks of poverty, food insecurity, violence, aggression and forced displacement *(90, 91)*.

Even watching the slow impacts of climate change unfold can be a source of stress. Various terms have emerged to describe the psychological reactions people experience, including "climate change anxiety", "solastalgia", "eco-anxiety", "environmental distress", and many others. Whatever the label, the anxiety and despair felt, increasingly reported by young people, can be considerable and may put people at risk of developing mental health conditions *(89)*.

Despite contributing the least to the climate crisis, low-income countries are more likely to experience greater risk, due to both climate-related impacts and fewer resources to address these impacts.

Young people, indigenous peoples, people living in poverty, and people with cognitive or mobility impairments may also be more vulnerable to the mental health consequences of the climate crisis *(92)*. Higher ambient temperatures have been linked with higher risk of worsening symptoms, hospital admission, suicidal behaviour, and death for people with mental health conditions *(93)*. Risk may also be higher in people taking psychotropic medication, possibly because people on these medicines may be less able to regulate heat or notice that their body temperature is rising *(94)*.

A number of protective factors have been identified that may promote resilience in the face of the climate crisis, including social support and mental health literacy *(95)*.

Despite mental health's critical importance to our health and well-being, too many of us do not get the support we need. In 2019, an estimated one in eight people globally were living with a mental disorder *(96)*. At the same time, the services, skills and funding available for mental health remain in short supply, and fall far below what is needed, especially in LMICs.

In all countries, mental health conditions are widespread (yet misunderstood) and undertreated, and services to address them are insufficiently resourced (see Fig. 3.1). And, as discussed in Chapter 2 Principles and drivers in public mental health, the various interacting biopsychosocial factors that undermine mental health – ranging from population-wide stressors such as poverty, conflict and social inequalities to individual factors such as low self-worth – will continue to generate threats to mental health for the foreseeable future.

This chapter presents the latest data available at the time of writing (see Box 3.1 Data for assessing world mental health). In most cases, the data pre-date the COVID-19 pandemic, which has greatly exacerbated the risk factors for mental health conditions for many people. The pandemic is sure to impact the prevalence and burden of mental disorders, just as access to mental health services has been compromised (see Chapter 2, In focus: COVID-19 and mental health). A long-term upsurge in the number and severity of mental health conditions worldwide has been anticipated and, as shown below, the most recent global estimates confirm this *(97, 69)*.

FIG. 3.1

Mental health conditions are widespread, undertreated and under-resourced

Source: IHME, 2019 (*98*); WHO, 2021 (*5*).

3.1 Epidemiological overview

3.1.1 Prevalence

Pre-pandemic, in 2019, an estimated 970 million people in the world were living with a mental disorder, 82% of whom were in LMICs *(96)*.*1* Between 2000 and 2019, an estimated 25% more people were living with mental disorders, but since the world's population has grown at approximately the same rate the (point) prevalence of mental disorders has remained steady, at around 13% (see Fig. 3.2) *(99)*.

Additionally, according to various estimates, 283 million people had alcohol use disorders in 2016 *(100)*, 36 million people had drug use disorders in 2019 *(101)*, 55 million people had dementia in 2019 *(102)* and 50 million people had epilepsy in 2015 *(9)*. In many countries mental health care systems are responsible for the care of people with these conditions.

970 million
people globally were living with a mental disorder in 2019.

[1] This estimate includes people living with schizophrenia, depressive disorders (including dysthymia), anxiety disorders, bipolar disorder, autism spectrum disorders, attention-deficit/hyperactivity disorder, conduct disorder, idiopathic developmental intellectual disability, eating disorders and other mental disorders, as covered in the GBD 2019.

Prevalence in children and adolescents

Around 8% of the world's young children (aged 5–9 years) and 14% of the world's adolescents (aged 10–19 years) live with a mental disorder (see Table 3.1). A seminal nationwide study in the United States found that half of the mental disorders present in adulthood had developed by the age of 14 years; three quarters appeared by the age of 24 years *(108)*.

Idiopathic developmental disorders, which cause developmental disability, are the most common type of mental disorder in young children, affecting 1 in 50 children aged under five years. The second most prevalent mental disorder in young children is autism spectrum disorder (another developmental disorder), which affects 1 in 200 children aged under five years (see Table 3.1). Both disorders become gradually less prevalent with age, as many people with developmental disorders die young.

Attention-deficit/hyperactivity disorder and conduct disorders are particularly common in adolescence, especially among younger boys (4.6% and 4.5%, respectively in boys 10–14 years of age). Anxiety is the most prevalent mental disorder among older adolescents (4.6%) and even more so among adolescent girls (5.5%). Anxiety and depressive disorders at this age may be associated with bullying victimization. Eating disorders occur mainly among young people and, within this group, are more common among females (for example, 0.6% in women aged 20–24 years compared with 0.3% in men in the same age group) *(109)*.

Prevalence in older adults

Around 13% of adults aged 70 years and over lived with a mental disorder in 2019, mainly depressive and anxiety disorders. Sex differences in rates of mental disorders increase in this age category as 14.2% of women and 11.7% of men aged over 70 years are estimated to have a mental disorder. Prevalence estimates for schizophrenia are lower in adults aged over 70 years (0.2%) compared with adults under 70 years of age (0.3%), which in part may be explained by premature mortality (see section 3.1.2 Mortality).

Notably, these estimates on mental disorders do not include dementia, which is a key public health concern that is often addressed by mental health or aging policy and plans. An estimated 6.9% of adults aged 65 years and over live with dementia *(102)*.

Geographical disparities

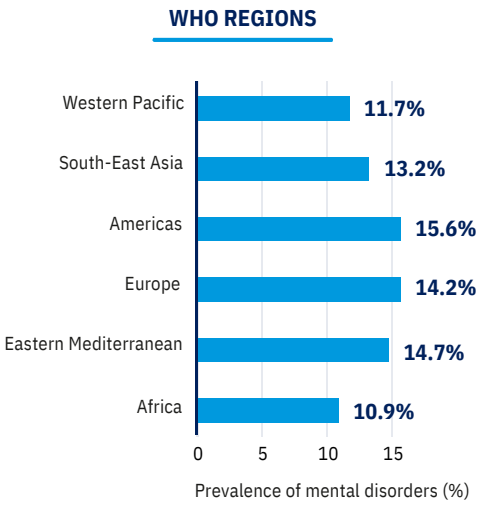
Mental disorders are common in all countries: they occur across all WHO Regions, ranging from 10.9% prevalence in the WHO African Region to 15.6% in the WHO Region of the Americas (see Fig. 3.3) *(110)*.

Mental disorders are somewhat more common in high-income countries (15.1%) but they are also common in low-income countries (11.6%) (see Fig. 3.3).

The variations in prevalence rates across regions and income groups may be explained by at least three factors. First, demographic factors lessen prevalence rates in low-income countries: populations here tend to have a higher proportion of children under ten years of age, for whom mental disorders are much less common. Second, war and conflict contribute to the relatively higher rates of mental disorder in WHO's Eastern Mediterra- nean Region. Third, sociocultural factors have a role. For example, differing cultural understand- ings and conceptualizations of mental health and mental health conditions may influence people's readiness to disclose mental health symptoms in surveys. Local cultural concepts of distress – which can be associated with psychopathology – are typically not well-covered in epidemiological studies *(111)*. And while stigma and discrimination is high in all countries, it may even be higher in many LMICs, which could lead to underreporting.

Combining factors such as age, sex and geographical location can reveal important differences in people's specific mental health needs. For example, while an estimated 4% of all

FIG. 3.3
Prevalence of mental disorders across WHO regions, 2019



Source: IHME, 2019 *(112)*.

age groups worldwide lived with anxiety disorders in 2019 (see Table 3.1), the rate rises to around 10% among working age women in the Americas *(113)*.

3.1.2 Mortality

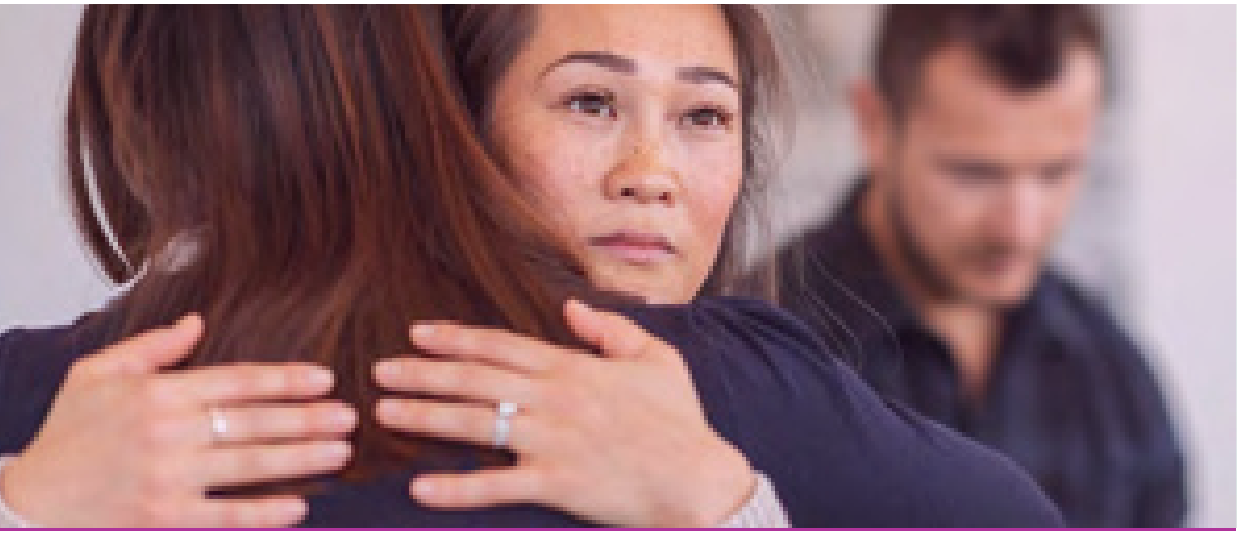
Premature mortality

Estimating mortality from mental health conditions is complex. Both mental health conditions and suicide are rarely recorded as the cause of death on death certificates or in country mortality statistics. Yet poor mental health is often an important underlying or causative factor. Across the world, people with mental health conditions are known to experience disproportionately higher mortality rates compared with the general population *(114)*. People with severe mental health conditions – including schizophrenia and bipolar disorder – die on average 10 to 20 years earlier than the general population *(115)*. Most of these deaths are due to preventable diseases, especially cardiovascular disease, respiratory disease and infection, which are more common in people with mental health conditions. In these cases, having a mental health condition may not be the cause of death, but it is likely to be a major contributing factor.

Side effects of medications for severe mental health conditions can have a role in premature mortality by contributing, for example, to obesity, glucose intolerance and dyslipidemia *(116)*. Moreover, people with mental health conditions are more likely to be exposed to the well-known risk factors for noncommunicable diseases (NCDs), including smoking, alcohol use, unhealthy diet and physical inactivity.

This is further exacerbated by the fragmented approach health systems take in caring for physical and mental health conditions: once a person is channelled into a mental health service, their physical health too often gets neglected. At the same time, in both general and specialized mental health care settings, the signs and symptoms of physical illness are often misattributed to a concurrent mental health condition in what is known as “diagnostic overshadowing” *(117)*. These two factors have, for example, led to a systematic under-recognition and undertreatment of cardiovascular conditions among people living with schizophrenia and bipolar disorder *(118, 119)*. WHO and its expert advisers have developed a multilevel intervention framework and guidelines aimed at addressing these shortcomings (see section 4.1.2 Improved physical health, subsection Integrated care is good care) *(114, 120)*.

> People with severe mental health conditions die
> **10 to 20 years**
> earlier than the general population.



The cumulative mortality burden of mental health conditions can be derived using natural history models that relate prevalence to observed rates of excess deaths. These models are not part of the estimation of fatal burden (see section 3.1.3 Burden), which attributes deaths to the primary cause (such as cardiovascular disease), but researchers have used these models to show that the mortality burden of mental health conditions is grossly underestimated. One analysis of 2010 data shows there were more than four million excess deaths attributable to mental disorders, including 2.2 million from major depressive disorder, 1.3 million from bipolar disorder and 700 000 from schizophrenia – compared with just 20 000 cause-specific deaths, all from schizophrenia, calculated using the standard burden of disease calculations *(121)*.

This huge yet hidden mortality burden of mental health conditions has been labelled a scandal, and one that contravenes international conventions for the right to the highest attainable standard of health *(122)*.

Suicide

Suicide accounts for more than one in every 100 deaths globally *(123)*. And for every death by suicide there are more than 20 suicide attempts *(124)*. Suicide affects people from all countries and contexts. And at all ages suicides and suicide attempts have a ripple effect on families, friends, colleagues, communities and societies (read Marie's experience).

In 2019, an estimated 703 000 people across all ages (or 9 per 100 000 population) lost their life to suicide (see Fig. 3.4) *(125)*. Estimates of suicide rates vary significantly across countries – from fewer than two deaths by suicide per 100 000 in some nations to more than 80 per 100 000 in others. Around three-quarters (77%) of all suicides occur in LMICs, where most of the world's population live. But high-income countries grouped together have the highest suicide rates at 10.9 per 100 000. These countries are also more likely to have high-quality vital registration data.

Suicide rates also vary between males and females. Globally, women are more likely to attempt suicide than men. And yet twice as many men die by suicide than

women do. In high-income countries the male-to-female ratio for death by suicide is even higher, at three men to every woman.

In both males and females, suicide is a major cause of death among young people. In 2019, it was the third leading cause of death in 15–29-year-old females; and the fourth leading cause of death in males in this age group. Overall, it is the fourth leading cause of death among 15–29-year-olds and accounts for some 8% of all deaths in this age group. More than half (58%) of suicides happen before the age of 50 years. And suicide rates in people aged over 70 years are more than twice those of working age people *(126)*.

Suicide accounts for

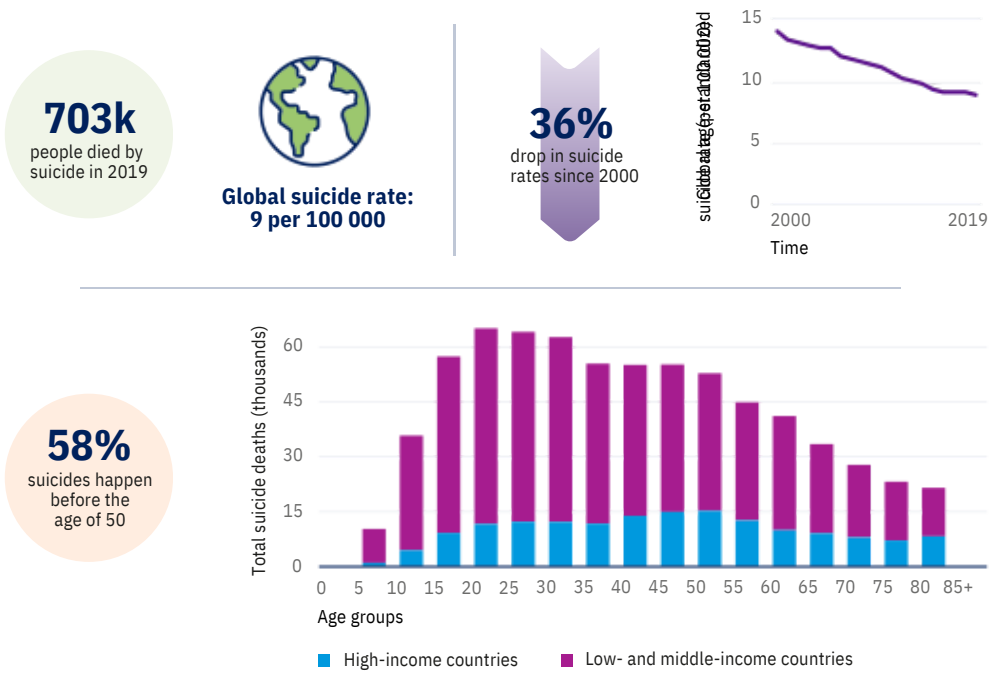
1 in 100 deaths

globally.

Globally, the suicide rate has dropped by 36% since 2000, with decreases ranging from 17% in WHO's Eastern Mediterranean Region to 47% in WHO's European Region and 49% in WHO's Western Pacific Region. Yet, in WHO's Region of the Americas, suicide rates have increased 17% over the past 20 years. (For more information on and examples of successful suicide prevention see section 6.3.1 Preventing suicide.)

FIG. 3.4

Suicides in 2019



Source: WHO, 2021 *(125)*.

NARRATIVE

I abandoned everything and everyone

Marie's experience

I am a high-functioning lady living with a history of trauma. I come from a family with a lot of experience of mental health conditions, but my family and the society we lived in didn't acknowledge mental health and didn't know how to take care of a loved one living with mental health challenges. We didn't get the care we needed. We lost my brother when he was just 33 years of age, without a conclusive diagnosis.

I suffered with behavioural issues. My greatest trauma was the breakdown of my parent's marriage. I struggled and self-medicated with dangerous relationships and risky sexual behaviours.

In 2009, I attempted suicide. I was five months pregnant. Me and the baby survived, but I knew I couldn't continue this way. I abandoned everything and everyone, including my three sons. I left my country without a single word to anyone. Only a mental illness makes you behave this way.

I continued to struggle and eventually got professional help. Four years later I returned as a much stronger person. I am now a commonwealth scholar doing an MSc in professional practice health care provision; and committed to raising awareness of mental health especially through people with lived experience sharing their stories in countries like mine.

Marie Abanga, Cameroon

3.1.3 Burden

Burden of disease studies estimate the population-wide impact of living with disease and injury and dying prematurely. They involve calculations using the Disability-Adjusted Life Year (DALY), where one DALY represents the loss of one year of full health. DALYs combine in one measure the years of life lost to premature mortality (YLLs) and years of healthy life lost to disability (YLDs) to estimate the overall burden from each cause of disease and injury.

In 2019, across all ages, mental, neurological and substance use disorders together accounted for one in ten DALYs (10.1%) worldwide. Mental disorders accounted for 5.1% of the global burden (see Fig. 3.5). Neurological disorders accounted for another 3.5%; while substance use conditions accounted for 1.5%.

In all countries, the burden of mental disorders spans the entire life-course: from early life, where conditions such as developmental disorders and childhood behavioural disorders are the biggest contributors to burden; through to

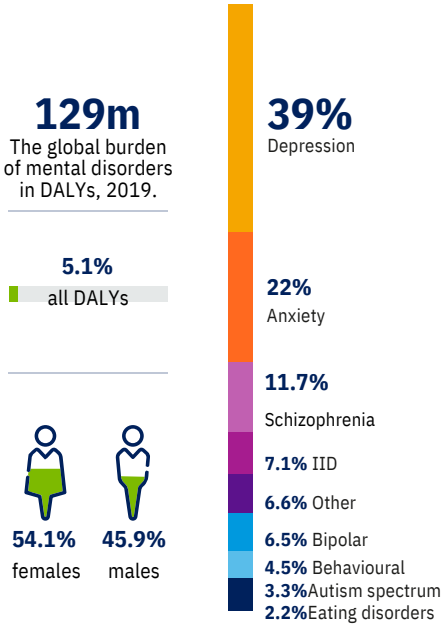
adulthood and old age, where depressive and anxiety disorders dominate. Overall, the greatest burden is carried during early adulthood.

Across all mental disorders, most of the burden manifests as YLDs, rather than YLLs. This is because of the way burden estimates are calculated, which does not attribute any deaths to conditions such as depressive disorders or bipolar disorder, and which includes self-harm and suicide under a separate category of intentional injuries *(127)*.

Mental disorders are the leading cause of years lived with disability, accounting for one in every six (15.6%) YLDs globally. Substance use disorders account for a further 3.1% of YLDs; and neurological conditions account for 6.4%. Combined mental, neurological and substance use disorders account for one in every four YLDs globally.

FIG. 3.5

The global burden of mental disorders in disability-adjusted life years (DALYs), 2019



Source: WHO, 2019 *(128)*.

Globally, mental disorders account for

1 in 6 years

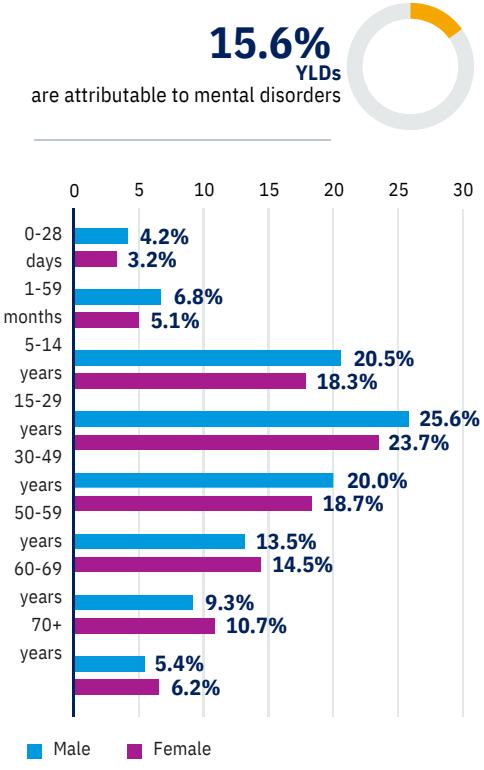
lived with disability.

The contribution of mental disorders to YLDs varies across the lifespan, from less than 10% for children and older adults to more than 23% for young people aged 15–29 years (see Fig. 3.6).

Since 2000, both depressive and anxiety disorders have consistently been among the top ten leading causes of all YLDs worldwide.

FIG. 3.6

Proportion of all-cause years lived with disability (YLDs) attributable to mental disorders, across the life-course, 2019

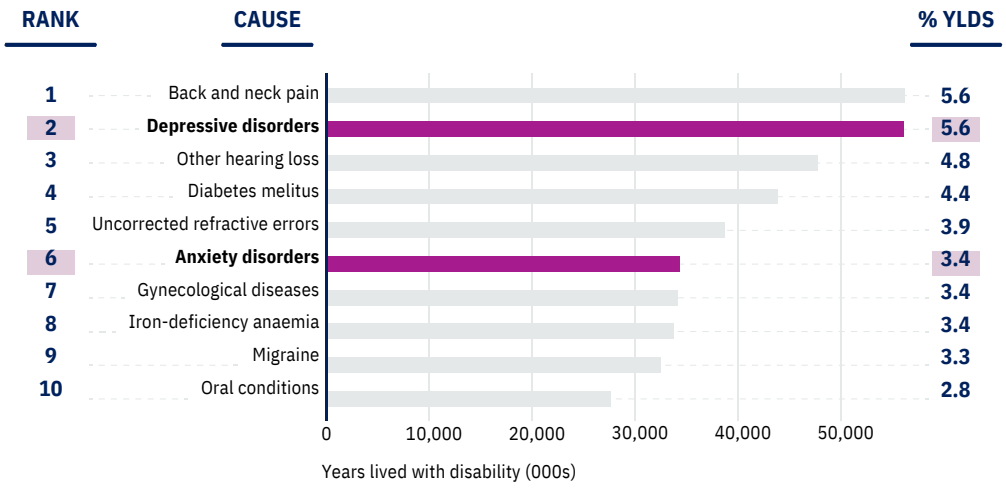


Source: WHO, 2019 *(129)*.

Depressive disorders alone are the second leading cause of global YLDs, accounting for 5.6% of all YLDs in 2019 (see Fig. 3.7). Two important risk factors for these common mental disorders have been quantified as part of GBD 2019: childhood sexual abuse (exposure before 15 years to any unwanted sexual contact); and bullying victimization (intentional and repeated harm of children and adolescents attending school by peers). In 2019, global age-standardized levels of lifetime exposure to childhood sexual abuse and bullying victimization in the preceding year amounted to 9.4% and 7.3%, respectively *(130)*. Together, these modifiable risk factors accounted for 7.1% of all anxiety disorder DALYs and 9.9% of all major depressive disorder DALYs globally.

FIG. 3.7

Top ten leading causes of global years lived with disability (YLDs), 2019



Source: WHO, 2019 *(129)*.

3.2 Economic consequences

In addition to the direct costs of treatment, mental health conditions come with a variety of indirect costs associated with reduced economic productivity, higher rates of unemployment and other economic impacts.

These costs to society can be significant, often far outstripping health care costs. Researchers from the World Economic Forum calculated that a broadly defined set of mental health conditions cost the world economy approximately US$ 2.5 trillion in 2010, combining lost economic productivity (US$ 1.7 trillion) and direct costs of care (US$ 0.8 trillion) *(131)*. This total cost was projected to rise to US$ 6 trillion by 2030 alongside increased social costs. That's more than the researchers projected for the costs of cancer, diabetes and chronic respiratory disease combined. LMICs were predicted to bear 35% of the cost of these mental health conditions.

The indirect costs related to mental health conditions can also be significant to countries. For example, in the Philippines, an analysis calculated that in 2019 six conditions (psychosis, bipolar disorder, depressive disorders, anxiety disorders, alcohol dependence and epilepsy) cost the national economy around US$ 1.3 billion in lost productive capacity due to premature death, disability and reduced productivity while at work *(132)*. Combined with the direct costs of care (around US$ 53 million), this amounts to 0.4% of the country's gross domestic product.

Most recently, in 2020, a systematic review of cost-of-illness studies from around the world showed that the average annual societal cost of mental health conditions – adjusted for purchasing power parity to the US price level – ranges between US$ 1180 and US$ 18313 per treated person, depending on the condition *(133)*. This cost includes both direct costs of treatment and other services as well as other costs such as foregone production and income.

The most costly mental health condition per person globally was found to be schizophrenia. Depressive and anxiety disorders were much less costly per treated case; but they are much more prevalent, and so majorly contribute to the overall national cost of mental health conditions. Across all conditions, nearly half the total societal cost was found to be driven by indirect costs such as reduced productivity *(133)*.

Of course, even cost-of-illness studies do not provide a complete picture of the societal costs of mental health conditions. Typically they do not attach monetized value to people outside the paid workforce, including carers and home-makers. They only focus on productivity losses, rather than on other social factors that individuals may value more, such as interpersonal relationships. And, importantly, they do not include intangible costs such as any psychological pain experienced *(133)*.

3.3 Gaps in public mental health

In addition to affecting every country in the world and being costly, mental health conditions are also severely underserved. Results from the latest assessment in WHO Member States – the *Mental health atlas 2020* – show that mental health systems all over the world continue to be marked by major gaps in governance, resources, services, information and technologies for mental health (see Fig. 3.8). These gaps are important because they can severely hamper a country's mental health response. The sections that follow highlight the defining features of some of the key gaps.

3.3.1 The information gap

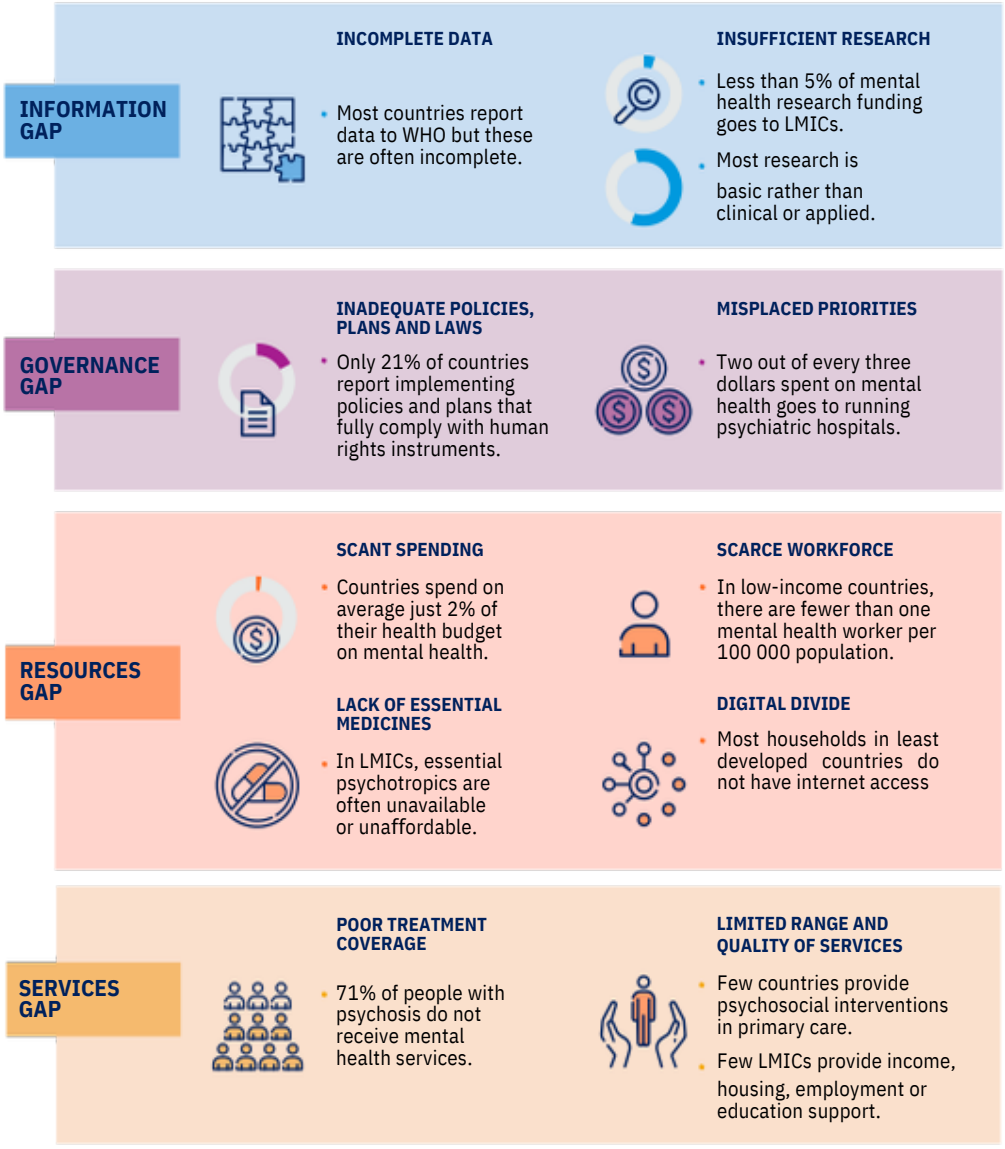
Limited mental health data

In part, the information gap is about countries' capacities for gathering, reporting and monitoring reliable, up-to-date mental health data, including on policies and laws, workforces and services.

There has been much progress in the past decade. Since 2014, the vast majority of countries (88–91%) consistently report data on mental health to WHO *(5)*. And 76% of WHO Member States confirmed their ability to report against five core mental health indicators, compared with 60% in 2014 and 62% in 2017.

FIG. 3.8

A snapshot of key gaps in public mental health



But often the data that are reported are incomplete, particularly on service availability and use, which can be difficult to track. Nearly half of countries said they regularly compile data on mental health service activity in the public sector for policy, planning or management. In most cases, especially among low-income countries, these data are only compiled as part of general

health statistics and are not available for reporting to WHO. A quarter of LMICs had not compiled any mental health data in the past two years.

In many cases, data reported from LMICs come exclusively from public psychiatric hospitals, and do not include mental health services and interventions provided in general hospitals, community settings, primary health care, schools or the private sector *(134)*. This is a major limitation, given the importance of moving mental health care away from psychiatric hospitals to community-based settings (see Chapter 7 Restructuring and scaling up care for change) and the need to keep watch over these changes.

The lack of comprehensive, independent and comparable data poses a major barrier to monitoring and accountability in mental health. To address this challenge, the Countdown Global Mental Health 2030 initiative uses a broad and integrated set of indicators to track progress in mental health *(135)*. These indicators, which to date have focused on child and caregiver mental health, extend beyond those captured by existing mental health service surveys such as WHO's *Mental health atlas* to also include data on the determinants of mental health and on factors that shape the demand or need for mental health care. They are available through an interactive, publicly-accessible dashboard, which the initiative intends for use to inform action towards improved mental health *(136)*.

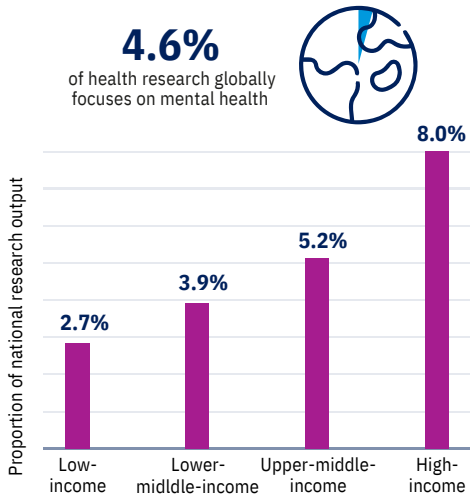
Insufficient and imbalanced research

The second part of the information gap is a gap in research that could help countries develop and implement relevant and tailored intervention strategies. Analyses by the *Mental health atlas 2020* show that while the absolute level of mental health research output (as measured by published studies reflected in research databases) has risen by 12% since 2013, other health research output has risen even faster, so the proportion of health research that focuses on mental health is slightly falling (from 5.0% in 2013 to 4.6% in 2019).

The *Mental health atlas 2020* also reveals major differences in mental health research across regions and income groups. In particular, the proportion of a country's health research output that focuses on mental health is nearly three times greater in high-income countries compared with low-income countries (see Fig. 3.9).

FIG. 3.9

Proportion of national health research focused on mental health across income groups



Source: WHO, 2021 *(5)*.

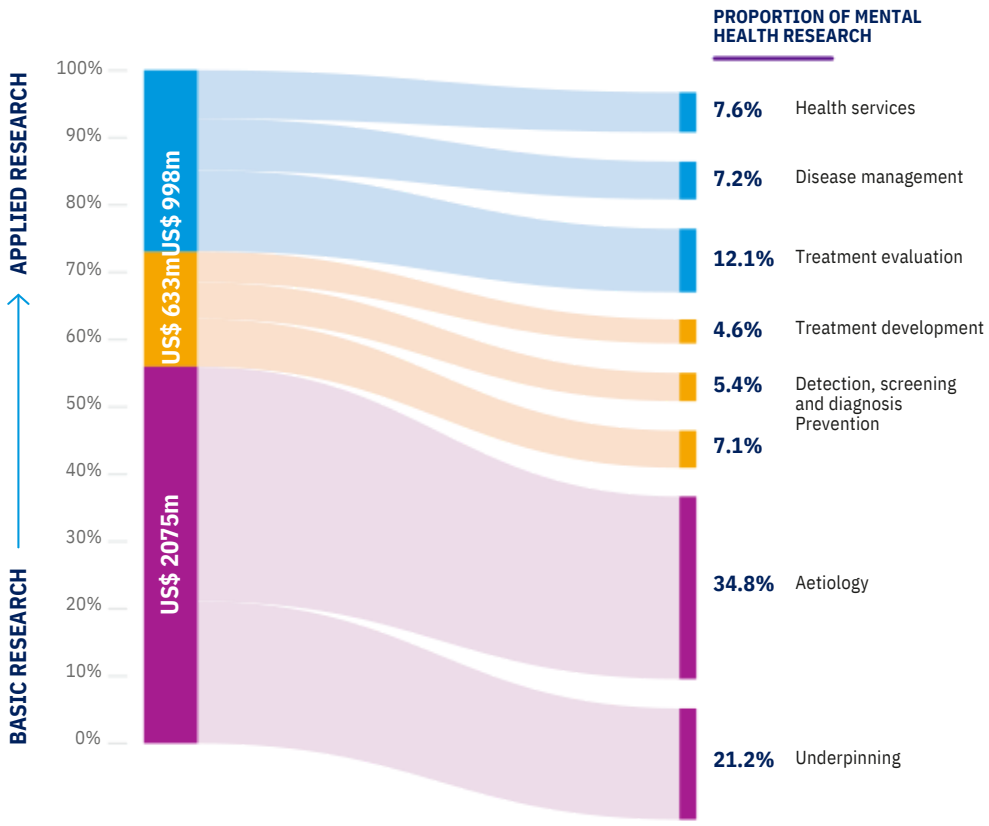
A recent analysis of inequities in mental health research funding shows that 99% of research is funded by high-income countries, and most research in mental health is done in high-income countries, with less than 5% of research funding going to LMICs *(137)*. Where high-profile research is done in LMICs, it is often led by researchers from, or based in, high-income countries, so reinforcing power asymmetries *(138)*.

About US$ 3.7 billion a year is spent globally on mental health research worldwide – an estimated 7% of global health research funding *(137)*. Overall, more than half (56%) of all global funding for mental health research is spent on

basic research rather than clinical or applied research (see Fig. 3.10). Moreover, some fields of mental health are underfunded compared with others. Most notably, suicide and self-harm, which is the subject of the only explicit SDG indicator on mental health, receives less than 1% of the overall mental health research funding.

FIG. 3.10

Most mental health research is focused on the basic end of the spectrum



Source: Woelbert et al, 2020 (*137*).

3.3.2 The governance gap

Inadequate policies, plans and laws

Well-defined policies, plans and laws provide the basis for action on mental health. Assuming they are appropriately and fully implemented, they are the mainstay of good governance.

In total, 146 countries (86% of WHO Member States) reported having a mental health policy or plan in place – either stand-alone or integrated into general health policies or plans. Slightly more than half (56%) of responding countries reported updating their mental health plans within the past two years. Around 90 countries

(fewer than half of WHO Member States) had a plan specifically for children and adolescents. A third of these had not been updated since 2017.

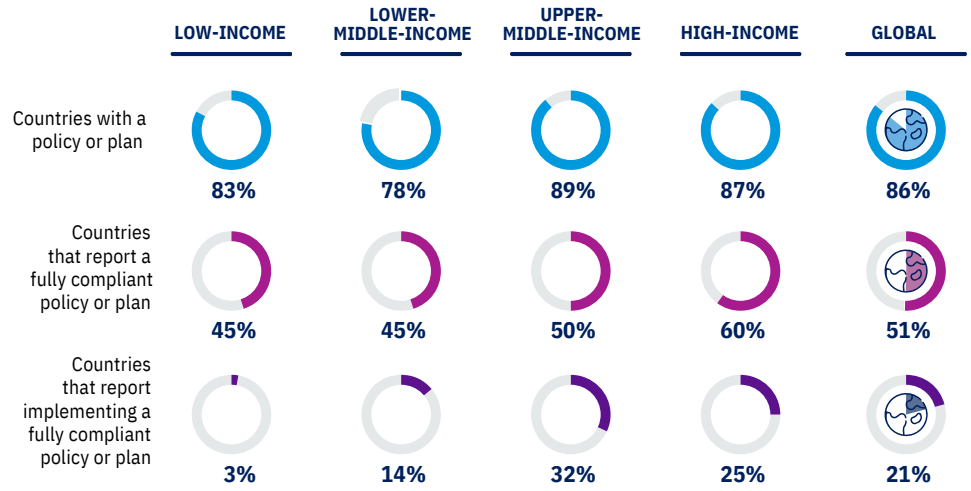
But simply having a plan in place is not enough to meet mental health care needs: plans need to comply with human rights instruments, be fully resourced and implemented, and regularly monitored and evaluated.

Only half (51%) of WHO Member States reported that their mental health policies or plans fully complied with human rights instruments. About a third (31%) reported plans that were being implemented. And only 21% of WHO Member States reported policies or plans that were being implemented and fully compliant with human rights instruments. This proportion varied significantly across income groups, from 32% for upper-middle-income countries to just 3% for low-income countries (see Fig. 3.11).

Few countries monitored the implementation of their mental health policies or plans effectively. Only 23% of responding countries reported using indicators or targets to monitor most or all the components of their mental health plan. A third of responding countries reported using indicators to monitor some components of their plan. Nearly a quarter reported having no indicators at all.

FIG. 3.11

The state of national mental health policies and plans grouped according to countries' income



Source: WHO, 2021 (*5*).

A similar pattern is seen in mental health legislation: 80% of WHO Member States reported having a stand-alone or integrated law for mental health; but only 38% reported that their laws were fully compliant with human rights instruments; and only 28% reported having fully compliant laws that were in the process of implementation.

Again, there was a wide gap between income groups, with 40% of high-income WHO Member States having a fully compliant law in the process of implementation, compared with just 3% of low-income WHO Member States. For both policies and legislation, people with mental health conditions remain

poorly represented in decision-making and development processes of most countries, as well as in the accountability mechanisms that monitor, evaluate and report compliance with human rights instruments *(139)*.

Disparities and misplaced priorities

Within broader health policies and plans, most LMICs give low priority to mental health compared with other burdensome health conditions such as communicable and noncommunicable diseases. Mental health resources are also unfairly distributed across countries, regions and communities. So populations with high rates of socioeconomic deprivation end up having the lowest access to care *(140)*. Urban areas tend to be better resourced than rural ones.

Adult mental health services are typically prioritized over services for children or older adults, leading to less available or appropriate care for these groups. Targeted services are also deficient for many marginalized groups such as indigenous peoples, ethnic and sexual minorities, homeless people, refugees, and migrants. Importantly, it is not only people in low-income countries that receive less accessible and poorer quality care, but also less privileged groups within all countries *(141)*.

Across all population groups, providing beds and treatment in institutions is consistently prioritized over making services available in the community. Across both staff and budgets, most resources available for mental health end up concentrated in psychiatric hospitals, especially in LMICs. More than 70% of mental health expenditure in middle-income countries (compared with 35% in high-income countries) goes towards psychiatric hospitals, which largely cater for people with severe mental health conditions *(5)*. In low-income countries psychiatric hospitals use up similarly large, if not larger, proportions of the mental health budget. Overall, stand-alone inpatient psychiatric hospitals account for two out of every three

> Most countries spent
> **less than 20%**
> of their mental health budget on community mental health services.

dollars (66%) spent globally by governments on mental health *(5)*. This is an inefficient way of using resources for mental health.

In 2019, most of the reporting countries (67%) spent less than 20% of their mental health budget on community mental health services. Around 80% of countries spent less than 20% on mental health in general hospitals and similarly 80% of countries spent less than 20% on mental health in primary care. Expenditures on prevention and promotion programmes were even less common *(5)*.

International funders similarly side-line mental health, giving it only a fraction of the funding that other health conditions receive and often focusing on short-term projects rather than supporting design and delivery of long-term mental health systems. While health budget allocation should never be based on burden alone, burden is a factor to be considered when setting priorities for health interventions. From 2006 to 2016, just 0.3% of global development assistance for health went to mental health *(142)*. In comparison, the control of sexually-transmitted infections (STIs), including HIV/AIDS, received almost 50% of global development assistance for health in the same timeframe – even though the burden in DALYs attributed to mental disorders was more than three times as great as that of STIs *(143)*.

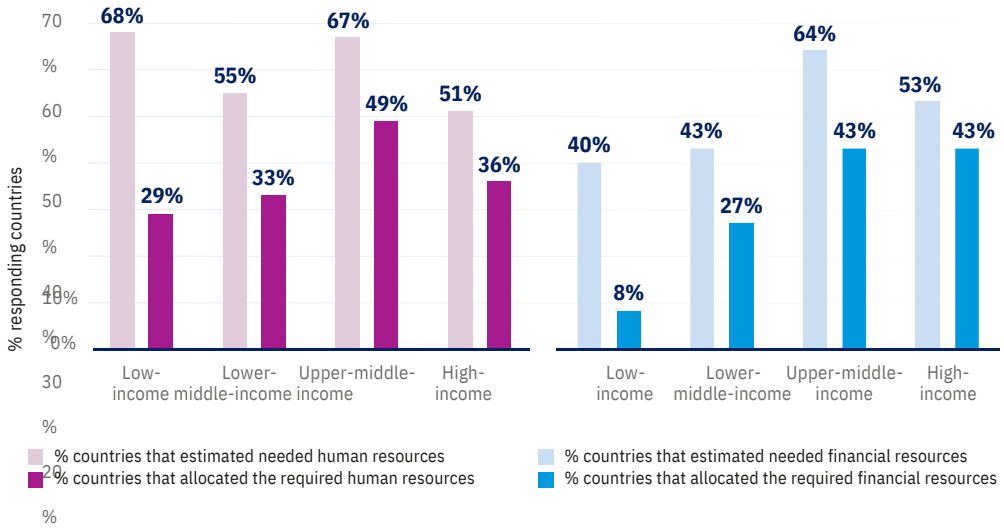
3.3.3 The resources gap

The limited implementation of mental health plans, policies and legislation is, in part, due to a lack of resources – both human and

financial – available for mental health.
The *Mental health atlas 2020* shows that only half of countries with a mental health policy or plan have also estimated the financial resources they need to implement it (60% include an estimate of human resources required). And only around a third of countries have actually allocated financial and human resources to implement their mental health policy or plan. The gap between estimating resources and allocating them is particularly stark among low-income countries. For example, while 40% of these countries have estimated the funding they need, only 8% have actually allocated the requisite resources (see Fig. 3.12).

FIG. 3.12

The gap between estimating and allocating resources to implement mental health plans



Source: WHO, 2021 (*5*).

Scant spending

Mental health spending includes activities delivered at all levels of care as well as programme costs, such as administration, training and supervision, and promotion and prevention activities. Calculating the full level of mental health spending in many countries is difficult because of the range of services, service providers and funding sources involved.

In many cases, even calculating government spending can be hard. Budgets for general health care tend to allocate funds to generic categories such as hospitals or primary health care, rather than to specific health conditions (such as depression). All health conditions treated at that level or facility are then funded from the generic allocation. The budget may further be broken down into allocations for medicines, personnel and equipment for instance; but it will rarely describe funds specifically for mental health care.

> Governments around the world allocate **just 2%** of their health budgets to the treatment and prevention of mental health conditions.

Even so, most (but not all) countries dedicate only a small fraction of their health care budgets to mental health; and their spending is disproportionately low to their needs. Although a few high-income countries spend up to or more than 10%, the *Mental health atlas 2020* shows that the median allocation of government health budgets around the world to mental health amounts to just 2%.1 In LMICs this figure drops to just 1%.

The need for investments into mental health promotion, protection and care are not limited to the health sector. Supporting social integration for people living with mental health conditions requires action across social services, education, labour and justice. Investments by these sectors into mental health tends to be even less than those made by the health sector.

Scarce workforce for mental health

In addition to scant spending, many countries face huge scarcities of personnel trained for dealing with mental health. This includes shortages in mental health nurses, psychiatric social workers, psychiatrists, psychologists, counsellors and other paid mental health workers.

Around half the world's population lives in countries where there is just one psychiatrist to serve 200 000 or more people. Other mental health care providers who are trained to use psychosocial interventions are even scarcer (*5*). In low-income countries there are fewer than one mental health worker of any kind per 100 000 population, compared with more than 60 in high-income countries (see Fig. 3.13; the median across all countries is 13 mental health workers per 100 000 population). Across all income groups, most mental health workers are nurses, who combined make up 44% of the global workforce for mental health.

Across all income groups, there is a great shortage of specialized mental health workers for children and adolescents, with just three mental health workers of any kind per 100 000 population, and a median rate as low as 0.01 per 100 000 population in low-income countries. In these countries, the mental health workforce for children and adolescents is almost non-existent.

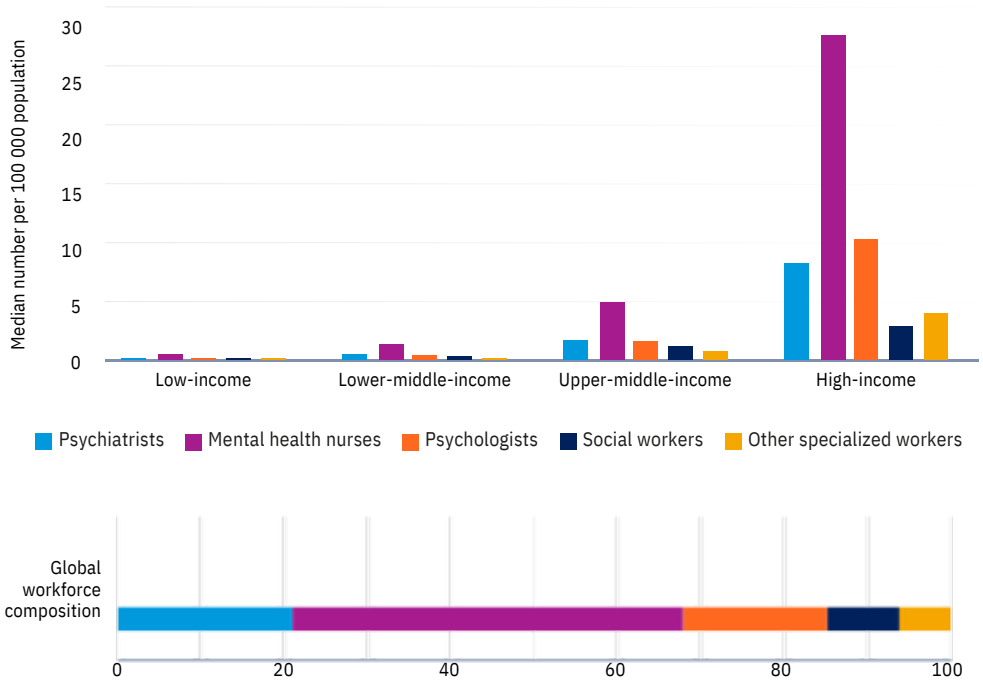
> *In LMICs, the mental health workforce for children and adolescents is almost non-existent.*

The scarcities in skills are compounded because few non-specialist doctors, nurses, and clinical officers have been trained to recognize and treat patients with mental health conditions in primary health care. In 2020, the number of countries reporting that primary health care workers receive training on how to manage mental health conditions is high (146 or 88% of countries) *(5)*. This would seem to indicate an appetite for task-sharing to increase the pool of workers available for mental health care. But still most countries have nowhere near the level of trained and skilled personnel required to provide for everyone in need, with only 25% of WHO Member States reporting that they had integrated mental health into primary care (see section 3.3.4 The services gap). This means that, beyond task-sharing, other solutions can and must be rapidly scaled up, including e-health solutions, even though the digital divide remains a further barrier to health service access and socioeconomic development more broadly (see A digital divide).

[1] This figure should be interpreted with caution as only 67 countries reported data on government spending to the *Mental health atlas 2020 (5)*.

FIG. 3.13

The specialized mental health workforce across country income groups



Source: WHO, 2021 *(5)*.

Lack of essential medicines

Another aspect of the resources gap is the limited availability of essential psychotropic medicines, especially in LMICs. And when they are available, far more people in LMICs also end up paying for these medicines out of pocket *(5)*.

A recent review of 112 national essential medicines lists – commissioned for this report – found inequities in the listing, availability, pricing and affordability of essential psychotropic medicines in countries *(144)*.

The review showed that up to 40% of low-income countries did not include essential medicines that have been on the WHO *Model list for essential medicines* for decades, such as long-acting (depot) fluphenazine for schizophrenia and lithium carbonate mood stabilizer for bipolar disorder. Other supply gaps may be behind some of these omissions, for example laboratory tests are needed to monitor use of some medicines, to avoid inappropriate use or serious side effects (read Eleni's experience).

The review also showed that some second-generation antipsychotics on the model list for schizophrenia (risperidone and clozapine) were only included in 35% and 25% of national essential medicines lists in low-income countries respectively.

The actual availability of different essential psychotropic medicines was lower in the public sector compared with the private sector, and well below 50% worldwide, often much lower in low-income countries where there is a high incidence of stock-outs. The antidepressant medicines amitriptyline and fluoxetine in the public sector in low-income countries were three times more expensive than the international unit reference price. Overall, the review found that essential psychotropic medicines were less affordable to people in low-income countries compared with people in other countries *(144)*.

A digital divide

Whether through electronic systems or mobile applications, digital technologies are becoming a standard part of mental health care around the world (see Chapter 5, In focus: Harnessing digital technologies for mental health). They can be key to scaling up access to care for common mental health conditions such as depression or anxiety and can also provide a platform for providing remote care, as during the COVID-19 pandemic when face-to-face options were shut down as part of social restrictions.

But relying on digital technologies to deliver mental health services risks excluding some of the world's most vulnerable people from accessing the care they need and fails to address the full spectrum of mental health conditions that people experience. For many people in LMICs, mobile phones offer the only way of connecting to the internet and accessing valuable information and resources that would otherwise be out of reach. Access to mobile phones has grown exponentially in recent years, with mobile networks now covering more than 85% of the population in every region of the world *(145)*. But even where networks are available, not everyone has a smart phone, and even for those who do, internet access can be prohibitively expensive.

Indeed, the figures for mobile network coverage only tell half the story: analysis from 2019 showed that around half the world's population had no internet connection, with big disparities between and within countries *(145)*. Just 20% of households in low-income countries were connected to the internet in 2019, compared with 87% of people in developed ones *(145)*. In sub-Saharan Africa, 4G or newer wireless systems remained largely unavailable. Across all regions, but especially in sub-Saharan Africa, people living in rural areas were half as likely to be connected to the internet as those living in urban areas; and women were less likely to use the internet than men. In all regions, internet access was more prevalent among young people (15–24 years of age).

Surveys in high-income countries further suggest that people living with mental health conditions face a heightened risk of digital exclusion, because of material deprivation and diminished opportunities to use or be trained in information technology or the internet, including people residing in long-term care facilities *(146)*.

All these disparities add up to a digital divide that compounds existing inequities in access to mental health services.

Even if connectivity to the internet improves, many countries still need to step up their investment in mental health information systems, service user empowerment and workforce development to make the move from analogue to digital care provision a reality for all.

3.3.4 The services gap

Poor treatment coverage

With nearly a billion people in the world living with a mental disorder, the need for adequate and accessible services is evident. But all over the globe, mental health systems are failing to meet their populations' needs.

The gap between prevalence and treatment remains unacceptably large. Researchers suggest that all over the world a large proportion of people with mental health conditions go completely untreated, receiving no formal care at all. For example, WHO estimates that only 29% of people with psychosis receive mental health services *(5)*.

The gaps in treatment vary across countries and from one mental disorder to another. For example, while 70% of people with psychosis are reported to be treated in high-income countries, only 12% of people with psychosis receive mental health care in low-income countries *(5)*. For depression, the gaps in service coverage are wide across all countries: even in high-income countries, only one third of people with major depressive disorders receive formal mental health care *(147)*.

Variable quality and range of services available

In all countries, gaps in service coverage are compounded by variability in quality of care. Quality includes how well mental health care aligns with human rights principles, whether or not treatment meets any defined minimum standards for adequacy, and to what extent mental health care supports social inclusion.

Though difficult to quantify, mental health care does not align with human rights principles throughout the world *(22)*. Abuses and substandard living conditions in many psychiatric hospitals are especially notorious and widespread (read Mrs BN's experience and see section 4.2.2 The right to quality care).

Among those people with mental health conditions who are treated, only a small proportion receive care that meets minimum standards for adequacy. A recent systematic review of treatment coverage for major depressive disorder found that minimally-adequate treatment ranged from 23% in high-income countries to 3% in low- and lower-middle-income countries *(147)*.

Often the range of interventions available is severely limited, with few alternatives to biomedical-based care available. In 2020, WHO Member States reported that pharmacological interventions were much more widely available than psychosocial interventions *(5)*. The gap is particularly in high-income countries, where 71% countries report providing pharmacological interventions at primary care facilities but only 34% provide psychosocial interventions there. In LMICs, the gap in availability between different types of intervention is much smaller, but that is because neither type is widely provided in primary health care.

In many countries mental health care systems also fail to provide the full range of social support that people living with mental health conditions can require. In 2020, nearly all (96%) high-income countries reported providing social care and income support to people with mental health conditions, compared with 21% of low-income countries providing income support and 38% providing social care support *(5)*.

Other types of critical social support – including housing, employment, education and legal support – are scarce almost everywhere. Fewer than 45% of countries worldwide reported providing any of these types of support; and only 24% reported providing all of them. Housing was the least available form of support globally (36%), but especially so in low-income countries (4%), where employment and education support were similarly rare.

3.4 Barriers to demand for care

In part, the extremely high unmet need for mental health care, even among people with severe mental health conditions, is due to a lack of demand for, or uptake of, services. This reluctance or inability to seek help can be explained by a variety of factors, from high cost, poor quality and limited accessibility, through to lack of knowledge about mental health, stigma and poor previous experiences with seeking help.

The sections that follow summarize some of the biggest barriers to demand for care worldwide.

3.4.1 Poor supply

There is a close relationship between demand and supply of mental health care. Each of the gaps described previously (gaps in information, governance, resources and services) compromise the supply of appropriate, good quality mental health care. Yet, the lack of quality mental health services available, especially at the primary and secondary levels of care, in turn suppresses demand.

In many places, formal mental health services simply do not exist. Even when they are available, they are often inaccessible. Concerns about location, cost, treatment and confidentiality can all drive up reluctance to seek help.

Locating services appropriately is key. In LMICs many mental health services are disproportionately concentrated in psychiatric hospitals in or near major cities. This means that rural populations often cannot or choose not to use them: the journey may be too expensive; the transportation systems may be too unreliable; and the time required may be too much.

Even for those living near mental health services, the cost of treatment can prove a major barrier to demand for mental health care. Two-thirds of low-income countries reporting to WHO in 2020 did not include mental health care in national health insurance schemes *(5)*. This means that people in need have to fund their care themselves, often spending significant and potentially impoverishing sums out of pocket. Research in Ethiopia, India, Nepal and Nigeria shows that spending money on mental health care significantly increases the likelihood of a household outspending its resources, which can lead to debt and poverty *(148)*. One study in Goa, India, showed that depressed women were three times more likely than other women to spend more than half their monthly household expenditure on out-of-pocket health care costs *(149)*.

Weak or low-quality care systems pose another barrier to demand. Negative past experiences with mental health services, distrust of health professionals and treatment and unwillingness to disclose mental health problems can all play a big part in preventing help-seeking. Many people, faced with the option of no care versus contacting services that may offer little help, may not be confidential, or may stigmatize or even mistreat them, choose to go untreated.

Two-thirds
of low-income countries did not include mental health in national health insurance schemes.

3.4.2 Low levels of health literacy about mental health

Low demand for mental health care can also be driven by low levels of health literacy

about mental health, including a lack of knowledge and understanding of mental health as well as prevailing beliefs and attitudes that undermine the value placed on mental health and effective mental health care.

When it comes to physical health, it is widely accepted that people need to appreciate and look after their own health, and that governments can help to inform and support people, for example by promoting physical activity, healthy diets and no tobacco and alcohol use. This approach is just as important for mental health.

A recent global survey by the Wellcome Trust found that most people around the world believe mental health is as or more important than physical health *(150)*. Yet the idea that mental health is something everyone needs to understand and nurture is not part of the common public discourse in most communities.

The reality is that most people may not have access to evidence-based information on opportunities that can promote their mental health. Meanwhile, pervasive negative attitudes continue to devalue and perpetuate discrimination against and abuse of people living with mental health conditions.

The above mentioned global survey shows that people are not sure science can help in addressing mental health issues *(150)*. In many cases, people do not recognize their own need for treatment (read Steven's experience).

Caregivers may not have access to tailored information to recognize mental health conditions in their children, especially when these manifest as stomachaches, headaches, irritability, frustration, anger, rapid mood changes and emotional outbursts, and destructive or challenging behaviour. General health care providers can also often miss these symptoms of mental health problems *(151)*.

Differences in beliefs across cultures influence help-seeking outside the formal health system, for example through traditional or complementary medicine or self-reliance *(152)*. All societies probably have terms and concepts to describe people with mental health conditions, but ideas about how or why these conditions arise vary markedly.

Similarly, the need to provide dedicated support for people with severe mental health conditions is widely acknowledged, but ideas about what that support should look like may not match prevailing evidence-based treatments. For example, in many cultural contexts, common mental health conditions such as depression and anxiety are not regarded as health conditions that can be helped through the formal health care system. Rather, these conditions are often expected to improve through social and emotional support from relatives or through religious, traditional or alternative and complementary healing methods *(153)*.

3.4.3 Stigma

One of the biggest barriers to demand for mental health care is the stigma associated with mental health conditions. All over the world, people living with mental health conditions are the subject of deep-rooted stigma and discrimination.

> *All over the world, people living with mental health conditions are the subject of deep-rooted stigma and discrimination.*

Society in general has stereotyped views about mental health conditions and how they affect people. People with mental health conditions are commonly assumed to be lazy, weak, unintelligent or difficult *(154)*. They are also often believed to be violent and dangerous, when in fact they are more at risk of being attacked or harming themselves than harming other people *(155)*. Women with

The result is that people living with mental health conditions are often treated with fear, shame and contempt. For example, one survey in south-west Nigeria found that 97% of people believed people with mental health conditions were dangerous, 83% of people were afraid to talk to someone with a mental health condition and only 17% of people would consider marrying someone with a mental health condition *(157)*. In many cases, people with mental health conditions are also subject to human rights violations including isolation, incarceration and ill-treatment (see section 4.2 Promoting and protecting human rights).

The stigma attached to mental health conditions is universal, pervading across cultures and contexts in countries everywhere. People living with mental health conditions can experience stigma from families, neighbours, and from health professionals themselves *(158)*. In some cases, they can internalize negative messages and stereotypes and apply them to themselves in what is known as self-stigma. In many countries stigma extends to working in mental health care and can contribute to staff shortages in mental health systems *(158)*.

People will often choose to suffer mental distress without relief, rather than risk the discrimination and ostracization that comes with accessing mental health services (read Odireleng's experience). Yet with the right support, most people with severe mental health conditions can function at a very high social and economic level, maintaining excellent relationships and functioning well in employment.

NARRATIVE

Stigma stifled my recovery

Odireleng's experience

For the longest time I was afraid of speaking about my battle with mental health because of the stigma attached to it. My healing only began when I overcame the stigma and realized there is no shame in asking for help.

When I was diagnosed in 2014, I was very afraid, lonely and didn't believe that healing was possible. The single-sided story of bipolar illness that was narrated in my community focused only on the struggles it caused, rather than how to overcome them.

Even after diagnosis, I had a very difficult time and low self-esteem. But I remained hopeful and I made a pledge to myself to use the lessons I'd learned to help others. As part of my recovery I became a mental health advocate.

I am passionate about encouraging people to begin their healing by overcoming stigma and speaking up openly about their mental health condition. I strongly believe that it is possible to overcome the barrier of stigma and receive mental health care that enables you to lead a prosperous life.

Odireleng Kasale, Botswana