Mental health

Key facts

- **Affordable, effective and feasible strategies exist to promote, protect and restore mental health.**
- **The need for action on mental health is indisputable and urgent.**
- **Mental health has intrinsic and instrumental value and is integral to our well-being.**
- **Mental health is determined by a complex interplay of individual, social and structural stresses and vulnerabilities.**

Concepts in mental health

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.

Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.

Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm. 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.

Determinants of mental health

Throughout our lives, multiple individual, social and structural determinants may combine to protect or undermine our mental health and shift our position on the mental health continuum.

Individual psychological and biological factors such as emotional skills, substance use and genetics can make people more vulnerable to mental health problems.

Exposure to unfavorable social, economic, geopolitical and environmental circumstances – including poverty, violence, inequality and environmental deprivation – also increases people's 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. For example, harsh parenting and physical punishment is known to undermine child health and bullying is a leading risk factor for mental health conditions.

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 neighborhoods and community cohesion, among others.

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 include economic downturns, disease outbreaks, humanitarian emergencies and forced displacement and the growing climate crisis.

Each single risk and protective factor has only limited predictive strength. Most people do not develop a mental health condition despite exposure to a risk factor and many people with no known risk factor still develop a mental health condition. Nonetheless, the interacting determinants of mental health serve to enhance or undermine mental health.

Mental health promotion and prevention

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 and so promotion and prevention programmes should involve education, labor, justice, transport, environment, housing, and welfare sectors. The health sector can contribute significantly by embedding promotion and prevention efforts within health services; and by advocating, initiating and, where appropriate, facilitating multi-sectoral collaboration and coordination.

Suicide prevention is a global priority and included in the Sustainable Development Goals. Much progress can be achieved by limiting access to means, responsible media reporting, social and emotional learning for adolescents and early intervention. Banning highly hazardous pesticides is a particularly inexpensive and cost–effective intervention for reducing suicide rates.

Promoting child and adolescent mental health is another priority and can be achieved by policies and laws that promote and protect mental health, supporting caregivers to provide nurturing care, implementing school-based programmes and improving the quality of community and online environments. School-based social and emotional learning programmes are among the most effective promotion strategies for countries at all income levels.

Promoting and protecting mental health at work is a growing area of interest and can be supported through legislation and regulation, organizational strategies, manager training and interventions for workers.

Mental health care and treatment

In the context of national efforts to strengthen mental health, it is vital to not only protect and promote the mental well-being of all, but also to address the needs of people with mental health conditions.

This should be done through community-based mental health care, which is more accessible and acceptable than institutional care, helps prevent human rights violations and delivers better recovery outcomes for people with mental health conditions. Community-based mental health care should be provided through a network of interrelated services that comprise:

- mental health services that are integrated in general health care, typically in general hospitals and through task-sharing with non-specialist care providers in primary health care;
- community mental health services that may involve community mental health centers and teams, psychosocial rehabilitation, peer support services and supported living services; and
- services that deliver mental health care in social services and non-health settings, such as child protection, school health services, and prisons.

The vast care gap for common mental health conditions such as depression and anxiety means countries must also find innovative ways to diversify and scale up care for these conditions, for example through non-specialist psychological counselling or digital self-help.

WHO response

All WHO Member States are committed to implementing the “Comprehensive mental health action plan 2013–2030", which aims to improve mental health by strengthening effective leadership and governance, providing comprehensive, integrated and responsive community-based care, implementing promotion and prevention strategies, and strengthening information systems, evidence and research. In 2020, WHO’s “Mental health atlas 2020” analysis of country performance against the action plan showed insufficient advances against the targets of the agreed action plan.

WHO’s “World mental health report: transforming mental health for all” calls on all countries to accelerate implementation of the action plan. It argues that all countries can achieve meaningful progress towards better mental health for their populations by focusing on three “paths to transformation”:

- deepen the value given to mental health by individuals, communities and governments; and matching that value with commitment, engagement and investment by all stakeholders, across all sectors;
- 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; and
- 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 supports.

WHO gives particular emphasis to protecting and promoting human rights, empowering people with lived experience and ensuring a multisectoral and multistakeholder approach.

WHO continues to work nationally and internationally – including in humanitarian settings – to provide governments and partners with the strategic leadership, evidence, tools and technical support to strengthen a collective response to mental health and enable a transformation towards better mental health for all.

Mental health in emergencies

Key facts

- **Almost all people affected by emergencies will experience psychological distress, which for most people will improve over time.**
- **Among people who have experienced war or other conflict in the previous 10 years, one in five (22%) will have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia.**
- **People with severe mental disorders are especially vulnerable during emergencies and need access to mental health care and other basic needs.**
- **International guidelines recommend services at a number of levels–from basic services to clinical care–and indicate that mental health care needs to be made available immediately for specific, urgent mental health problems as part of the health response.**
- **Despite their tragic nature and adverse effects on mental health, emergencies have shown to be opportunities to build sustainable mental health systems for all people in need.**

Types of problems

There are various types of social and mental health problems in any large emergency.

Social problems:

- pre-existing: e.g. poverty and discrimination of marginalized groups;
- emergency-induced: e.g. family separation, lack of safety, loss of livelihoods, disrupted social networks, and low trust and resources; and
- humanitarian response-induced: e.g. overcrowding, lack of privacy, and undermining of community or traditional support.

Mental health problems:

- pre-existing: e.g. mental disorders such as depression, schizophrenia or harmful use of alcohol;
- emergency-induced: e.g. grief, acute stress reactions, harmful use of alcohol and drugs, and depression and anxiety, including post-traumatic stress disorder; and
- humanitarian response-induced: e.g. anxiety due to a lack of information about food distribution or about how to obtain basic services.

Prevalence

Most people affected by emergencies will experience distress (e.g. feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability or anger and/or aches and pains).

This is normal and will for most people improve over time. However, the prevalence of common mental disorders such as depression and anxiety is expected to more than double in a humanitarian crisis.

The burden of mental disorders among conflict-affected populations is extremely high: WHO's review of 129 studies in 39 countries showed that among people who have experienced war or other conflict in the previous 10 years, one in five people (22%) will have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia (1).

According to WHO's review, the estimated prevalence of mental disorders among conflict- affected populations at any specific point in time (point prevalence) is 13% for mild forms of depression, anxiety, and post-traumatic stress disorder and 4% for moderate forms of these disorders. The estimated point prevalence for severe disorders (i.e. schizophrenia, bipolar disorder, severe depression, severe anxiety, and severe post-traumatic stress disorder) is 5%. It is estimated that one in 11 people (9%) living in a setting that has been exposed to conflict in the previous 10 years will have a moderate or severe mental disorder.

In conflict-affected settings, depression and anxiety increase with age. Depression is more common in women than in men.

People with severe mental disorders can be especially vulnerable during and after emergencies and they need access to basic needs and clinical care. A review published in 2014 of the health information system from 90 refugee camps across 15 low- and middle-income countries found that 41% of health-care visits for mental, neurological and substance use disorders were for epilepsy/seizures, 23% for psychotic disorders, and 13% for moderate and severe forms of depression, anxiety or post-traumatic stress disorder.

Effective emergency response

WHO-endorsed interagency mental health and psychosocial support guidelines for an effective response to emergencies recommend services at a number of levels – from basic services to clinical care. Clinical care for mental health should be provided by or under the supervision of mental health specialists such as psychiatric nurses, psychologists or psychiatrists.

Community self-help and social support should be strengthened, for example by creating or re-establishing community groups in which members solve problems collaboratively and engage in activities such as emergency relief or learning new skills, while ensuring the involvement of people who are vulnerable and marginalized, including people with mental disorders.

Psychological first aid offers first-line emotional and practical support to people experiencing acute distress due to a recent event and should be made available by field workers, including health staff, teachers or trained volunteers.

Basic clinical mental health care covering priority conditions (e.g. depression, psychotic disorders, epilepsy, alcohol and substance abuse) should be provided at every health-care facility by trained and supervised general health staff.

Psychological interventions (e.g. problem-solving interventions, group interpersonal therapy, interventions based on the principles of cognitive-behavioral therapy) for people impaired by prolonged distress should be offered by specialists or by trained and supervised community workers in the health and social sector.

Protecting and promoting the rights of people with severe mental health conditions and psychosocial disabilities is especially critical in humanitarian emergencies. This includes visiting, monitoring and supporting people at psychiatric facilities and residential homes.

Links and referral mechanisms need to be established between mental health specialists, general health-care providers, community-based support and other services (e.g. schools, social services and emergency relief services such as those providing food, water and housing/shelter).

Looking forward: emergencies can build better mental health systems

Mental health is crucial to the overall social and economic recovery of individuals, societies, and countries after emergencies.

Global progress on mental health reform will happen more quickly if, during every crisis, efforts are initiated to convert the short-term increase in attention to mental health issues combined with a surge of aid, into momentum for long-term service development. Many countries have capitalized on emergency situations to build better mental health systems after crises.

In the Syrian Arab Republic, despite — or perhaps because of — the challenges presented by the ongoing conflict, mental health services and psychosocial support are becoming more widely available than ever before. Mental health and psychosocial support is now offered in primary and secondary health and social care facilities, through community and women's centers and through school-based programmes, in more than 12 Syrian cities located in governorates severely affected by the conflict. This contrasts with the situation before the conflict, when mental health care was mainly provided in mental hospitals in Aleppo and Damascus.

In Sri Lanka, during the immediate aftermath of the 2004 tsunami, mental health was a key priority. This led to a mental health system reform, supported by WHO, which addressed the shortage of human resources for mental health such as different cadres of dedicated mental health staff. As a result, 20 of the country's 27 districts now have mental health services infrastructure, compared with only 10 before the tsunami.

When Typhoon Haiyan devastated the Philippines in 2013, there were only two facilities that provided basic mental health services and the number of people able to provide support was insufficient to meet the need. A major scale up of government mental health services was supported by WHO and partners. As a result, 100% of the Philippines general health facilities in the affected region now have staff who are trained in the management of mental disorders.

Mental health should also be a component of national disaster preparedness plans. WHO and the Pan-American Health Organization are supporting countries in the Caribbean sub-region of the Americas so that they will be able to provide adequate mental health and psychosocial support to people in need following hurricanes and other natural disasters.

In many humanitarian and conflict settings, access to quality, affordable mental health care is limited. This access can be further diminished due to public health emergencies such as COVID-19, which tend to disrupt services and increase needs further.

WHO response

WHO is the lead agency in providing technical advice on mental health in emergency situations. In 2022 WHO is operational on mental health in a range of countries and territories affected by large-scale emergencies such as Afghanistan, Bangladesh, Ethiopia, Iraq, Jordan, Lebanon, Libya, Nigeria, South Sudan, the Syrian Arab Republic, Turkey, Ukraine, the West Bank and Gaza Strip and Yemen.

WHO co-chairs the IASC Reference Group on Mental Health and Psychosocial Support (MHPSS)in Emergency Settings that provides advice and support to organizations working in emergencies and to country-level MHPSS technical working groups in more than 50 countries affected by emergencies.

The Organization works globally to ensure that the humanitarian mental health response is both coordinated and effective, and that following humanitarian emergencies, all efforts are made to build/rebuild mental health services for the long-term.

WHO's advice and tools are used by most large international humanitarian organizations active in mental health. WHO and partners have published a range of practical tools and guidelines to meet the mental health needs of people affected by emergencies.

1. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis

Mental health and forced displacement

Key facts

- **There were an estimated 272 million international migrants in 2019 (1). Refugees, asylum seekers and irregular migrants are of special concern and need protection and support.**
- **Migrants and refugees can be exposed to various stress factors which affect their mental health and well-being before and during their migration journey and during their settlement and integration.**
- **The prevalence of common mental disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD) tends to be higher among migrants exposed to adversity and refugees than among host populations.**
- **Many migrants and refugees lack access to mental health services or experience barriers in accessing these. They also face disruptions in continuity of care.**
- **The mental health needs of migrants and refugees should be addressed by organizing inclusive and accessible promotion and prevention programmes; strengthening mental health as part of general health services; and ensuring timely diagnosis, treatment, and rehabilitation.**
- **Migrants and refugees contribute positively to society, but they cannot reach their full potential unless they are in good physical and mental health.**

Problems and stressors facing migrants and refugees

Migrants and refugees often face various problems and stressors which can take place at various stages of the migration process:

Pre-migration: lack of livelihoods and opportunities for education and development, exposure to armed conflict, violence, poverty and/or persecution.

Migration travel and transit: exposure to challenging and life-threatening conditions including violence and detention and lack of access to services to cover their basic needs.

Post-migration: barriers to accessing health care and other services to meet their basic needs as well as poor living conditions, separation from family members and support networks, possible uncertainty regarding work permits and legal status (asylum application), and in some cases immigration detention.

Integration and settlement: poor living or working conditions, unemployment, assimilation difficulties, challenges to cultural, religious, and gender identities, challenges with obtaining entitlements, changing policies in host countries, racism and exclusion, tension between host population and migrants and refugees, social isolation and possible deportation.

Risk and protective factors for mental health conditions

All of the above-mentioned stressors can increase the risk of developing mental health conditions. For example, unemployment, poor socioeconomic conditions, and lack of social integration among migrants and refugees are risk factors for mental health conditions such as depression. At the same time, these stressors can also exacerbate pre-existing social and mental health problems.

Factors that negatively impact the mental health and well-being of migrant and refugee children include socioeconomic deprivation, discrimination, racism, low family cohesion, and frequent school changes. Children who have been separated from migrating parents are at heightened risk of developing depression, anxiety, suicidal ideation, conduct disorder, and substance use problems.

On the other hand, the impact of stressors can be buffered by protective factors such as access to employment and services, social support, proficiency in the language of the host country, and family reunification. Among resettled refugee children, protective factors include better socioeconomic status, access to education, a perceived sense of safety, contacts with family, living and socializing alongside other people of the same ethnic origin, a stable and cohesive family structure and good parental mental health.

Prevalence of mental health conditions

Many migrants and refugees will experience distress (e.g. feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability, anger and/or aches and pains). For most people, these reactions will improve over time.

Some studies show that the prevalence of common mental disorders (e.g. depression, anxiety and post-traumatic stress disorder (PTSD)) is higher among migrants and refugees than among host populations. Asylum seekers tend to be at elevated risk of suicide. There is also consistent evidence that the incidence of psychoses is higher among migrant populations in a number of countries, and this has been linked with the cumulative effect of social disadvantages before, during and after migration.

Responding to the mental health needs of migrants and refugees

A comprehensive, multi-disciplinary and inclusive approach is needed to address the mental health needs of migrants and refugees.

Overcoming barriers to receiving mental health care

Addressing barriers to receiving mental health care should include:

- provision of clear information on mental health care entitlements and how to receive services (e.g. through reception centers, community outreach, schools, religious or cultural settings);
- outreach to at-risk groups (e.g. unaccompanied minors, persons with disabilities, persons who identify as LGBTIQ+);
- facilitation of affordable and non-discriminatory access to care regardless of legal status, ensuring financial coverage of mental health services and care provided;
- facilitation of communication (e.g. through engaging interpreters and cultural mediators);
- providing person-centered care that is respectful of cultural differences; and
- facilitating the engagement of multiple sectors and systems (e.g. law enforcement, protection, social services and education) to integrate mental health considerations and support and ensure referral and access to mental health services.

Integrating mental health in primary health care

Making mental health care available through general health care can help identify migrants and refugees with mental health conditions and can make care more accessible and cost effective (e.g. see WHO mhGAP intervention guides mhGAP-HIG and mhGAP-IG). The delivery of interventions may require adaptation to migrant and refugee

populations to take into account language and cultural considerations. Interventions provided should be consistent with the national guidelines and policies on mental health of the host country.

Ensuring continuity of care

When providing mental health care, an important consideration is related to the length of stay of the migrant or refugee in the host country. The continuity and quality of mental health care of migrants and refugees on the move can be improved by creating international protocols for assuring continuity of care, improving communication among different social and mental health service providers and providing key written information tailored to their needs that migrants and refugees can take with them and share with different providers.

Addressing social determinants and promoting social integration and inclusion

Migration management policies and provision that have proved to have a negative effect on the mental well-being of migrants (e.g. separation of families and children) should be avoided. The social integration of migrants and refugees can be facilitated by equal access to employment opportunities and decent work, vocational training, financial support, social protection services, and legal and law enforcement agencies, as well as mental health care and psychosocial support. The recognition of skills and qualifications acquired pre-migration can also help their integration into the employment sector. Activities and events that promote the social inclusion of migrants and refugees include community forums or peer-mentorship programmes organized by members of the same refugee or migrant group who are already well-integrated into the local community. Special attention is required to support asylum seekers.

WHO response

WHO is the lead International agency in providing technical advice on mental health.

WHO developed a Global Action Plan (2019-2023) to promote the health of migrants and refugees, approved by the World Health Assembly in May 2019. The Global Action Plan describes overarching priorities and guiding principles to promote the health of migrants and refugees and to contribute to achieving the aim of the 2030 Agenda for Sustainable Development – to leave no one behind. The Global Action Plan highlights how the many barriers that migrants and refugees experience in accessing health-care services can precipitate negative mental health outcomes.

The plan recommends priorities and options for action by the Secretariat in coordination and collaboration with the International Organization for Migration (IOM), the United Nations High Commissioner for Refugees (UNHCR) and other relevant partners.

In May 2021, the World Health Assembly endorsed an update of the Comprehensive Mental Health Action Plan (2013-2030), with the overall goal to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability of persons with mental disorders.

WHO is committed to supporting Member States in promoting the physical and mental health of migrants and refugees by strengthening health care services, as appropriate and acceptable to country contexts and financial situations, and in line with their national priorities and legal frameworks and competence. WHO is also committed to ensuring that essential components are addressed, including the provision of treatment and care for mental and behavioral disorders.

In line with the Global Action Plan, WHO is operational on mental health in a range of countries and territories that host large numbers of migrants and refugees. These include Bangladesh, Colombia, Pakistan, Iraq, Jordan, Lebanon, Libya, Pakistan, South Sudan, Sudan, Turkey and Uganda.

WHO has close working relationship with other UN partners, including IOM and UNHCR to meet the mental health needs of migrants and refugees.

WHO co-chairs the Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support in Emergency Settings that provides advice and support to organizations working in emergencies and helps ensure that the mental health response is coordinated and effective. Emergency situations often cause displacement and may lead to people becoming refugees or internally displaced.

WHO's advice and tools are used by most large international humanitarian organizations active in mental health. WHO and partners have published a range of practical tools and guidelines to meet the mental health needs of people affected by emergencies, including migrants and refugees.

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(1) World Migration Report 2020. International Organization for Migration, Geneva.

Mental health at work

Key facts

- Decent work is good for mental health.
- Poor working environments – including discrimination and inequality, excessive workloads, low job control and job insecurity – pose a risk to mental health.
- 15% of working-age adults were estimated to have a mental disorder in 2019.
- Globally, an estimated 12 billion working days are lost every year to depression and anxiety at a cost of US$ 1 trillion per year in lost productivity.
- There are effective actions to prevent mental health risks at work, protect and promote mental health at work, and support workers with mental health conditions.

Overview

Almost 60% of the world population is in work (1). All workers have the right to a safe and healthy environment at work. Work can protect mental health. Decent work supports good mental health by providing:

- a livelihood;
- a sense of confidence, purpose and achievement;
- an opportunity for positive relationships and inclusion in a community; and
- a platform for structured routines, among many other benefits.

For people with mental health conditions, decent work can contribute to recovery and inclusion, improve confidence and social functioning.

Safe and healthy working environments are not only a fundamental right but are also more likely to minimize tension and conflicts at work and improve staff retention, work performance and productivity. Conversely, a lack of effective structures and support at work, especially for those living with mental health conditions, can affect a person's ability to enjoy their work and do their job well; it can undermine people's attendance at work and even stop people getting a job in the first place.

Risks to mental health at work

At work, risks to mental health, also called psychosocial risks, may be related to job content or work schedule, specific characteristics of the workplace or opportunities for career development among other things.

Risks to mental health at work can include:

- under-use of skills or being under-skilled for work;
- excessive workloads or work pace, understaffing;
- long, unsocial or inflexible hours;
- lack of control over job design or workload;
- unsafe or poor physical working conditions;

- organizational culture that enables negative behaviours;
- limited support from colleagues or authoritarian supervision;
- violence, harassment or bullying;
- discrimination and exclusion;
- unclear job role;
- under- or over-promotion;
- job insecurity, inadequate pay, or poor investment in career development; and
- conflicting home/work demands.

More than half the global workforce works in the informal economy (2), where there is no regulatory protection for health and safety. These workers often operate in unsafe working environments, work long hours, have little or no access to social or financial protections and face discrimination, all of which can undermine mental health.

Although psychosocial risks can be found in all sectors, some workers are more likely to be exposed to them than others, because of what they do or where and how they work. Health, humanitarian or emergency workers often have jobs that carry an elevated risk of exposure to adverse events, which can negatively impact mental health.

Economic recessions or humanitarian and public health emergencies elicit risks such as job loss, financial instability, reduced employment opportunities or increased unemployment.

Work can be a setting which amplifies wider issues that negatively affect mental health, including discrimination and inequality based on factors such as, race, sex, gender identity, sexual orientation, disability, social origin, migrant status, religion or age.

People with severe mental health conditions are more likely to be excluded from employment, and when in employment, they are more likely to experience inequality at work. Being out of work also poses a risk to mental health. Unemployment, job and financial insecurity, and recent job loss are risk factors for suicide attempts.

Action for mental health at work

Government, employers, the organizations which represent workers and employers, and other stakeholders responsible for workers' health and safety can help to improve mental health at work through action to:

- prevent work-related mental health conditions by preventing the risks to mental health at work;
- protect and promote mental health at work;
- support workers with mental health conditions to participate and thrive in work; and
- create an enabling environment for change.

Action to address mental health at work should be done with the meaningful involvement of workers and their representatives, and persons with lived experience of mental health conditions.

Prevent work-related mental health conditions

Preventing mental health conditions at work is about managing psychosocial risks in the workplace. WHO recommends employers do this by implementing organizational interventions that directly target working conditions and environments. Organizational interventions are those that assess, and then mitigate, modify or remove workplace risks to mental health. Organizational interventions include, for example, providing flexible working arrangements, or implementing frameworks to deal with violence and harassment at work.

Protect and promote mental health at work

Protecting and promoting mental health at work is about strengthening capacities to recognize and act on mental health conditions at work, particularly for persons responsible for the supervision of others, such as managers.

To protect mental health, WHO recommends:

- **manager training for mental health**, which helps managers recognize and respond to supervisees experiencing emotional distress; builds interpersonal skills like open communication and active listening; and fosters better understanding of how job stressors affect mental health and can be managed;
- **training for workers** in mental health literacy and awareness, to improve knowledge of mental health and reduce stigma against mental health conditions at work; and
- **interventions for individuals** to build skills to manage stress and reduce mental health symptoms, including psychosocial interventions and opportunities for leisure-based physical activity.

Support people with mental health conditions to participate in and thrive at work

People living with mental health conditions have a right to participate in work fully and fairly. The UN Convention on the Rights of Persons with Disabilities provides an international agreement for promoting the rights of people with disabilities (including psychosocial disabilities), including at work. WHO recommends three interventions to support people with mental health conditions gain, sustain and participate in work:

- **Reasonable accommodations** at work adapt working environments to the capacities, needs and preferences of a worker with a mental health condition. They may include giving individual workers flexible working hours, extra time to complete tasks, modified assignments to reduce stress, time off for health appointments or regular supportive meetings with supervisors.

- **Return-to-work programmes** combine work-directed care (like reasonable accommodations or phased re-entry to work) with ongoing clinical care to support workers in meaningfully returning to work after an absence associated with mental health conditions, while also reducing mental health symptoms.
- **Supported employment initiatives** help people with severe mental health conditions to get into paid work and maintain their time on work through continue to provide mental health and vocational support.

Create an enabling environment for change

Both governments and employers, in consultation with key stakeholders, can help improve mental health at work by creating an enabling environment for change. In practice this means strengthening:

- **Leadership** and commitment to mental health at work, for example by integrating mental health at work into relevant policies.
- **Investment** of sufficient funds and resources, for example by establishing dedicated budgets for actions to improve mental health at work and making mental health and employment services available to lower-resourced enterprises.
- **Rights** to participate in work, for example by aligning employment laws and regulations with international human rights instruments and implementing non-discrimination policies at work.
- **Integration** of mental health at work across sectors, for example by embedding mental health into existing systems for occupational safety and health.
- **Participation** of workers in decision-making, for example by holding meaningful and timely consultations with workers, their representatives and people with lived experience of mental health conditions.
- **Evidence** on psychosocial risks and effectiveness of interventions, for example by ensuring that all guidance and action on mental health at work is based on the latest evidence.
- **Compliance** with laws, regulations and recommendations, for example by integrating mental health into the responsibilities of national labour inspectorates and other compliance mechanisms.

WHO response

WHO is committed to improving mental health at work. The WHO global strategy on health, environment and climate change and WHO Comprehensive mental health action plan (2013–2030) outline relevant principles, objectives and implementation strategies to enable good mental health in the workplace. These include addressing social determinants of mental health, such as living standards and working conditions; reducing stigma and discrimination; and increasing access to evidence-based care through health service development, including access to occupational health services. In 2022, WHO's World mental health report: transforming mental health for all, highlighted the workplace as a key example of a setting where transformative action on mental health is needed.

The WHO guidelines on mental health at work provide evidence-based recommendations to promote mental health, prevent mental health conditions, and enable people living with mental health conditions to participate and thrive in work. The recommendations cover organizational interventions, manager training and worker training, individual interventions, return to work, and gaining employment. The accompanying policy brief by WHO and the International Labour Organization, Mental health at work: policy brief provides a pragmatic framework for implementing the WHO recommendations. It specifically sets out what governments, employers, organizations representing employers and workers, and other stakeholders can do to improve mental health at work.

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1. World employment and social outlook - Trends 2022. Geneva: International Labour Organization; 2022 (https://www.ilo.org/global/research/global-reports/weso/trends2022/WCMS_834081/lang--en/index.htm, accessed 26 August 2022)
2. Women and men in the informal economy: a statistical picture. Geneva: International Labour Organization; 2018 (https://www.ilo.org/global/publications/books/WCMS_626831/lang--en/index.htm, accessed 26 August 2022).

Related

Guidelines on mental health at work
Policy brief on mental health at work
Comprehensive mental health action plan 2013–2030
World mental health report: transforming mental health for all
WHO global strategy on health, environment and climate change

More about mental health

WHO's work on mental health
Learn more about mental health
World Mental Health Day

Mental health of adolescents

Key facts

- **Globally, one in seven 10-19-year-olds experiences a mental disorder, accounting for 15% of the global burden of disease in this age group.**
- **Depression, anxiety and behavioral disorders are among the leading causes of illness and disability among adolescents.**
- **Suicide is the third leading cause of death among those aged 15–29 years old.**
- **The consequences of failing to address adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults.**

Introduction

One in six people are aged 10–19 years. Adolescence is a unique and formative time. Physical, emotional and social changes, including exposure to poverty, abuse, or violence, can make adolescents vulnerable to mental health problems. Protecting adolescents from adversity, promoting socio-emotional learning and psychological well-being, and ensuring access to mental health care are critical for their health and well-being during adolescence and adulthood.

Globally, it is estimated that one in seven (14%) of 10–19-year-olds experience mental health conditions (1), yet these remain largely unrecognized and untreated.

Adolescents with mental health conditions are particularly vulnerable to social exclusion, discrimination, stigma (affecting readiness to seek help), educational difficulties, risk-taking behaviors, physical ill-health and human rights violations.

Mental health determinants

Adolescence is a crucial period for developing social and emotional habits important for mental well-being. These include adopting healthy sleep patterns; exercising regularly; developing coping, problem-solving, and interpersonal skills; and learning to manage emotions. Protective and supportive environments in the family, at school and in the wider community are important.

Multiple factors affect mental health. The more risk factors adolescents are exposed to, the greater the potential impact on their mental health. Factors that can contribute to stress during adolescence include exposure to adversity, pressure to conform with peers and exploration of identity. Media influence and gender norms can exacerbate the disparity between an adolescent's lived reality and their perceptions or aspirations for the future. Other important determinants include the quality of their home life and relationships with peers. Violence (especially sexual violence and bullying), harsh parenting and severe and socioeconomic problems are recognized risks to mental health.

Some adolescents are at greater risk of mental health conditions due to their living conditions, stigma, discrimination or exclusion, or lack of access to quality support and services. These include adolescents living in humanitarian and fragile settings; adolescents with chronic illness, autism spectrum disorder, an intellectual disability or other neurological condition; pregnant adolescents, adolescent parents, or those in early or forced marriages; orphans; and adolescents from minority ethnic or sexual backgrounds or other discriminated groups.

Emotional disorders

Emotional disorders are common among adolescents. Anxiety disorders (which may involve panic or excessive worry) are the most prevalent in this age group and are more common among older than among younger adolescents. It is estimated that 4.4% of 10–14-year-olds and 5.5% of 15–19-year-olds experience an anxiety disorder (1). Depression is estimated to occur among 1.4% of adolescents aged 10–14 years, and 3.5% of 15–19-year-olds (1). Depression and anxiety share some of the same symptoms, including rapid and unexpected changes in mood.

Anxiety and depressive disorders can profoundly affect school attendance and schoolwork. Social withdrawal can exacerbate isolation and loneliness. Depression can lead to suicide.

Behavioral disorders

Behavioral disorders are more common among younger adolescents than older adolescents. Attention deficit hyperactivity disorder (ADHD), characterized by difficulty paying attention and/or excessive activity and acting without regard to consequences, occurs among 2.9% of 10–14-year-olds and 2.2% of 15–19-year-olds (1). Conduct disorder (involving symptoms of destructive or challenging behavior) occurs among 3.5% of 10–14-year-olds and 1.9% of 15–19-year-olds (1). Behavioral disorders can affect adolescents' education and increases the risk of criminal behavior.

Eating disorders

Eating disorders, such as anorexia nervosa and bulimia nervosa, commonly emerge during adolescence and young adulthood. Eating disorders involve abnormal eating behavior and preoccupation with food, accompanied in most instances by concerns about body weight and shape. Girls are more commonly affected than boys. Eating disorders can affect physical health and often co-exist with depression, anxiety and substance use disorders. They occur in an estimated 0.1% of 10–14-year-olds and and 0.4% of 15–19-year-olds (1). They are associated with suicide. Anorexia nervosa can lead to premature death, often due to medical complications or suicide, and has higher mortality than any other mental disorder.

Psychosis

Conditions that include symptoms of psychosis most commonly emerge in late adolescence or early adulthood. Symptoms can include hallucinations or delusions. These experiences can impair an adolescent's ability to participate in daily life and education and often lead to stigma or human rights violations. Schizophrenia occurs in 0.1% of 15–19-year-olds (1).

Suicide and self-harm

Suicide is the third leading cause of death in older adolescents and young adults (15–29 years) (2). Risk factors for suicide are multifaceted, and include harmful use of alcohol, abuse in childhood, stigma against help-seeking, barriers to accessing care and access to means of suicide. Digital media, like any other media, can play a significant role in either enhancing or weakening suicide prevention efforts.

Risk-taking behaviors

Many risk-taking behaviors for health, such as substance use or sexual risk-taking, start during adolescence. Risk-taking behaviors can be an unhelpful strategy to cope with emotional difficulties and can severely impact an adolescent's mental and physical well-being.

Young people are especially vulnerable to developing harmful substance use patterns that can persist across the lifespan. In 2019, the prevalence of alcohol use among 15–19-year-olds was high worldwide (22%) with very few gender differences, and showing an increase in consumption in some regions (3).

The use of tobacco and cannabis are additional concerns. Many adult smokers had their first cigarette prior to the age of 18 years. In 2022, the prevalence of cannabis use among adolescents was higher than that of adults globally (5.5 per cent compared with 4.4 per cent, respectively) (4).

Perpetration of violence is a risk-taking behavior that can increase the likelihood of low educational attainment, injury, involvement with crime or death.

Interpersonal violence was ranked among the leading causes of death of older adolescents in 2021 (1).

Promotion and prevention

Mental health promotion and prevention interventions aim to strengthen an individual's capacity to regulate emotions, enhance alternatives to risk-taking behaviors, build resilience for managing difficult situations and adversity, and promote supportive social environments and social networks.

These programmes require a multi-level approach with varied delivery platforms – for example, digital media, health or social care settings, schools or the community – and varied strategies to reach adolescents, particularly the most vulnerable.

Early detection and treatment

It is crucial to address the needs of adolescents with mental health conditions. Avoiding institutionalization and over-medicalization, prioritizing non-pharmacological approaches, and respecting the rights of children in line with the United Nations Convention on the Rights of the Child and other human rights instruments are key for adolescents' mental health.

WHO response

WHO works on strategies, programmes and tools to assist governments in responding to the health needs of adolescents.

For example, the Helping Adolescents Thrive (HAT) Initiative is a joint WHO-UNICEF effort to strengthen policies and programmes for the mental health of adolescents. More specifically, the efforts made through the Initiative are to promote mental health and prevent mental health conditions. They are also intended to help prevent self-harm and other risk behaviors, such as harmful use of alcohol and drugs, that have a negative impact on the mental – and physical – health of young people.

WHO has also developed a module on Child and Adolescent Mental and Behavioral Disorders as part of the mhGAP Intervention Guide 2.0. This Guide provides evidence-based clinical protocols for the assessment and management of a range of mental health conditions in non-specialized care settings.

Furthermore, WHO is developing and testing scalable psychological interventions to address emotional disorders of adolescents, and guidance on mental health services for adolescents.

WHO's Regional Office for the Eastern Mediterranean has developed a mental health training package for educators for improved understanding of the importance of mental health in the school setting and to guide the

implementation of strategies to promote, protect and restore mental health among their students. It includes training manuals and materials to help scale up the number of schools promoting mental health.

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Mental health of older adults

Key facts

- **By 2030, one in six people in the world will be aged 60 years or over.**
- **Loneliness and social isolation are key risk factors for mental health conditions in later life.**
- **One in six older adults experience abuse, often by their own carers.**
- **Approximately 14% of adults aged 60 and over live with a mental disorder.**
- **Mental disorders among older adults account for 10.6% of the total years lived with disability for this age group.**

Overview

The world's population is ageing fast. In 2020, 1 billion people in the world were aged 60 years or over. That figure will rise to 1.4 billion by 2030, representing one in six people globally. By 2050, the number of people aged 60 years and over will have doubled to reach 2.1 billion. The number of persons aged 80 years or older is expected to triple between 2020 and 2050 to reach 426 million (1).

Older adults contribute to society as family and community members, and many are volunteers and workers. While most have good health, many are at risk of developing mental health conditions such as depression and anxiety disorders. Many may also experience reduced mobility, chronic pain, frailty, dementia or other health problems, for which they require some form of long-term care. As people age, they are more likely to experience several conditions at the same time.

Prevalence

Around 14% of adults aged 60 and over live with a mental disorder (2). According to the Global Health Estimates (GHE) 2019, these conditions account for 10.6% of the total disability (in disability adjusted life years, DALYs) among older adults. The most common mental health conditions for older adults are depression and anxiety. GHE 2019 shows that globally, around a quarter of deaths from suicide (27.2%) are among people aged 60 or over.

Mental health conditions among older people are often underrecognized and undertreated, and the stigma surrounding these conditions can make people reluctant to seek help.

Risk factors

At older ages, mental health is shaped not only by physical and social environments but also by the cumulative impacts of earlier life experiences and specific stressors related to ageing. Exposure to adversity, significant loss in intrinsic capacity and a decline in functional ability can all result in psychological distress.

Older adults are more likely to experience adverse events such as bereavement, or a drop in income or reduced sense of purpose with retirement. Despite their many contributions to society, many older adults are subject to ageism, which can seriously affect people's mental health.

Social isolation and loneliness, which affect about a quarter of older people, are key risk factors for mental health conditions in later life (3). So too is abuse of older people, which includes any kind of physical, verbal, psychological, sexual or financial abuse, as well as neglect. One in six older adults experience abuse, often by their own carers (4). Abuse of older adults has serious consequences and can lead to depression and anxiety.

Many older people are carers of spouses with chronic health conditions, such as dementia. The responsibilities of such care can be overwhelming and can affect the carer's mental health.

Some older adults are at greater risk of depression and anxiety, because of dire living conditions, poor physical health or lack of access to quality support and services. This includes older adults living in humanitarian settings and those living with chronic illnesses (such as heart disease, cancer or stroke), neurological conditions (such as dementia), or substance use problems.

Promotion and prevention

Mental health promotion and prevention strategies for older adults focus on supporting healthy ageing. That means creating physical and social environments that support well-being and enable people to do what is important to them, despite losses in capacity.

Key mental health promotion and prevention strategies for healthy ageing include:

- measures to reduce financial insecurity and income inequality;

- programmes to ensure safe and accessible housing, public buildings and transport;
- social support for older adults and their carers;
- support for healthy behaviours, especially to eat a balanced diet, be physically active, refrain from tobacco and reduce alcohol use; and
- health and social programmes targeted at vulnerable groups such as those who live alone or in remote areas and those living with a chronic health condition.

For older adults, social connection is particularly important to reduce risk factors such as social isolation and loneliness. At this stage of life, meaningful social activities can significantly improve positive mental health, life satisfaction and quality of life; they can also reduce depressive symptoms. Example interventions include befriending initiatives, community and support groups, social skills training, creative arts groups, leisure and education services and volunteering programmes.

Protection from ageism and abuse is also critical. Key interventions include anti-discrimination policies and laws, educational interventions and intergenerational activities. A range of carer interventions – including respite care, advice, education, financial support and psychological interventions – can support carers to maintain a good and healthy caring relationship that avoids abuse of older people.

Treatment and care

Prompt recognition and treatment of mental health conditions (and associated neurological and substance use conditions) in older adults is essential. This should follow standards for integrated care for older people, which is community-based and focused on both the long-term care of older adults living with mental health conditions and declines in intrinsic capacity, as well as the education, training and support of carers. A mix of mental health interventions are usually recommended, alongside other supports to address the health, personal care and social needs of individuals.

Dementia is often an important concern. It affects people's mental health (for example, sparking symptoms of psychosis and depression), and requires access to quality mental health care.

Responding to the abuse of older adults is also critical. Promising interventions include mandatory reporting of abuse, self-help groups, helplines and emergency shelters, psychological programmes for abusers, training of health care providers and other caregiver support interventions.

WHO response

WHO works with diverse partners on strategies, programmes and tools to support governments respond to the mental health needs of older adults.

For example, the Decade of Healthy Ageing (2021–2030) is a global collaboration led by WHO to improve the lives of older people, their families and the communities in which they live.

WHO Member States have also endorsed the Comprehensive mental health action plan 2013–2030, which supports improved mental health and mental health care for all populations, including older adults.

WHO's Mental Health Gap Action Programme (mhGAP) provides evidence-based clinical protocols for assessing, managing and following up a set of priority mental, neurological and substance use conditions in non-specialized settings, including depression and dementia. The mhGAP intervention guide includes clinical tips for working with older adults.

During the COVID-19 pandemic, WHO and partners in the Inter-Agency-Standing Committee (IASC) developed the Living with the times toolkit of illustrated posters to help older adults maintain good mental health and well-being. Other WHO activities to support the mental health of older adults include the development of scalable psychological interventions to address depression and anxiety, research and guidance on interventions to reduce social isolation and loneliness, and cost–effective solutions to prevent abuse of older adults.

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Mental disorders

Key facts

- **1 in every 8 people in the world live with a mental disorder**
- **Mental disorders involve significant disturbances in thinking, emotional regulation, or behaviour**
- **There are many different types of mental disorders**
- **Effective prevention and treatment options exist**
- **Most people do not have access to effective care**

A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning. There are many different types of mental disorders. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm. This fact sheet focuses on mental disorders as described by the International Classification of Diseases 11th Revision (ICD-11).

In 2019, 1 in every 8 people, or 970 million people around the world were living with a mental disorder, with anxiety and depressive disorders the most common (1). In 2020, the number of people living with anxiety and depressive disorders rose significantly because of the COVID-19 pandemic. Initial estimates show a 26% and 28% increase respectively for anxiety and major depressive disorders in just one year (2). While effective prevention and treatment options exist, most people with mental disorders do not have access to effective care. Many people also experience stigma, discrimination and violations of human rights.

Anxiety Disorders

In 2019, 301 million people were living with an anxiety disorder including 58 million children and adolescents (1). Anxiety disorders are characterised by excessive fear and worry and related behavioural disturbances. Symptoms are severe enough to result in significant distress or significant impairment in functioning. There are several different kinds of anxiety disorders, such as: generalised anxiety disorder (characterised by excessive worry), panic disorder (characterised by panic attacks), social anxiety disorder (characterised by excessive fear and worry in social situations), separation anxiety disorder (characterised by excessive fear or anxiety about separation from those individuals to whom the person has a deep emotional bond), and others. Effective psychological treatment exists, and depending on the age and severity, medication may also be considered.

Depression

In 2019, 280 million people were living with depression, including 23 million children and adolescents (1). Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. During a depressive episode, the person experiences depressed mood (feeling sad, irritable, empty) or a loss of pleasure or interest in activities, for most of the day, nearly every day, for at least two weeks. Several other symptoms are also present, which may include poor concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, thoughts about dying or suicide, disrupted sleep, changes in appetite or weight, and feeling especially tired or low in energy. People with depression are at an increased risk of suicide. Yet, effective psychological treatment exists, and depending on the age and severity, medication may also be considered.

Bipolar Disorder

In 2019, 40 million people experienced bipolar disorder (1). People with bipolar disorder experience alternating depressive episodes with periods of manic symptoms. During a depressive episode, the person experiences depressed mood (feeling sad, irritable, empty) or a loss of pleasure or interest in activities, for most of the day, nearly every day. Manic symptoms may include euphoria or irritability, increased activity or energy, and other symptoms such as increased talkativeness, racing thoughts, increased self-esteem, decreased need for sleep, distractibility, and impulsive reckless behaviour. People with bipolar disorder are at an increased risk of suicide. Yet effective treatment options exist including

psychoeducation, reduction of stress and strengthening of social functioning, and medication.

Post-Traumatic Stress Disorder (PTSD)

The prevalence of PTSD and other mental disorders is high in conflict-affected settings (3). PTSD may develop following exposure to an extremely threatening or horrific event or series of events. It is characterised by all of the following: 1) re-experiencing the traumatic event or events in the present (intrusive memories, flashbacks, or nightmares); 2) avoidance of thoughts and memories of the event(s), or avoidance of activities, situations, or people reminiscent of the event(s); and 3) persistent perceptions of heightened current threat. These symptoms persist for at least several weeks and cause significant impairment in functioning. Effective psychological treatment exists.

Schizophrenia

Schizophrenia affects approximately 24 million people or 1 in 300 people worldwide (1). People with schizophrenia have a life expectancy 10-20 years below that of the general population (4). Schizophrenia is characterised by significant impairments in perception and changes in behaviour. Symptoms may include persistent delusions, hallucinations, disorganised thinking, highly disorganised behaviour, or extreme agitation. People with schizophrenia may experience persistent difficulties with their cognitive functioning. Yet, a range of effective treatment options exist, including medication, psychoeducation, family interventions, and psychosocial rehabilitation.

Eating Disorders

In 2019, 14 million people experienced eating disorders including almost 3 million children and adolescents (1). Eating disorders, such as anorexia nervosa and bulimia nervosa, involve abnormal eating and preoccupation with food as well as prominent body weight and shape concerns. The symptoms or behaviours result in significant risk or damage to health, significant distress, or significant impairment of functioning. Anorexia nervosa often has its onset during adolescence or early adulthood and is associated with premature death due to medical complications or suicide. Individuals with bulimia nervosa are at a significantly increased risk for substance use, suicidality, and health complications. Effective treatment options exist, including family-based treatment and cognitive-based therapy.

Disruptive behaviour and dissocial disorders

40 million people, including children and adolescents, were living with conduct-dissocial disorder in 2019 (1). This disorder, also known as conduct disorder, is one of two disruptive behaviour and dissocial disorders, the other is oppositional defiant disorder. Disruptive behaviour and dissocial disorders are characterised by persistent behaviour problems such as persistently defiant or disobedient to behaviours that persistently violate the basic rights of others or major age-appropriate societal norms, rules, or laws. Onset of disruptive and dissocial

disorders, is commonly, though not always, during childhood. Effective psychological treatments exist, often involving parents, caregivers, and teachers, cognitive problem-solving or social skills training.

Neurodevelopmental disorders

Neurodevelopmental disorders are behavioural and cognitive disorders, that~~?~~ arise during the developmental period, and involve significant difficulties in the acquisition and execution of specific intellectual, motor, language, or social functions.

Neurodevelopmental disorders include disorders of intellectual development, autism spectrum disorder, and attention deficit hyperactivity disorder (ADHD) amongst others. ADHD is characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity that has a direct negative impact on academic, occupational, or social functioning. Disorders of intellectual development are characterised by significant limitations in intellectual functioning and adaptive behaviour, which refers to difficulties with everyday conceptual, social, and practical skills that are performed in daily life. Autism spectrum disorder (ASD) constitutes a diverse group of conditions characterised by some degree of difficulty with social communication and reciprocal social interaction, as well as persistent restricted, repetitive, and inflexible patterns of behaviour, interests, or activities.

Effective treatment options exist including psychosocial interventions, behavioural interventions, occupational and speech therapy. For certain diagnoses and age groups, medication may also be considered.

Who is at risk from developing a mental disorder?

At any one time, a diverse set of individual, family, community, and structural factors may combine to protect or undermine mental health. Although most people are resilient, people who are exposed to adverse circumstances – including poverty, violence, disability, and inequality – are at higher risk. Protective and risk factors include individual psychological and biological factors, such as emotional skills as well as genetics. Many of the risk and protective factors are influenced through changes in brain structure and/or function.

Health systems and social support

Health systems have not yet adequately responded to the needs of people with mental disorders and are significantly under resourced. The gap between the need for treatment and its provision is wide all over the world; and is often poor in quality when delivered. For example, only 29% of people with psychosis (5) and only one third of people with depression receive formal mental health care (6).

People with mental disorders also require social support, including support in developing and maintaining personal, family, and social relationships. People

with mental disorders may also need support for educational programmes, employment, housing, and participation in other meaningful activities.

WHO response

WHO's Comprehensive Mental Health Action Plan 2013-2030 recognizes the essential role of mental health in achieving health for all people. The plan includes 4 major objectives:

- to strengthen effective leadership and governance for mental health;
- to provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
- to implement of strategies for promotion and prevention in mental health; and
- to strengthen information systems, evidence, and research for mental health.

WHO's Mental Health Gap Action Programme (mhGAP) uses evidence-based technical guidance, tools and training packages to expand services in countries, especially in resource-poor settings. It focuses on a prioritized set of conditions, directing capacity building towards non-specialized health-care providers in an integrated approach that promotes mental health at all levels of care. The WHO mhGAP Intervention Guide 2.0 is part of this Programme, and provides guidance for doctors, nurses, and other health workers in non-specialist health settings on assessment and management of mental disorders.

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Anxiety disorders

Key facts

- Anxiety disorders are the world's most common mental disorders, affecting 301 million people in 2019.
- More women are affected by anxiety disorders than men.
- Symptoms of anxiety often have onset during childhood or adolescence.
- There are highly effective treatments for anxiety disorders.
- Approximately 1 in 4 people with anxiety disorders receive treatment for this condition.

Overview

Everyone can feel anxious sometimes, but people with anxiety disorders often experience fear and worry that is both intense and excessive. These feelings are typically accompanied by physical tension and other behavioural and cognitive symptoms. They are difficult to control, cause significant distress and can last a long time if untreated. Anxiety disorders interfere with daily activities and can impair a person's family, social and school or working life.

An estimated 4% of the global population currently experience an anxiety disorder (1). In 2019, 301 million people in the world had an anxiety disorder, making anxiety disorders the most common of all mental disorders (1).

Although highly effective treatments for anxiety disorders exist, only about 1 in 4 people in need (27.6%) receive any treatment (2). Barriers to care include lack of awareness that this is a treatable health condition, lack of investment in mental health services, lack of trained health care providers, and social stigma.

Symptoms and patterns

People with an anxiety disorder may experience excessive fear or worry about a specific situation (for example, a panic attack or social situation) or, in the case of generalized anxiety disorder, about a broad range of everyday situations. They typically experience these symptoms over an extended period – at least several months. Usually they avoid the situations that make them anxious.

Other symptoms of anxiety disorders may include:

- trouble concentrating or making decisions
- feeling irritable, tense or restless
- experiencing nausea or abdominal distress
- having heart palpitations
- sweating, trembling or shaking
- trouble sleeping
- having a sense of impending danger, panic or doom.

Anxiety disorders increase the risk for depression and substance use disorders as well as the risk of suicidal thoughts and behaviours.

There are several different kinds of anxiety disorders, including:

- generalized anxiety disorder (persistent and excessive worry about daily activities or events);
- panic disorder (panic attacks and fear of continued panic attacks);
- social anxiety disorder (high levels of fear and worry about social situations that might make the person feel humiliated, embarrassed or rejected);
- agoraphobia (excessive fear, worry and avoidance of situations that might cause a person to panic or feel trapped, helpless or embarrassed);
- separation anxiety disorder (excessive fear or worry about being separated from people with whom the person has a deep emotional bond);
- specific phobias (intense, irrational fears of specific objects or situations that lead to avoidance behaviour and significant distress); and

- selective mutism (consistent inability to speak in certain social situations, despite the ability to speak comfortably in other settings, primarily affecting children).

People may experience more than one anxiety disorder at the same time. Symptoms often begin during childhood or adolescence and continue into adulthood. Girls and women are more likely to experience an anxiety disorder than boys and men.

Contributing factors and prevention

Anxiety disorders, like other mental health conditions, result from a complex interaction of social, psychological and biological factors. Anyone can have an anxiety disorder, but people who have lived through abuse, severe losses or other adverse experiences are more likely to develop one.

Anxiety disorders are closely related to and affected by physical health. Many of the impacts of anxiety (such as physical tension, nervous system hyperactivity or harmful use of alcohol) are also known risk factors for diseases such as cardiovascular disease. In turn, people with these diseases may also find themselves experiencing anxiety disorders due to the difficulties associated with managing their conditions.

Effective community based approaches to prevent anxiety include parental education and school-based programmes to enhance social and emotional learning and build positive coping in children and adolescents. Exercise programmes can also be effective in preventing anxiety disorders in adults.

Diagnosis and treatment

There are several effective treatments for anxiety disorders. People with symptoms of anxiety should seek care.

Psychological interventions are essential treatments for anxiety disorders and refer primarily to talk therapy with professionals or supervised lay therapists. These interventions can help people learn new ways of thinking, coping or relating to their anxiety, to others or to the world. They can teach people how to face the situations, events, people or places that trigger their anxiety.

Psychological interventions can be provided to individuals or groups, in person or online. They may also be accessed through self-help manuals, websites and apps. The psychological interventions with the most evidence for treating a range of anxiety disorders are those based on principles of cognitive-behavioural therapy. These include exposure therapy, during which people learn to face their fears.

In addition, learning stress management skills, such as relaxation skills and mindfulness skills, can help reduce symptoms of anxiety disorders.

Antidepressant medications, such as selective serotonin reuptake inhibitors (SSRIs), can also be useful in treating adults with anxiety disorders. Health-care providers should keep in mind the possible adverse effects associated with antidepressant medication, the ability to deliver either intervention (in terms of expertise, and/or treatment availability), and individual preferences.

Benzodiazepines, which have historically been prescribed for anxiety disorders, are generally not recommended for anxiety disorders because of their high potential for dependence as well as their limited long-term effectiveness.

Self-care

Self-care can play an important role in supporting treatment. To help manage your symptoms of anxiety and promote your overall well-being, you can:

- avoid or cut down on alcohol and don’t use illicit drugs, which can make anxiety worse;
- exercise regularly, even if it’s just a short walk;
- stick to regular eating and sleeping habits as much as possible and eat a healthy diet;
- learn relaxation techniques, such as slow breathing and progressive muscle relaxation; and
- develop the habit of mindfulness meditation, even if it’s just a few minutes per day.

WHO response

WHO’s Comprehensive mental health action plan 2013–2030 highlights the steps required to provide appropriate interventions for people with mental health conditions, including anxiety disorders.

Generalized anxiety disorder and panic disorder are included in the priority conditions covered by WHO's mhGAP Programme. This programme aims to help countries increase services for people with mental, neurological and substance use disorders through care provided by health workers who are not specialists in mental health.

WHO has developed brief psychological intervention manuals that may be delivered by lay therapists to individuals and groups. These interventions have been shown to be effective for multiple mental health problems, including anxiety and depression. An example is the Problem management plus (PM+) manual, which is based on principles of cognitive behavioural therapy and uses techniques like stress management, problem solving treatment and strengthening social support. Additionally, the Self-Help Plus (SH+) group-based stress management course and WHO's popular Doing What Matters in Times of Stress self-help book describe skills that can be used to reduce anxiety and stress.

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Bipolar disorder

Key facts

- Bipolar disorder is a mental health condition that affects a person's mood, energy, activity and thought and is characterized by manic (or hypomanic) and depressive episodes.
- An estimated 40 million people live with bipolar disorder worldwide.
- Bipolar disorder is associated with significant disability and difficulties in many areas of life.
- Many people with bipolar disorder are misdiagnosed or untreated and experience discrimination and stigma.
- There are a range of effective care options, which combine medicines and psychosocial interventions to help people with bipolar disorder stay well.

Overview

In 2019, approximately 1 in 150 adults (40 million people, or 0.53% of the global population) were living with bipolar disorder (1). The condition is primarily observed among working-age people, but also in youth. While the prevalence of bipolar disorder among men and women is approximately equal, available data indicate that women are more often diagnosed.

Worldwide, the treatment coverage for people with bipolar disorder is low. Both men and women are often misdiagnosed. Many lack access to services and recommended interventions, especially in low- and middle-income countries (LMICs).

Stigma and discrimination against people with bipolar disorder are widespread, both in communities and health services. This can undermine access to health care. It also fuels social exclusion and can limit opportunities for education, employment and housing.

Bipolar disorder is one of the leading causes of disability globally as it can affect many areas of life. People with bipolar disorder may experience strained relationships, problems at school or work, and difficulties in carrying out daily activities. Having bipolar disorder also increases the risk of suicide and of developing anxiety and substance use disorders.

People with bipolar disorder are more likely to smoke, use alcohol, have a physical health condition (e.g. cardiovascular or respiratory disease), and experience difficulties in accessing health care. On average, people with bipolar disorder die more than 10 years earlier than the general population (2).

Symptoms and patterns

Bipolar disorder is a mental health condition characterized by mood swings from one extreme to another.

During a manic episode, a person experiences an extremely high mood with lots of energy (feeling very happy, excited, overactive). They may have a sense of euphoria, sudden shifts in mood or an excess of emotion (uncontrollable laughing or feeling much more irritable, agitated or restless than usual).

In manic episodes, the changes in mood and activities are accompanied by other characteristic symptoms, which may include:

- highly inflated sense of self-worth or self-esteem;
- talking quickly and rapidly shifting from one idea to the next;
- having trouble concentrating and being easily distracted;
- decreased need for sleep;
- reckless or risk-taking behaviour, for example overspending, risky sexual activity, drinking, or harming oneself or others; and
- fixed and mistaken grandiose or persecutory beliefs in something untrue (e.g. “I am a very famous person”, “My neighbour is spying on me”).

On the contrary, during a depressive episode, a person experiences a depressed mood (feeling sad, irritable, empty). They may feel a loss of interest or pleasure in activities that they had previously enjoyed.

Other symptoms are also present, which may include:

- poor concentration
- feelings of excessive guilt or low self-worth
- hopelessness about the future
- thoughts about dying or suicide
- disrupted sleep
- changes in appetite or weight
- feeling very tired or low in energy.

A depressive episode is different from mood fluctuations commonly experienced by most people, in that the symptoms last most of the day, nearly every day, for at least two weeks.

Both manic and depressive episodes can cause significant difficulties in all aspects of life, including at home, work and school. They may require specialized care to prevent the person from doing harm to themselves or others.

Some people with bipolar disorder may experience what are called hypomanic episodes. Hypomanic episodes involve similar symptoms to manic episodes, but the symptoms are less intense and do not typically disrupt the person's ability to function to the same extent.

There are two main types of bipolar disorder, depending on patterns of manic or hypomanic and depressive episodes.

- People with **bipolar type I disorder** experience one or more manic episodes interspaced with episodes of depression which usually become more common over time (compared with manic episodes).
- People with **bipolar type II disorder** have had one or more hypomanic episodes and at least one depressive episode, but no history of manic episodes.

Risks and protective factors

The exact cause of bipolar disorder is unknown. Several factors – including biological (e.g. genetic), psychological, social and structural factors – may contribute to its onset, trajectory and outcomes.

Adverse circumstances or life-altering events can trigger or exacerbate the symptoms of bipolar disorder. These may include bereavement, violence or the breakdown of a relationship. The use of alcohol or drugs can also influence the onset and trajectory of bipolar disorder.

Although employment can be a source of stress for people living with bipolar disorder, it can also be protective. Under good working conditions, and when supported at their workplace with reasonable adjustments, employment can promote recovery by improving functioning, reducing symptoms and leading to a higher quality of life and improved self-esteem.

Treatment and care

Even though symptoms often recur, recovery is possible. With appropriate care, people with bipolar disorder can cope with their symptoms and live meaningful and productive lives.

There are a range of effective treatment options, typically a mix of medicines and psychological and psychosocial interventions. Medicines are considered essential for treatment, but themselves are usually insufficient to achieve full recovery. People with bipolar disorder should be treated with respect and dignity and should be meaningfully involved in care choices, including through shared decision-making regarding treatment and care, balancing effectiveness, side-effects and individual preferences.

Medicines

People with bipolar disorder need treatment and care across acute episodes of mania and depression and when indicated, longer-term treatment to prevent relapse.

Mood stabilizers (such as lithium, valproate) and antipsychotics are proven to help manage acute mania. Lithium prescription requires clinical and laboratory monitoring. Girls and women who are pregnant, breastfeeding or have childbearing potential should not use valproate. Lithium and carbamazepine also need to be avoided during pregnancy and breastfeeding whenever possible.

Antidepressants should not be taken during a manic episode and they may be combined with mood stabilizers or antipsychotics during episodes of depression.

Some medicines for bipolar disorder can make people feel sleepy, have involuntary muscle spasms or tremors, or experience metabolic changes (e.g. involving weight gain). These side effects can affect adherence to treatment and should be monitored and managed.

Adults with bipolar disorder who are in complete remission (no symptoms) usually need to continue with mood stabilizers or antipsychotic medicines for at least six months. Those experiencing multiple episodes of mania and depression will usually require longer-term treatment to minimize relapses.

Psychological and psychosocial interventions

People with bipolar disorder can benefit from lifestyle changes involving regular sleep, physical activity, a healthy diet, reduction of stressors, and mood monitoring.

Psychological interventions (e.g. cognitive behavioural therapy, interpersonal therapy, psychoeducation) can effectively reduce depressive symptoms and the possibility of them coming back.

Family psychoeducation can also help families understand and support their loved one better. Support from family and friends is very important. Support groups – where people can receive encouragement, learn coping skills, and share experiences – can be helpful to people with bipolar disorder and their families.

Recovery-oriented psychosocial interventions include supported employment, supported housing, peer support, and social and life skills training. They serve to promote hope and to support the autonomy, personal empowerment and social inclusion of people with bipolar disorder.

Medicines and psychological or psychosocial interventions should be tailored to the needs of the person and combined for best outcomes.

WHO response

The Comprehensive Mental Health Action Plan 2013-2030 highlights the steps needed to provide appropriate services for people with mental health conditions, including bipolar disorder. The WHO Special Initiative for Mental Health aims to further progress

towards the plan's objectives by ensuring 100 million more people can access quality and affordable care for mental health conditions.

WHO's Mental Health Gap Action Programme (mhGAP), which is being implemented in more than 100 countries, provides evidence-based technical guidance, tools and training packages to build capacities and expand treatment coverage for a set of priority conditions, including bipolar disorder, in non-specialized settings in LMICs.

WHO's guidelines on Management of physical health conditions in adults with severe mental disorders provide evidence-based recommendations to practitioners on how to recognize and manage comorbid physical and mental health conditions, including bipolar disorder.

WHO's QualityRights initiative aims to improve the quality of care and human rights standards in mental health and social care facilities and to empower organizations to advocate for the health of people with mental health conditions, including bipolar disorder.

The Guidance on community mental health services and person-centred and rights-based approaches describes what person-centred and human rights-based approaches look like in mental health, and give examples of good practice services.

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Related

- mhGAP guideline for mental, neurological and substance use disorders
- mhGAP Intervention Guide - Version 2.
- World Mental Health Report: transforming mental health for al
- More on mental health

Depressive disorder (depression)

Key facts

- **Depression is a common mental disorder.**
- **Globally, an estimated 5% of adults suffer from depression.**
- **More women are affected by depression than men.**
- **Depression can lead to suicide.**
- **There is effective treatment for mild, moderate and severe depression.**

Overview

Depressive disorder (also known as depression) is a common mental disorder. It involves a depressed mood or loss of pleasure or interest in activities for long periods of time.

Depression is different from regular mood changes and feelings about everyday life. It can affect all aspects of life, including relationships with family, friends and community. It can result from or lead to problems at school and at work.

Depression can happen to anyone. People who have lived through abuse, severe losses or other stressful events are more likely to develop depression. Women are more likely to have depression than men.

An estimated 3.8% of the population experience depression, including 5% of adults (4% among men and 6% among women), and 5.7% of adults older than 60 years. Approximately 280 million people in the world have depression (1). Depression is about 50% more common among women than among men. Worldwide, more than 10% of pregnant women and women who have just given birth experience depression (2). More than 700 000 people die due to suicide every year. Suicide is the fourth leading cause of death in 15–29-year-olds.

Although there are known, effective treatments for mental disorders, more than 75% of people in low- and middle-income countries receive no treatment (3). Barriers to effective care include a lack of investment in mental health care, lack of trained health-care providers and social stigma associated with mental disorders.

Symptoms and patterns

During a depressive episode, a person experiences a depressed mood (feeling sad, irritable, empty). They may feel a loss of pleasure or interest in activities.

A depressive episode is different from regular mood fluctuations. They last most of the day, nearly every day, for at least two weeks.

Other symptoms are also present, which may include:

- poor concentration
- feelings of excessive guilt or low self-worth
- hopelessness about the future
- thoughts about dying or suicide
- disrupted sleep
- changes in appetite or weight
- feeling very tired or low in energy.

Depression can cause difficulties in all aspects of life, including in the community and at home, work and school.

A depressive episode can be categorized as mild, moderate, or severe depending on the number and severity of symptoms, as well as the impact on the individual's functioning.

There are different patterns of depressive episodes including:

- single episode depressive disorder, meaning the person's first and only episode;
- recurrent depressive disorder, meaning the person has a history of at least two depressive episodes; and
- bipolar disorder, meaning that depressive episodes alternate with periods of manic symptoms, which include euphoria or irritability, increased activity or energy, and other symptoms such as increased talkativeness, racing thoughts, increased self-esteem, decreased need for sleep, distractibility, and impulsive reckless behaviour.

Contributing factors and prevention

Depression results from a complex interaction of social, psychological, and biological factors. People who have gone through adverse life events (unemployment, bereavement, traumatic events) are more likely to develop depression. Depression can, in turn, lead to more stress and dysfunction and worsen the affected person's life situation and the depression itself.

Depression is closely related to and affected by physical health. Many of the factors that influence depression (such as physical inactivity or harmful use of alcohol) are also known risk factors for diseases such as cardiovascular disease,

cancer, diabetes and respiratory diseases. In turn, people with these diseases may also find themselves experiencing depression due to the difficulties associated with managing their condition.

Prevention programmes have been shown to reduce depression. Effective community approaches to prevent depression include school-based programmes to enhance a pattern of positive coping in children and adolescents. Interventions for parents of children with behavioural problems may reduce parental depressive symptoms and improve outcomes for their children. Exercise programmes for older persons can also be effective in depression prevention.

Diagnosis and treatment

There are effective treatments for depression. These include psychological treatment and medications. Seek care if you have symptoms of depression.

Psychological treatments are the first treatments for depression. They can be combined with antidepressant medications in moderate and severe depression. Antidepressant medications are not needed for mild depression.

Psychological treatments can teach new ways of thinking, coping or relating to others. They may include talk therapy with professionals and supervised lay therapists. Talk therapy can happen in person or online. Psychological treatments may be accessed through self-help manuals, websites and apps.

Effective psychological treatments for depression include:

- behavioural activation
- cognitive behavioural therapy
- interpersonal psychotherapy
- problem-solving therapy.

Antidepressant medications include selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine.

Health-care providers should keep in mind the possible adverse effects associated with antidepressant medication, the ability to deliver either intervention (in terms of expertise, and/or treatment availability), and individual preferences.

Antidepressants should not be used for treating depression in children and are not the first line of treatment in adolescents, among whom they should be used with extra caution.

Different medications and treatments are used for bipolar disorder.

Self-care

Self-care can play an important role in managing symptoms of depression and promoting overall well-being.

What you can do:

- try to keep doing activities you used to enjoy
- stay connected to friends and family
- exercise regularly, even if it’s just a short walk
- stick to regular eating and sleeping habits as much as possible
- avoid or cut down on alcohol and don’t use illicit drugs, which can make depression worse
- talk to someone you trust about your feelings
- seek help from a healthcare provider.

If you have thoughts of suicide:

- remember you are not alone, and that many people have gone through what you’re experiencing and found help
- talk to someone you trust about how you feel
- talk to a health worker, such as a doctor or counsellor
- join a support group.

If you think you are in immediate danger of harming yourself, contact any available emergency services or a crisis line.

WHO response

WHO's Mental health action plan 2013–2030 highlights the steps required to provide appropriate interventions for people with mental disorders including depression.

Depression and self-harm/suicide are among the priority conditions covered by WHO's Mental Health Gap Action Programme (mhGAP). The Programme aims to help countries increase services for people with mental, neurological and substance use disorders through care provided by health workers who are not specialists in mental health.

WHO has developed brief psychological intervention manuals for depression that may be delivered by lay therapists to individuals and groups. An example is the Problem management plus (PM+) manual, which describes the use of behavioural activation, stress management, problem solving treatment and strengthening social support. Moreover, the Group interpersonal therapy for depression manual describes group treatment of depression. Finally, the Thinking healthy manual covers the use of cognitive-behavioural therapy for perinatal depression.

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Schizophrenia

Key facts

- **Schizophrenia causes psychosis and is associated with considerable disability and may affect all areas of life including personal, family, social, educational, and occupational functioning.**
- **Stigma, discrimination, and violation of human rights of people with schizophrenia are common.**
- **More than two out of three people with psychosis in the world do not receive specialist mental health care.**
- **A range of effective care options for people with schizophrenia exist and at least one in three people with schizophrenia will be able to fully recover.**

Symptoms

Schizophrenia is characterized by significant impairments in the way reality is perceived and changes in behavior related to:

- persistent delusions: the person has fixed beliefs that something is true, despite evidence to the contrary;
- persistent hallucinations: the person may hear, smell, see, touch, or feel things that are not there;
- experiences of influence, control or passivity: the experience that one's feelings, impulses, actions, or thoughts are not generated by oneself, are being placed in one's mind or withdrawn from one's mind by others, or that one's thoughts are being broadcast to others;
- disorganized thinking, which is often observed as jumbled or irrelevant speech;
- highly disorganized behavior e.g. the person does things that appear bizarre or purposeless, or the person has unpredictable or inappropriate emotional responses that interfere with their ability to organize their behavior;
- "negative symptoms" such as very limited speech, restricted experience and expression of emotions, inability to experience interest or pleasure, and social withdrawal; and/or
- extreme agitation or slowing of movements, maintenance of unusual postures.

People with schizophrenia often also experience persistent difficulties with their cognitive or thinking skills, such as memory, attention, and problem-solving.

At least one third of people with schizophrenia experiences complete remission of symptoms (1). Some people with schizophrenia experience worsening and remission of symptoms periodically throughout their lives, others a gradual worsening of symptoms over time.

Magnitude and impact

Schizophrenia affects approximately 24 million people or 1 in 300 people (0.32%) worldwide. This rate is 1 in 222 people (0.45%) among adults (2). It is not as common as many other mental disorders. Onset is most often during late adolescence and the twenties, and onset tends to happen earlier among men than among women.

Schizophrenia is frequently associated with significant distress and impairment in personal, family, social, educational, occupational, and other important areas of life.

People with schizophrenia are 2 to 3 times more likely to die early than the general population (3). This is often due to physical illnesses, such as cardiovascular, metabolic, and infectious diseases.

People with schizophrenia often experience human rights violations both inside mental health institutions and in community settings. Stigma against people with this condition is intense and widespread, causing social exclusion, and impacting their relationships with others, including family and friends. This contributes to discrimination, which in turn can limit access to general health care, education, housing, and employment.

During humanitarian and public health emergencies, extreme stress and fear, breakdown of social supports, isolation and disruption of health-care services and supply of medication can occur. These changes can have an impact on the lives of people with schizophrenia, such as exacerbation of existing symptoms. During emergencies, people with schizophrenia are more vulnerable than others to various human rights violations, including neglect, abandonment, homelessness, abuse and exclusion.

Causes of schizophrenia

Research has not identified one single cause of schizophrenia. It is thought that an interaction between genes and a range of environmental factors may cause schizophrenia. Psychosocial factors may also affect the onset and course of schizophrenia. Heavy use of cannabis is associated with an elevated risk of the disorder.

Services

Currently, the vast majority of people with schizophrenia around the world are not receiving mental health care. Approximately 50% of people in mental hospitals have a schizophrenia diagnosis (4). Only 31.3% of people with psychosis receive specialist mental health care (5). Most resources for mental health services are inefficiently spent on care within mental hospitals.

There is clear evidence that mental hospitals are not effective in providing the care that people with mental health conditions need and, regularly, violate the basic human rights of persons with schizophrenia. Efforts to transfer care from mental health institutions to the community need to be expanded and accelerated. Such efforts start with the development of a range of quality community-based mental health services. Options for community-based mental health care include integration in primary health and general hospital care, community mental health centers, day centers, supported housing, and outreach services for home-based support. The engagement of the person with schizophrenia, family members and the wider community in providing support is important.

Management and support

A range of effective care options for people with schizophrenia exist, and these include medication, psychoeducation, family interventions, cognitive-behavioral therapy and psychosocial rehabilitation (e.g., life skills training). Facilitated assisted living, supported housing and supported employment are essential care options that should be available for people with schizophrenia. A recovery-oriented approach – giving people agency in treatment decisions – is essential for people with schizophrenia and for their families and/or caregivers as well.

WHO response

WHO's Comprehensive Mental Health Action Plan 2013-2030 highlights the steps required to provide appropriate services for people with mental disorders including schizophrenia. A key recommendation of the Action Plan is to shift services from institutions to the community. The WHO Special Initiative for Mental Health aims to further progress

towards objectives of the Comprehensive Mental Health Action Plan 2013-2030 by ensuring 100 million more people have access to quality and affordable care for mental health conditions.

WHO's Mental Health Gap Action Programme (mhGAP) uses evidence-based technical guidance, tools and training packages to expand service in countries, especially in resource-poor settings. It focuses on a prioritized set of conditions, including psychosis, directing capacity building towards non-specialized health-care providers in an integrated approach that promotes mental health at all levels of care. Currently mhGAP is being implemented in more than 100 WHO Member States.

The WHO Quality Rights Project involves improving the quality of care and human rights conditions in mental health and social care facilities and to empower organizations to advocate for the health of people with mental health conditions and psychosocial disabilities.

The WHO guidance on community mental health services and person-centered and rights-based approaches provides information and support to all stakeholders who wish to develop or transform their mental health system and services to align with international human rights standards including the UN Convention on the Rights of Persons with Disabilities.

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Suicide

Key facts

- More than 720 000 people die due to suicide every year.
- Suicide is the third leading cause of death among 15–29-year-olds.
- Seventy-three per cent of global suicides occur in low- and middle-income countries.
- The reasons for suicide are multi-faceted, influenced by social, cultural, biological, psychological, and environmental factors present across the life-course.
- For every suicide there are many more people who attempt suicide. A prior suicide attempt is an important risk factor for suicide in the general population.

Overview

Every year 726 000 people take their own life and there are many more people who make suicide attempts. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind. Suicide occurs throughout the lifespan and was the third leading cause of death among 15–29-year-olds globally in 2021.

Suicide does not just occur in high-income countries but is a global phenomenon in all regions of the world. In fact, close to three quarters (73%) of global suicides occurred in low- and middle-income countries in 2021.

Suicide is a serious public health problem that requires a public health response. With timely, evidence-based and often low-cost interventions, suicides can be prevented. For national responses to be effective, a comprehensive multisectoral suicide prevention strategy is needed.

Who is at risk?

The link between suicide and mental disorders (in particular, depression and alcohol use disorders) and a previous suicide attempt is well established in high-income countries. However, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship disputes, or chronic pain and illness.

In addition, experiencing conflict, disaster, violence, abuse or loss and a sense of isolation are strongly associated with suicidal behaviour. Suicide rates are also high among vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex (LGBTI) persons; and prisoners.

Prevention and control

There are several measures that can be taken at population, sub-population and individual levels to prevent suicide and self-harm. LIVE LIFE, WHO's initiative for suicide prevention, recommends the following key effective evidence-based interventions:

- limit access to the means of suicide (e.g. pesticides, firearms, certain medications);
- interact with the media for responsible reporting of suicide;
- foster socio-emotional life skills in adolescents; and
- early identify, assess, manage and follow up anyone who is affected by suicidal behaviors.

These need to go hand-in-hand with the following foundational pillars: situation analysis, multisectoral collaboration, awareness raising, capacity building, financing, surveillance and monitoring and evaluation.

Suicide prevention efforts require coordination and collaboration among multiple sectors of society, including the health sector and other sectors such as education, labor, agriculture, business, justice, law, defense, politics and the media. These efforts must be comprehensive and integrated given the multifaceted nature of suicide.

Challenges and obstacles

Stigma and taboo

Stigma, particularly surrounding mental disorders and suicide, means many people thinking of taking their own life or who have attempted suicide are not seeking help and are therefore not getting the help they need. The prevention of suicide has not been adequately addressed due to a lack of awareness of suicide as a major public health problem and the taboo in many societies to openly discuss it. To date, only a few countries have included suicide prevention among their health priorities and only 38 countries report having a national suicide prevention strategy.

Raising community awareness and breaking down the taboo is important for countries to make progress in preventing suicide.

Data quality

Globally, the availability and quality of data on suicide and self-harm is poor. Only some 80 WHO Member States have good-quality vital registration data that can be used directly to estimate suicide rates. This problem of poor-quality mortality data is not unique to suicide, but given the stigma surrounding suicide – and the illegality of suicidal behavior in some countries – it is likely that under-reporting and misclassification are greater problems for suicide than for most other causes of death.

Improved surveillance and monitoring of suicide and self-harm are required for effective suicide prevention strategies. Cross-national differences in the patterns of suicide, and changes in the rates, characteristics and methods of suicide, highlight the need for each country to improve the comprehensiveness, quality and timeliness of their suicide-related data. This includes vital registration of suicide, hospital-based registries of self-harm and nationally representative surveys collecting information about self-reported self-harm.

WHO response

The urgency to act to prevent suicides has been recognized and prioritized at the highest levels. The reduction of the suicide rate is an indicator in the UN Sustainable Development Goals (the only indicator for mental health), WHO's General Programme of Work and WHO's Comprehensive Mental Health Action Plan 2013–2030.

The first WHO world suicide report, Preventing suicide: a global imperative, published in 2014, aimed to increase the awareness of the public health significance of suicide and suicide attempts and to make suicide prevention a high priority on the global public health agenda. It also aimed to encourage and support countries to develop or strengthen comprehensive national suicide prevention strategies through a multisectoral public health approach.

In 2021, WHO launched LIVE LIFE: an implementation guide for suicide prevention in countries. Accompanying resources to support the implementation of the four key LIVE LIFE interventions have also been published including the 2024 brochure on Preventing suicide by phasing out highly hazardous pesticides to support limiting access to means, Preventing suicide: a resource for media professionals, update 2023 to encourage responsible reporting of suicide, and the Helping Adolescents Thrive toolkit to foster socio-emotional life-skills among young people. At the health sector level, suicide/self-harm is one of the priority conditions in the WHO Mental Health Gap Action Programme (mhGAP), which provides evidence-based technical guidance to scale up service provision and care in countries for mental, neurological and substance use disorders. The mhGAP Intervention Guide (mhGAP-IG) includes a specific module for suicide and self-harm to support early identification, assessment, management and follow-up. Through the LIVE LIFE initiative, governments are encouraged and supported to implement a suite of evidence-based interventions and foundational pillars for suicide prevention.