



World mental health report

Transforming mental health for all



World Health Organization



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| Transforming mental
| health for all

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Foreword

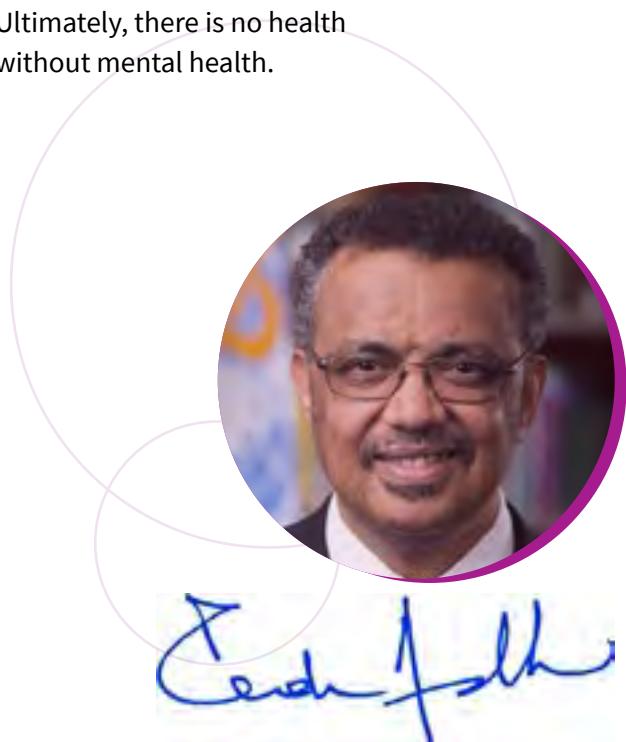
As the world comes to live with, and learn from, the far-reaching effects of the COVID-19 pandemic, we must all reflect on one of its most striking aspects – the huge toll it has taken on people's mental health. Rates of already-common conditions such as depression and anxiety went up by more than 25% in the first year of the pandemic, adding to the nearly one billion people who were already living with a mental disorder. At the same time, we must recognize the frailty of health systems attempting to address the needs of people with newly-presenting as well as pre-existing mental health conditions.

Mental health is a lot more than the absence of illness: it is an intrinsic part of our individual and collective health and well-being. As this report shows, to achieve the global objectives set out in the *WHO Comprehensive mental health action plan 2013–2030* and the *Sustainable Development Goals*, we need to transform our attitudes, actions and approaches to promote and protect mental health, and to provide and care for those in need. We can and should do this by transforming the environments that influence our mental health and by developing community-based mental health services capable of achieving universal health coverage for mental health. As part of these efforts, we must intensify our collaborative action to integrate mental health into primary health care.

In so doing, we will reduce suffering, preserve people's dignity and advance the development of our communities and societies. Our vision is a world where mental health is valued, promoted and protected; where mental health conditions are prevented; where anyone can exercise their human rights and access affordable, quality mental health care; and where everyone can participate fully in society free from stigma and discrimination.

To achieve this ambitious transformation, a concerted and renewed effort is needed in all countries, whether they are rich or poor, stable or fragile, affected by emergencies or not. WHO will play its part as the lead agency for global health and will continue to work nationally and internationally to provide strategic leadership, evidence, tools and technical support.

Ultimately, there is no health without mental health.



Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

Preface

Mental health conditions are very common in all countries of the world. Most societies and most health and social systems neglect mental health and do not provide the care and support people need and deserve. The result is that millions of people around the world suffer in silence, experience human rights violations or are negatively affected in their daily lives.

This should not be the story of mental health, globally or in your country. And it does not have to be. This report argues for a transformation in mental health and shows that it is possible. Using findings from research and practice, it explores diverse options to deepen the value and commitment we give to mental health, to reshape environments that influence mental health, and to develop and strengthen community-based mental health services. Using examples of positive change from across the globe, this report shows that every country, no matter its situation, has many opportunities to significantly improve mental health for its adults and children.

Throughout this report you will find narratives from people around the world with lived experience of mental health conditions. Their accounts show what effective health and social support looks like, how it can lead to recovery, and how this means different things to different people. And they tell of the suffering, stigma and social exclusion that happens in the absence of environments and services that protect and support mental health and that offer affordable, quality care. Ultimately, these stories are a reminder that investing in and transforming mental health means investing in people. Everyone has a right to mental health. Everyone deserves the chance to thrive.



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List of abbreviations

ADHD	attention deficit hyperactivity disorder
CAMHS	child and adolescent mental health services
CBT	cognitive behavioural therapy
COVID-19	coronavirus disease 2019
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DALY	disability-adjusted life year
EQUIP	Ensuring Quality in Psychological Support
IASC	Inter-Agency Standing Committee
ICD-11	International Classification of Diseases 11th Revision
ILO	International Labour Organization
IPT	interpersonal psychotherapy / interpersonal therapy
GBD	Global Burden of Diseases, Injuries and Risk Factors study
GHE	WHO Global Health Estimates
GMHPN	Global Mental Health Peer Network
HAT	Helping Adolescents Thrive
LMIC	low- and middle-income country
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	mhGAP Intervention Guide
MHPSS	mental health and psychosocial support
NCD	noncommunicable disease
NTD	neglected tropical disease
OCD	obsessive-compulsive disorder
PAHO	Pan American Health Organization
PM+	problem management plus
PTSD	post-traumatic stress disorder
SDG	Sustainable Development Goal
TB	tuberculosis
UHC	universal health coverage
UNICEF	United Nations Children's Fund
VCPH	Virtual Campus for Public Health
WHO	World Health Organization
YLL	years of life lost to premature mortality
YLD	years of healthy life lost to disability

A close-up photograph of a Black couple. On the left, a man with a full, grey beard and glasses is smiling warmly at a woman. On the right, a woman with short, dark hair styled in braids is laughing joyfully, her head tilted back slightly. They are both wearing casual clothing. A large, semi-transparent dark blue circle covers the bottom half of the image, containing the title text.

Executive summary

Overview of the *World mental health report: transforming mental health for all*

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inform change

Core concepts

Determinants

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DRIVERS OF PUBLIC
MENTAL HEALTH**

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public health

Protect
human rights

Support
development

**THE CASE FOR
TRANSFORMATION:
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in the community



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- In general health care
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for common
conditions

Deinstitutionalize
care for severe
conditions

8 PATHS TO TRANSFORMATION

Deepen
value and
commitment

Reshape
environments

Strengthen
mental
health care

Chapter 1. Introduction

A world report to inspire and inform change.



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

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

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

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

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

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

Business as usual for mental health simply will not do.

Chapter 2. Principles and drivers in public mental health

Mental health is critically important for everyone, everywhere.

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

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

Because the factors determining mental health are multisectoral, interventions to promote and protect mental health should also be delivered across multiple sectors. And when it comes to providing care, a multisectoral approach is

similarly needed because people with mental health conditions often require services and support that extend beyond clinical treatment.

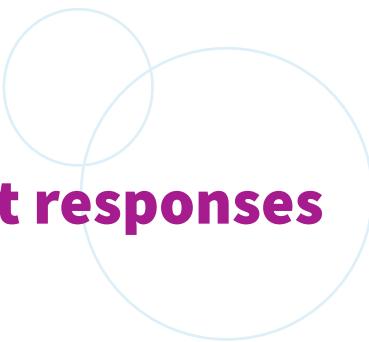
Mental health risks and protective factors can be found in society at different scales. Local threats heighten risk for individuals, families and communities. Global threats heighten risk for whole populations and can slow worldwide progress towards improved well-being. In this context, key threats today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

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

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

Chapter 3. World mental health today

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



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

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

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

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

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

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

Chapter 4. Benefits of change

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



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

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

Investing in mental health is needed to stop human rights violations. Around the world, people with mental health conditions are frequently excluded from community life and denied basic rights. For example, they are not only discriminated against in employment, education and housing, but also do not enjoy equal recognition

before the law. And too often they are subjected to human rights abuses by some of the very health services responsible for their care. By implementing internationally agreed human rights conventions, such as the Convention for the Rights of People with Disabilities, major advances can be made in human rights. Anti-stigma interventions – particularly social contact strategies through which people with lived experience help to shift attitudes and actions – can also reduce stigma and discrimination in the community.

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

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

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

Chapter 5. Foundations for change

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

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

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

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

To transform mental health services, commitment must be translated into action through appropriate

financing. In practice, this means policy-makers and planners need to devote more funds to mental health. This is achieved either by getting additional resources from the state treasury or external funders, or by redistributing resources towards mental health, both within the health budget as well as across government.

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

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

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

Chapter 6. Promotion and prevention for change

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

At all stages of life, promotion and prevention are required to enhance mental well-being and resilience, prevent the onset and impact of mental health conditions, and drive down the need for mental health care. There is increasing evidence that promotion and prevention can be cost-effective.

Promotion and prevention interventions work by identifying the individual, social and structural determinants of mental health, and then intervening to reduce risks, build resilience and establish supportive environments for mental health. Interventions can be designed for individuals, specific groups or whole populations.

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

Suicide prevention is an international priority, with a Sustainable Development Goal (SDG) target to reduce the suicide mortality rate by one third by 2030. To help countries reach this target, WHO has developed the LIVE LIFE approach to suicide prevention, which prioritizes four interventions with proven efficacy: limiting access to the means of suicide; interacting with the media for responsible reporting on suicide; fostering social and emotional life skills in adolescents; and early intervention for anyone affected by suicidal behaviours. Banning highly hazardous pesticides is a particularly inexpensive

and cost-effective intervention. In countries with a high burden of pesticide self-poisonings, bans can lead to an immediate and clear drop in overall suicide rates, without agricultural loss.

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

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

Chapter 7. Restructuring and scaling up care for impact

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

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

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

Integrating mental health into general health services typically involves task-sharing with non-specialist health care providers or adding dedicated mental health staff and resources to

primary and secondary health care. Task-sharing with primary health care providers has been shown to help reduce the treatment gap and increase coverage for priority mental health conditions. Task-sharing within disease-specific services such as HIV/AIDS or TB programmes can improve both physical and mental health outcomes.

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

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

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

Chapter 8. Conclusion

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



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

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

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

Second, we must **reshape the physical, social and economic characteristics of environments**

– in homes, schools, workplaces and the wider community – to better protect mental health and prevent mental health conditions. These environments need to give everyone an equal opportunity to thrive and reach the highest attainable level of mental health and well-being.

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

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

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



Introduction

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

The international health community had already been advocating for mental health action for decades (2). But the 2001 report marked a

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

1.1 Twenty years on

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

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

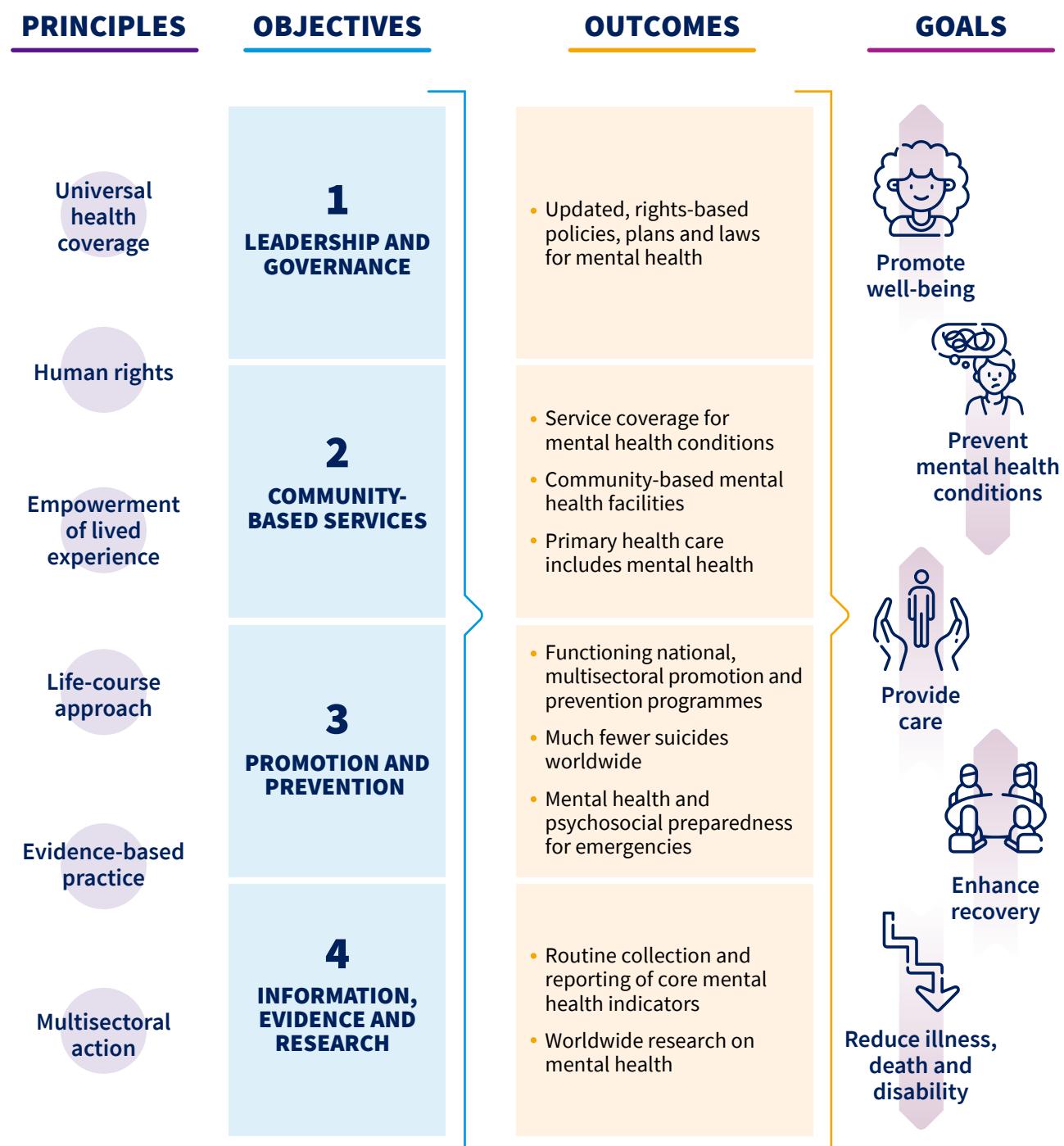
Recommendations made in 2001 remain valid, yet there has been progress.

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

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

FIG. 1.1

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



Source: WHO, 2021 (3).

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

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

Although in 2001 mental disorders were already known to be common, much more is known today about their epidemiology including their early onset, high prevalence and interacting determinants. Informed by

further research, the field has also advanced technically. Task-sharing between specialist and non-specialist mental health care providers has been widely demonstrated to be effective, including for psychological interventions, and is now more frequently implemented. The number of practical, evidence-based mental health guidelines, manuals and other tools has also vastly expanded.

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



1.2 Time for change

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.3 About this report

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

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

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

1.3.1 Scope

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

At times, the report also refers to neurological disorders, substance use disorders and cognitive and intellectual disabilities. While these conditions are not the main focus, this report acknowledges that all of them can be, and often are, closely linked with mental health conditions. About one third of all people who experience

a substance use condition also experience a mental health condition, and people with a mental health condition are also more likely to develop a substance use condition. Both types of condition increase the risk of suicide (8). And one in every four people who develop epilepsy will also develop depression or anxiety (9). In many countries, services for different mental health, neurological and substance use conditions are all combined at the point of care.

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

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

INSIGHT

BOX 1.1

Mental health terms

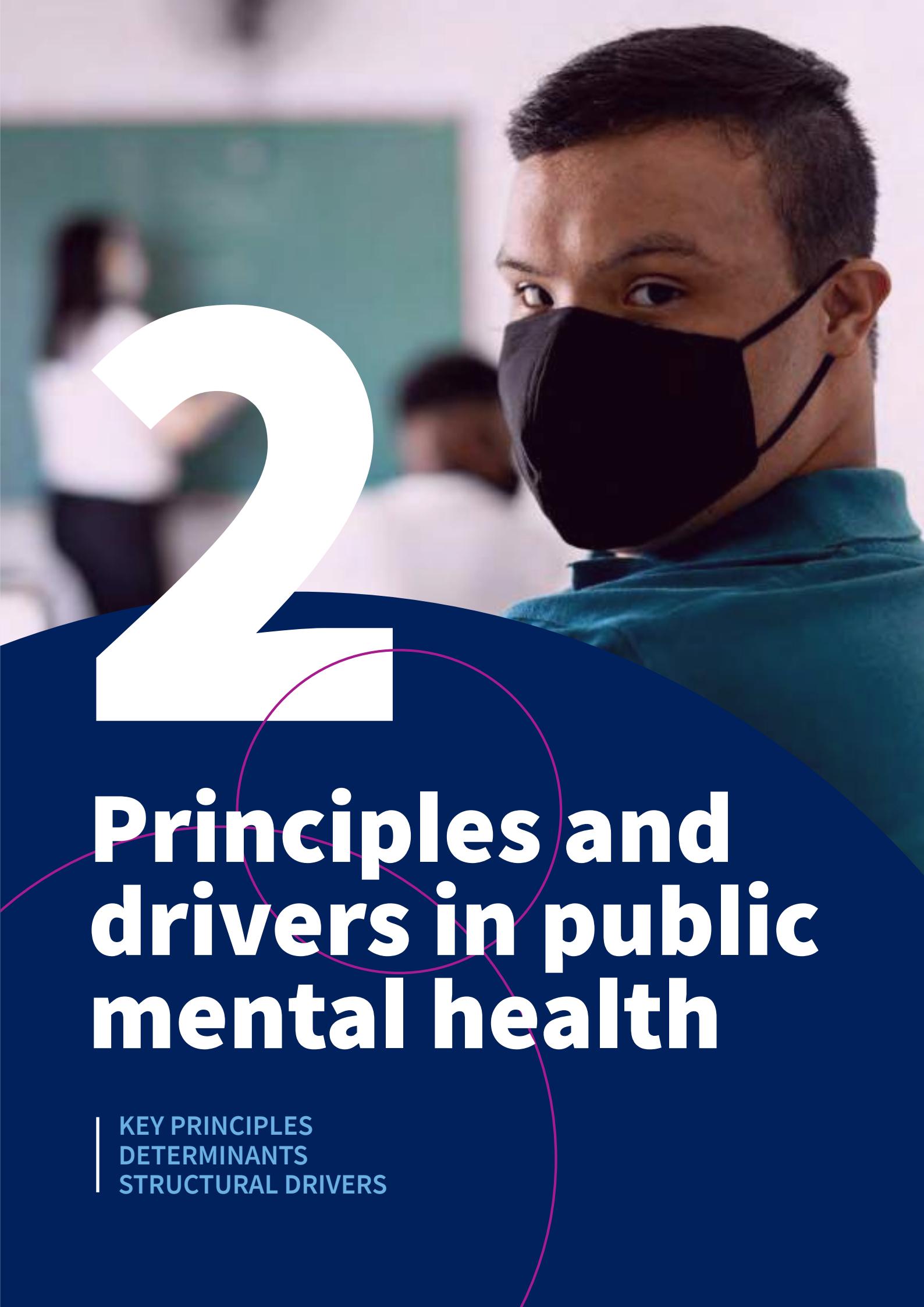
Mental health. A state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of mental disorder.

Mental health condition. A broad term covering mental disorders and psychosocial disabilities. It also covers other mental states associated with significant distress, impairment in functioning, or risk of self-harm. To bring together and speak to the widest group of stakeholders possible, the term “mental health condition” is used throughout this report except when describing data that rely on defined categories of mental disorder.

Mental disorder. As defined by the *International Classification of Diseases 11th Revision* (ICD-11), a mental disorder is a syndrome characterized by

clinically significant disturbance in an individual’s cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning. This report uses the term “mental disorder” when discussing data that rely on defined categories of mental disorder.

Psychosocial disability. Aligned with the Convention on the Rights of Persons with Disabilities, psychosocial disability is *disability that arises when someone with a long-term mental impairment interacts with various barriers that may hinder their full and effective participation in society on an equal basis with others*. Examples of such barriers are discrimination, stigma and exclusion.



Principles and drivers in public mental health

KEY PRINCIPLES
DETERMINANTS
STRUCTURAL DRIVERS

Chapter summary

In this chapter we explore **core concepts in mental health** to show that mental health is **critically important to everyone, everywhere**. We define mental health as an integral part of our general health and well-being and as a basic human right. We describe some of the changes in how we experience mental health over the life-course and explore how these are shaped by a complex interplay of individual, family, community and structural determinants. We highlight the key risks and protective factors for mental health and identify some of the greatest threats to world mental health today.



KEY MESSAGES FROM THIS CHAPTER

- Mental health has intrinsic and instrumental value and is integral to our general well-being.
- How we experience mental health changes over the course of our lives.
- Everyone has a right to mental health.
- Mental health is relevant to many sectors and stakeholders.
- Mental health is determined by a complex interplay of individual, social and structural stresses and vulnerabilities.
- Global threats to mental health today include: economic and social inequalities; public health emergencies (including COVID-19); humanitarian emergencies (including conflict and forced displacement); and the climate crisis.

2.1 Concepts in mental health

2.1.1 Mental health has intrinsic and instrumental value

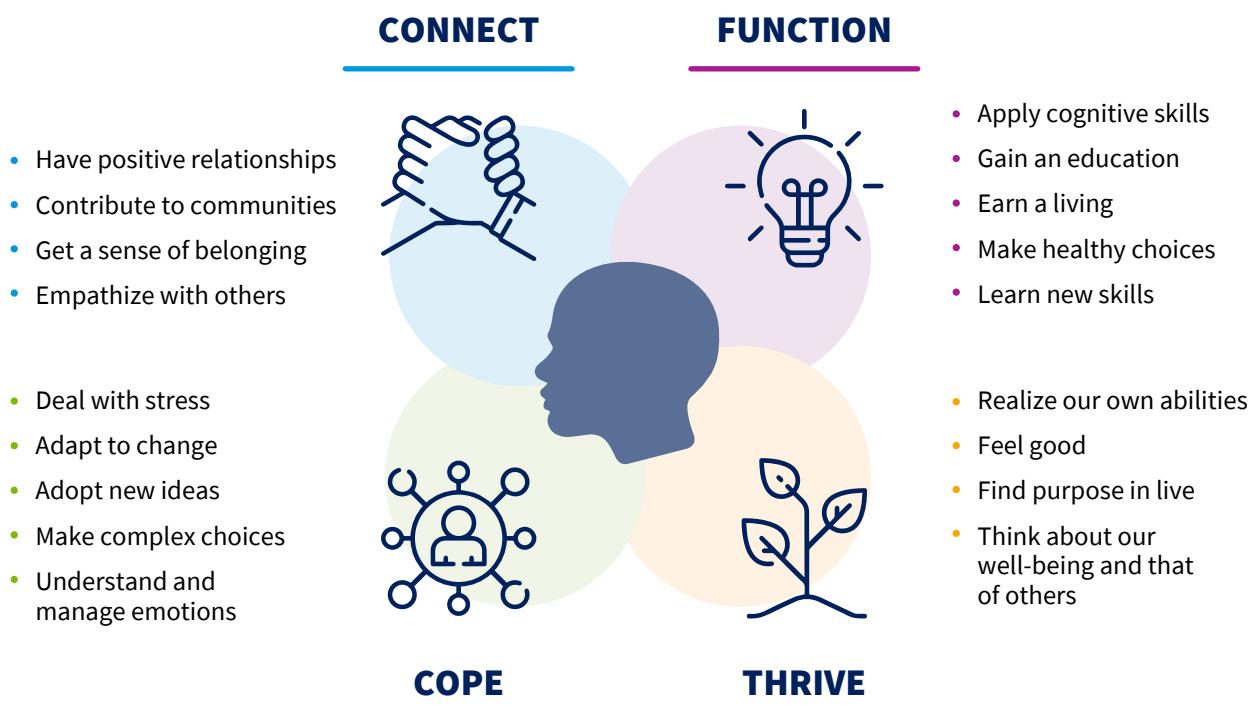
Mental health is intrinsic and instrumental to the lives of all people. It influences how we think, feel and act. It underpins our ability to make decisions, build relationships and shape the world we live in. Mental health is also a basic human right. And it is crucial to personal, community and socio-economic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

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

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

FIG. 2.1

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



Living with a mental health condition can impose a substantial financial burden on individuals and households (10). People experiencing mental health conditions are also often stigmatized, shunned, discriminated against and denied basic rights, including access to essential care (11). Partly because of these attitudes and responses, having a mental health condition often goes hand in hand with social isolation, interrupted or unfinished education, and unemployment.

Neglecting the intrinsic and instrumental value of mental health happens at the expense of individual and family well-being as well as local and national

economies. Close to 15% of the world's working population is estimated to experience a mental disorder at any given time (12). With mental health linked to productivity, the potential impact on economic performance and output is huge.

Mental health is linked to practically every key issue in international development. It impacts, and is impacted by, many of the 17 Sustainable Development Goals that make up the world's blueprint for a better and more sustainable future for all (see Table 4.3). Without prioritizing mental health, many of these goals will be difficult to meet (13).

NARRATIVE

I live with schizophrenia and I have mental well-being

Charlene's experience

My life is in no way defined by or confined within my diagnosis of schizophrenia. I do have some difficulties at times related to my diagnosis or to the side-effects of medications. But by being empowered and having a strong support system I am able to manage these.

I am a functional and productive member of society. I have purpose in life, and I maintain good relationships with family and friends. As the founder and CEO of the Global Mental Health Peer Network (GMHPN), an international mental health lived experience organization, I contribute meaningfully

to society and the economy. I've led GMHPN to its successes since inception and this has been the most rewarding experience of my life and one of the key elements that has contributed to my mental health and well-being.

I have the ability to recognize and develop my strengths and learn from my weaknesses. I am self-sufficient and independent. I know when I need support and where to access it. Most importantly I have mental well-being. I am mentally well. A diagnosis of a mental health condition should never be a precursor to defining mental well-being.

Charlene Sunkel, South Africa

2.1.2 Mental health exists on a continuum

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

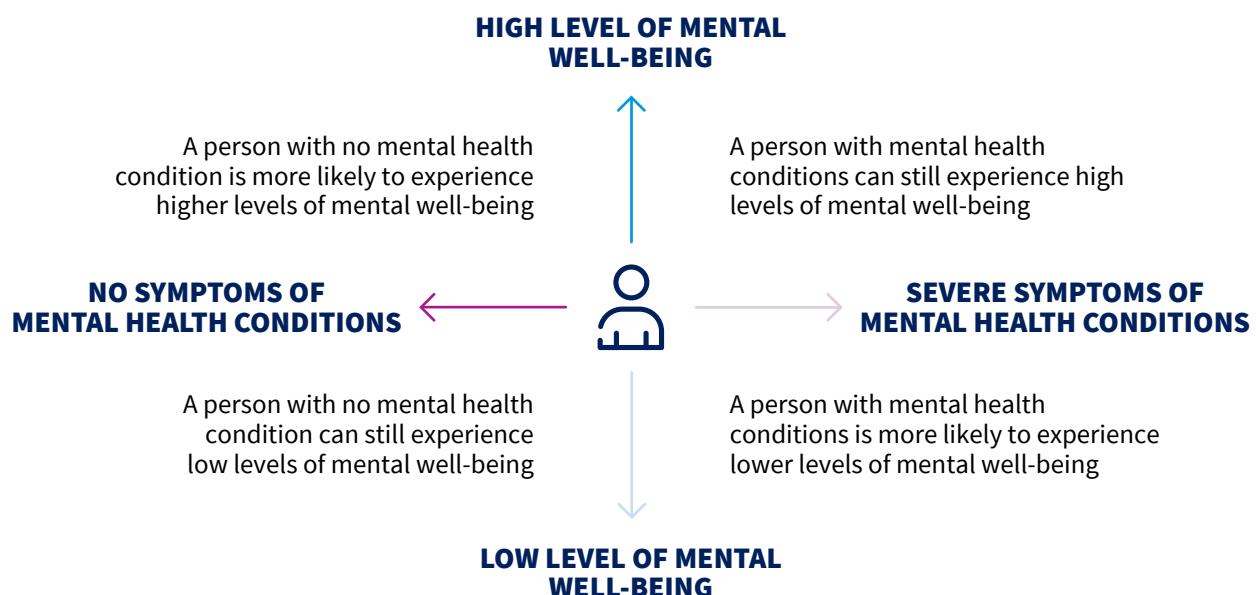
Mental health is not a binary state: we are not either mentally healthy or mentally ill. Rather, mental health exists on a complex continuum with experiences ranging from an optimal state of well-being to debilitating states of great suffering and emotional pain (15). So mental health is not defined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

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

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

FIG. 2.2

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



Source: Tudor, 1996 (17).

2.1.3 Mental health is experienced over the life-course

Mental health is fluid. Over the course of our lives, where we find ourselves on the mental health continuum will fluctuate in response to changing situations and stressors (read [Joanna's experience](#)). At any one time, a diverse set of individual, social and structural factors may combine to protect or undermine our mental health and shift our position on the mental health continuum (see [section 2.2 Determinants of mental health](#)). Some times in our lives are more critical than others.

Our infancy and childhood set the tone for the rest of our lives.

In many ways, our prenatal environments, infancy and early childhood can set the tone for the rest of our lives. Most mental health conditions in adults have their onset by adolescence. In early childhood, a safe, secure and loving environment, with responsive caregiving and opportunities for early learning builds neural connections at a vital time of early brain development ([18](#)). Conversely, adverse experiences during early childhood, including violence, neglect or death of a loved one, can disrupt early brain development and compromise the nervous and immune system for life. Maternal depression can have long-lasting adverse impacts on a child's brain development.

Adolescence is another developmentally sensitive time for a person's mental health. It is a crucial period for developing the social and emotional skills, habits and coping strategies that enable mental health, including healthy sleeping patterns, regular exercise, problem-solving and interpersonal skills. Many risk behaviours, such as use of substances, start during adolescence and can be particularly detrimental to mental health. Suicide is a leading cause of death in adolescents.

Teen parents in particular are often at higher risk of mental ill-health than their peers.

Even in adulthood, family building can be a risky time for mental health. For example, maternal depression and anxiety can impair a mother's ability to bond with her baby. Throughout adulthood, working life can also be difficult. Unemployment and especially loss of employment are known risk factors for suicide attempts ([19](#)). And negative working environments are associated with a greater risk of developing depression, anxiety and work-related stress ([20](#)).

At older ages, mental health continues to be shaped by physical, social and environmental conditions as well as the cumulative impacts of earlier life experiences and specific stressors related to ageing. For example, loss of functional ability, musculoskeletal pain, bereavement and isolation can all result in loneliness and psychological distress. One in six older adults experience elder abuse, often by their own carers, with serious consequences for mental health ([21](#)).

A life-course approach to mental health acknowledges the critical risks and protective factors that influence mental health at each stage of life, and designs policies, plans and services to address the needs of all age groups. It enables decision-makers to pay attention to critical stages, transitions and settings where interventions to promote, protect and restore mental health may be especially effective. This includes, for example, emphasizing response to mental health needs early in the life-course to prevent chronic mental health problems throughout life.

2.1.4 Everyone has a right to mental health

Mental health is a basic human right for all people. Everyone, whoever and wherever they are, has a deserving and inherent

NARRATIVE

Every step I take is a sign of progress

Joanna's experience

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

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

strength to get out of bed. The idea of a successful future had vanished.

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

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

Joanna Lovón, Peru

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

- the right to be protected from mental health risks;
- the right to available, accessible, acceptable and good quality care; and

- the right to liberty, independence and inclusion in the community.

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

NARRATIVE

To be in the open air is to be happy

Regina's experience

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

Now, thank God, I live in the community and I am free to be in the open air. For everyone, to be in the open air is to be happy. When my mind is empty I go out to the street – to see people and talk to them. Even if

I've never seen them before in my life I stop and talk. It is worthwhile to live in a supported home. It has given me many good things – a house, a bed. In my life I have been freezing, I have starved, I have lived like a beggar. I can tell you it's horrible. I thank God for having found out about the supported living service, otherwise I wouldn't be here, in this wonderful house.

Regina Célia Freire da Silva, Brazil

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

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

Improving access to quality mental health care is inherent to, and indivisible from, a better life for self and a better life for all (read [Regina's experience](#)). A rights-based approach to mental

health services protects those at risk of human rights violations, supports those living with mental health conditions, and promotes mental health for all (23). The UN Convention on the Rights of Persons with Disabilities (CRPD) needs to be implemented across the world.

2.1.5 Mental health is everyone's business

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

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



INSIGHT

BOX 2.1

Four roles for the health sector

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

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

Promote and prevent. The health sector can advocate for and provide promotion and prevention programmes, in collaboration with other sectors. Such programmes can build awareness and understanding of mental health, end stigma and

discrimination, and lessen the need for treatment and recovery services (see [Chapter 6 Promotion and prevention for change](#)).

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

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

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

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

- financial support (through the social sector);
- a place to stay (through the housing sector);

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

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

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

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

2.2 Determinants of mental health

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

mental health are mediated through brain structure and function (29). A person's mental health also depends on the stressors in their life, which are influenced by family, community and structural factors in the environment.

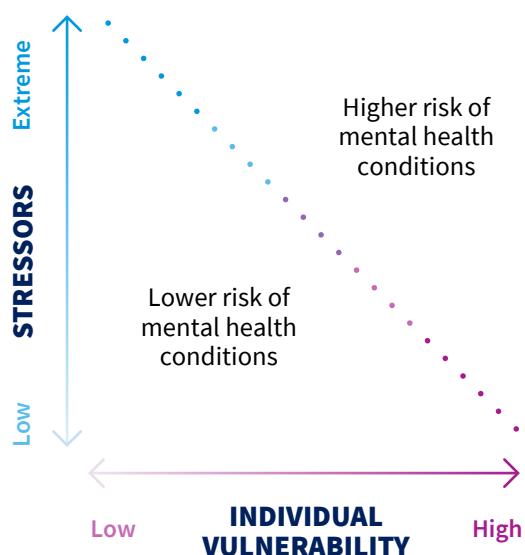
2.2.1 Spheres of influence

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

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

FIG. 2.3

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



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

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

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

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

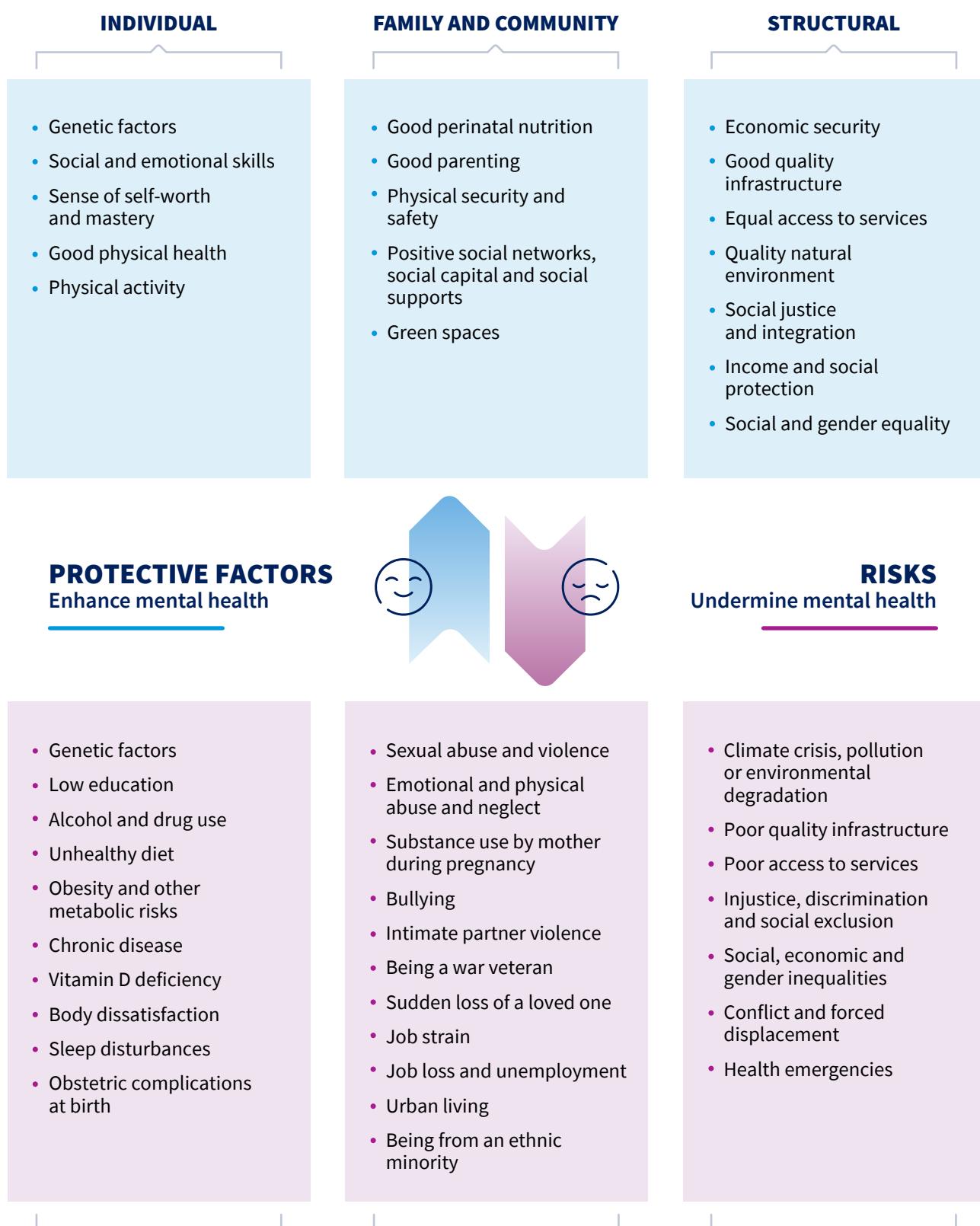
Notably, each single determinant has only limited predictive strength (33). Most at-risk people will not develop mental health conditions and many people with no known risk factor still develop a mental health condition. Nonetheless, across all these spheres of influence, the interacting determinants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

2.2.2 Risks undermine mental health

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

FIG. 2.4

Examples of risks and protective factors that determine mental health



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

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

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

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

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

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

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

Living in areas where the natural environment has been compromised – for example, through

climate change, biodiversity and habitat loss, exploitation or pollution – can also undermine mental health. For example, growing evidence suggests that exposure to air pollution is likely to adversely affect the brain and increase the risk, severity and duration of mental health conditions at all stages of life (43, 44).

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

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

The vicious cycle of disadvantage

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

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

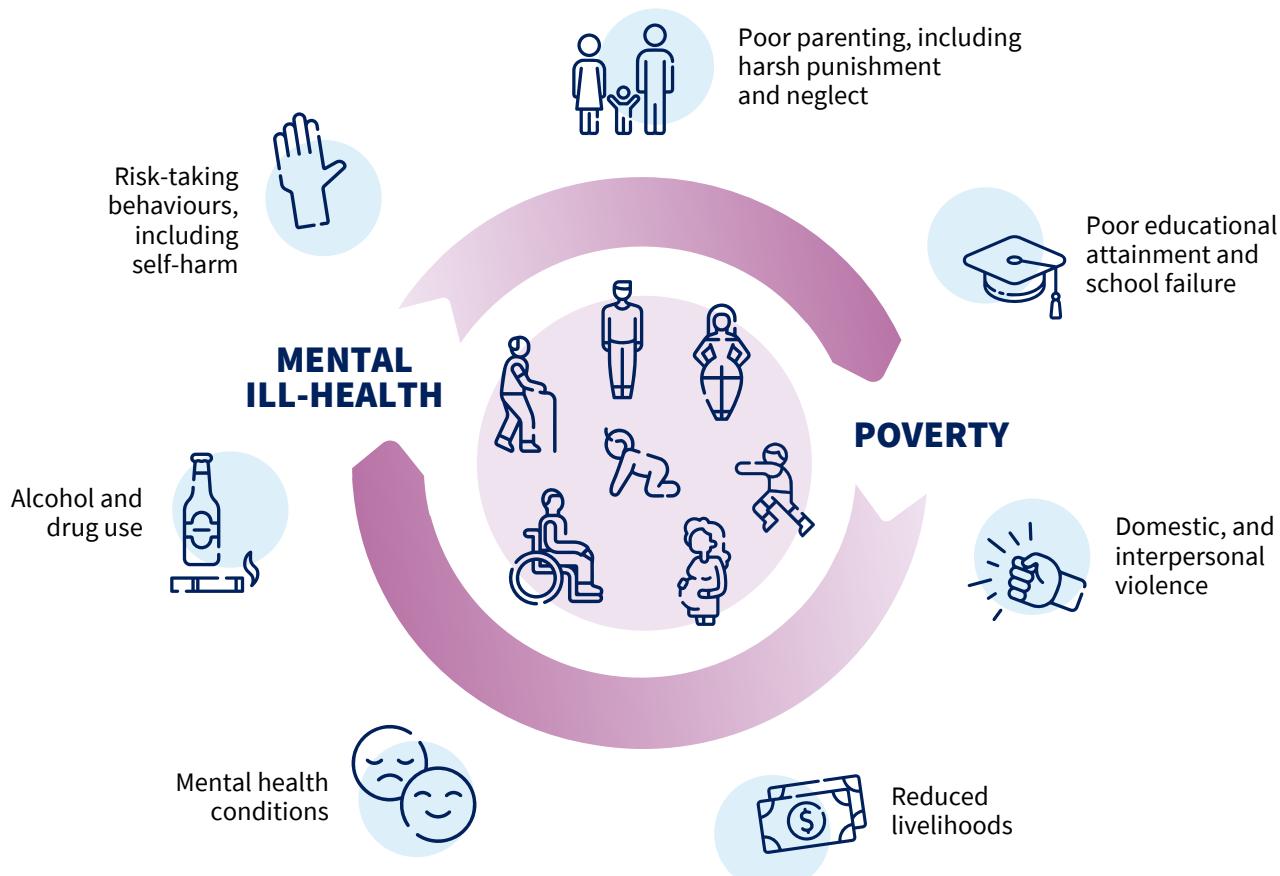
Similarly, people experiencing severe mental health conditions are more likely to fall into poverty through loss of employment and increased health expenditures. Stigma and discrimination may also undermine their social support structures. They are vulnerable to a downward spiral of lost resources and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

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

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

FIG. 2.5

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





NARRATIVE

No one told me I was basically a superhero

Lion's experience

I am a survivor of prolonged sexual abuse. My life has fallen apart twice: the first time was when I was abused and parts of me separated from myself to survive; the second time was much later when I could no longer keep ignoring what I had gone through and I had a mental health crisis.

It's difficult to describe how confusing it is to grow up within a life of constant pain and suffering. I felt good when things were bad, and worried and terrified when things were good. Sometimes I needed small doses of pain because the withdrawal from it was unbearable. Living with the expectation that abuse will happen again soon means living in a state of extreme sensory stimulation.

I met with quite a few therapists and rehabilitation experts. I did not receive a diagnosis of trauma, even when I shared some of what I had gone through, and unsurprisingly, therapy was not even slightly helpful. I remember saying over and over again that I was feeling detached from myself, that all I was trying to do was to detach myself, and yet, no one spoke to me about dissociation and the implications of trauma.

The therapists interpreted everything I did as stemming from my disorders. They told me that if I don't do exactly what they said, I wouldn't be able to get out of it. They told me that I just needed to give in; but giving in was also what my rapist had asked me to do.

No one told me that I was basically a superhero... that my crisis showed I had been keeping the hell I'd gone through to myself for too long.



Eventually I contacted a trauma specialist, who did a full evaluation and diagnosed me with trauma-related dissociative identity disorder. This diagnosis, which accounts for the repercussions of childhood trauma, provided me with the recognition and acknowledgment I was so desperate for and, most importantly, with proper treatment.

My therapist told me he was an external expert and I was an internal expert and that if we worked together as partners towards my recovery, we would succeed. I recently celebrated ten years of therapeutic partnership, and it is one of the longest and most beneficial, safest relationships I have ever had. It is thanks to this partnership that I am here today.

Now I work as a peer expert, a personal medicine coach and an advocate of lived experience. I am the Head of the Lived Experience Department at Enosh, the Israeli mental health association, and proud to be part of a group of unique, powerful people who contribute to highly influential transformations within my country's mental health system.

I hope that in the future, survivors who want to recover from the difficult experiences they've been through will be treated like heroes, like humans who have been through extreme human experiences, and who deserve compassion, respect, and value. And I will continue to pave this path, so that knowledge based on personal experience can someday lead the world's future health systems.

Lion Gai Meir, Israel

2.2.3 Protective factors build resilience

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

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

Family and community factors can also be influential in supporting mental health.

Protective factors at these levels include positive family interactions, quality education, decent work conditions, safe neighbourhoods, community cohesion and shared cultural meaning and identity (52).

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

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

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

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

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

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

184 countries
have ratified the CRPD.

2.3 Global threats to mental health

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

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

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

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

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

2.3.1 Economic and social inequalities

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

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

Economic downturns are associated with increased suicide.

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

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

2.3.2 Public health emergencies

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

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

- Fear of the virus can cause acute anxiety and distress.
- The grief of losing loved ones to the virus can last a long time.
- Survivors and their health care workers often face extreme stigma and discrimination.
- Physical isolation of exposed individuals and communities heightens the risk of psychosocial impacts.

- Outbreaks, and the response to them, can break local support systems, depleting people's coping resources, fracturing communities and undermining trust in health services.
- Many survivors develop mental health conditions, such as anxiety and mood disorders.

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



COVID-19 and mental health

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

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

At the same time, **mental health services have been severely disrupted**, especially in the first year of the pandemic. Staff and resources were often redeployed to COVID-19 relief. Social measures frequently prevented people from accessing care, and in many cases fear of the virus stopped people from seeking help. By early 2022 there were fewer disruptions, but too many people still could not get the mental health support they needed.

Of course, **people in some places and circumstances have been more affected than others**. And as the pandemic evolved, national public health measures changed, as did mental health stressors and impacts. Impacts during the early stages, when huge uncertainty and high death rates fuelled widespread fear and distress, were quite different from those seen during later stages, when isolation and fatigue became bigger threats to well-being.

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



NARRATIVE

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

Esenam's experience

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

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

Most people are afraid to seek help because they think that if they visit the hospital, they might



end up getting infected with COVID-19 because of the virus' subtle mode of transmission and contraction. I myself did not go to the clinic for therapy for an entire year partly because of this fear. I was also unemployed at the time and did not have the funds for treatment. But my pensioner parents managed to make sure my medications were always refilled.

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

Esenam Abra Drah, Ghana

Mental health stressors

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

Stress from the potential health impacts of the virus. For some people, and especially during the early months – when little was known about the virus and there were strict public health and social measures – the fear of infection and death (both for oneself and for loved ones) was distressing (read [Esenam's experience](#)). At that time, bereavement

could be particularly distressing because normal grieving processes and funeral rites were disrupted (64). Throughout the pandemic some people experienced major adversities: getting very ill; experiencing post-COVID condition; or witnessing suffering and death, which, like any adversity, can impact on mental health.

Stress from public health and social measures.

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

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

Stress from unemployment and financial insecurity.

Unemployment, poverty and adversity are known risk factors for mental health conditions (see [section 2.2.2 Risks undermine mental health](#)).

In early 2020, an acute global recession left millions of people jobless and prompted an unprecedented rise in extreme poverty (62). Recovery has been slow. In 2022 (at time of writing), the pandemic continued to affect labour markets, the increase in poverty lingered and global unemployment remained above pre-pandemic levels (63).

Stress from false information and uncertainty.

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

Widespread distress

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

But just as there has been extensive resilience, a great number of people have reported mental health

problems since the pandemic began, including psychological distress and symptoms of depression, anxiety or post-traumatic stress. People may resort to negative coping measures, including using alcohol, drugs, tobacco, and spending more time on addictive behaviours, such as gambling or online gaming. All these compound the risks to mental health (63).

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

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

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

Variable vulnerabilities

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

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

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

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

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

Service disruptions

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

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

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

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

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

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

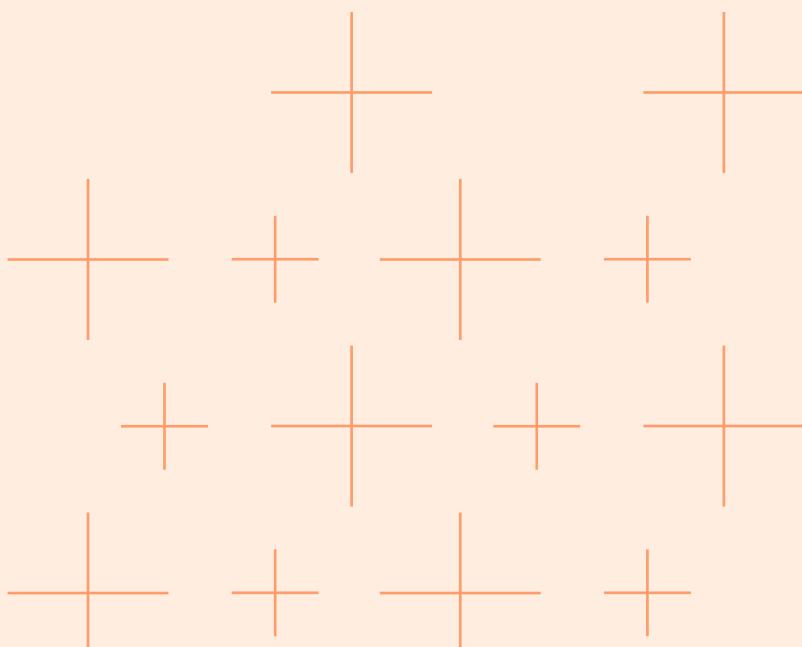
Within the first six months of the pandemic most countries surveyed by WHO – including half of all low-income countries – had built mental health and psychosocial support (MHPSS) into their national COVID-19 response plans (72). And by early 2021, the number of country-level multisectoral MHPSS coordination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

Recommendations for response

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

of the COVID-19 pandemic, the Executive Board also urged Member States to:

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



2.3.3 Humanitarian emergencies and forced displacement

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

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

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

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

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

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

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

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

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

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

2.3.4 Climate crisis

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

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

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

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

Incremental environmental change can also be devastating. It can upset food and water supplies, alter growing conditions, reshape natural habitats and landscapes and weaken

infrastructure. It can cause people to lose their homes and force communities to disperse. It can result in financial and social stress, and increase the risks of poverty, food insecurity, violence, aggression and forced displacement (90, 91).

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

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

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

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



3

World mental health today

EPIDEMIOLOGY
ECONOMIC COSTS
KEY GAPS
DEMAND FOR CARE

Chapter summary

In this chapter we outline the state of mental health and mental health systems in the world and show that mental health needs are high and that responses are insufficient and inadequate. We present the latest data available on the global prevalence and cost of mental disorders, looking beyond the impact of mortality and disability to also consider the formidable economic and social costs involved. This chapter also highlights the results of WHO's most recent *Mental health atlas* to reveal some of the enduring critical gaps in, and barriers to, mental health care around the world.



Key messages from this chapter are:

- In all countries, mental disorders are highly prevalent and largely undertreated.
- Mental disorders are the leading cause of years lived with disability and suicide remains a major cause of death globally.
- The economic consequences of mental health conditions are enormous, with productivity losses significantly outstripping the direct costs of care.
- Mental health systems all over the world are marked by major gaps in governance, resources, services, information and technologies for mental health.
- Several factors stop people from seeking help for mental health conditions, including limited access to quality services, low levels of health literacy about mental health, and pervasive stigma.

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

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

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

FIG. 3.1

Mental health conditions are widespread, undertreated and under-resourced

WIDESPREAD



1 in 8

live with a mental health condition

UNDERTREATED



71%

people with psychosis do not receive mental health services

UNDER-RESOURCED



2%

of health budgets, on average, go to mental health

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

INSIGHT

BOX 3.1

Data for assessing world mental health

To speak to the broadest group of stakeholders possible, this report generally uses the umbrella term “mental health conditions”, which covers mental disorders, psychosocial disabilities and other mental states associated with significant distress, impairment in functioning, or risk of self-harm. But when describing prevalence rates and global health estimates in this chapter, we refer to “mental disorders” since this term more accurately reflects data that are being collected and reported, and its scope is clearly defined by WHO’s ICD-11. We similarly refer in this chapter to diagnostic categories such as “depressive disorders” or “anxiety disorders”, rather than using the more general terms “depression” and “anxiety” as we do elsewhere in this report.

Mental disorders are distinct from neurological disorders and substance use disorders. The latter two, while not a focus of this report, are mentioned in this chapter to give a broad picture of the needs that mental health decision-makers often are responsible for in LMICs.

Measurement and monitoring of disease incidence, prevalence and mortality as well as disease distribution and determinants within and across populations – the defining features of epidemiology – provide vital information for health service planning, delivery and evaluation. The primary international sources of epidemiological data used in this chapter are WHO’s Global Health Estimates (GHE) and the Global Burden of Diseases, Injuries and Risk Factors Study 2019 (GBD 2019) by the Institute of Health

Metrics and Evaluation (IHME). These are closely linked in terms of mental health estimates. Together, they provide point prevalence and associated disease burden estimates for all major categories of communicable and noncommunicable diseases as well as injuries.

The term ‘burden of disease’ is only used in relation to published epidemiological assessments. This is the standard term used in public health for population-level impact estimates (e.g., disability-adjusted life years, years of life lost to premature mortality and years of healthy life lost to disability).

Estimates have to be interpreted with caution. These long-standing global studies offer the best available evidence of the extent, distribution and public health impact of mental disorders across age groups, gender and countries (grouped by income or geographical location). But while current estimates incorporate the latest available data and methodological advances in disease modelling, they remain uncertain because of the paucity of epidemiological data for mental disorders in many countries. In particular, estimates are often based on incomplete input data that do not cover all parameters or all countries, and on information that is outdated or poor quality. Moreover, it is important to acknowledge that mental disorders can be conceptualized in different ways across cultures, which raises challenges for measuring them from a particular reference point, such as in the global burden of disease studies.

3.1 Epidemiological overview

3.1.1 Prevalence

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

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

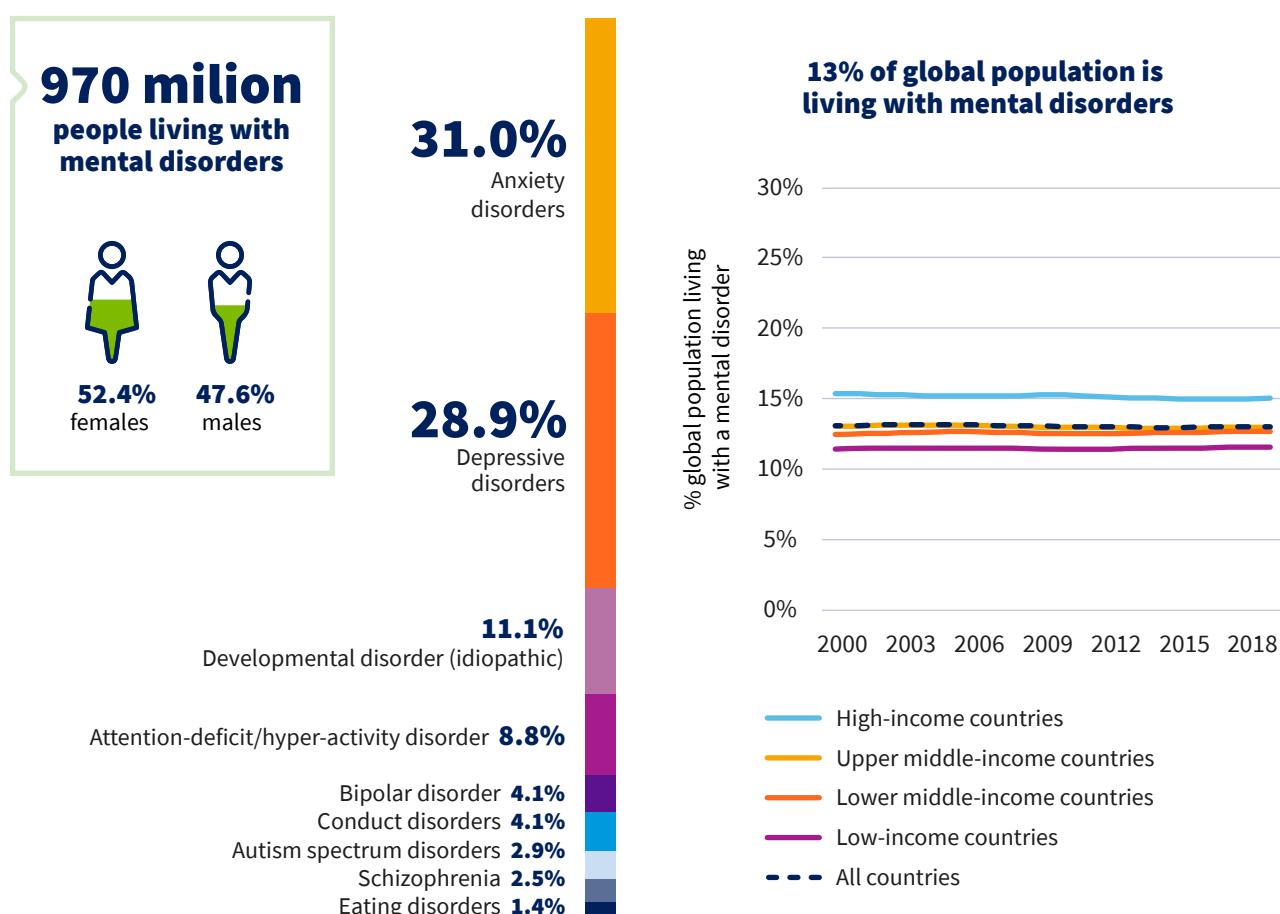
970 million
people globally
were living
with a mental
disorder in 2019.

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



FIG. 3.2

The global prevalence of mental disorders in 2019



Source: IHME, 2019 (99).

The prevalence of mental disorders varies with sex and age (see Table 3.1). In both males and females, anxiety disorders and depressive disorders are the two most common mental disorders. Anxiety disorders become prevalent at an earlier age than depressive disorders, which are rare before ten years of age. They continue to become more common in later life, with highest estimates in people between 50 and 69. Among adults, depressive disorders are the most prevalent of all mental disorders.

In 2019, 301 million people globally were living with anxiety disorders; and 280 million were living with depressive disorders (including both major depressive disorder and dysthymia). In 2020, these numbers rose significantly as a

result of the COVID-19 pandemic (see Box 3.2 Depression and anxiety in times of COVID-19).

Schizophrenia, which occurs in 24 million people and in approximately 1 in 200 adults (aged 20 years and over), is a primary concern of mental health services in all countries (see Table 3.1). In its acute states, it is the most impairing of all health conditions (see Box 3.3 Severity of mental health conditions and the principle of vertical equity) (103). Bipolar disorder, another key concern of mental health services around the world, occurs in 40 million people and approximately 1 in 150 adults globally in 2019 (see Table 3.1). Both disorders primarily affect working-age populations.

TABLE 3.1

Prevalence of mental disorders across age and sex (2019)

	ALL AGES (MILLIONS)	ALL AGES (%)			AGE (%)							AGED 20+ YEARS (%)			
		ALL	MALE	FEMALE	< 5	5-9	10-14	15-19	20-24	25-49	50-69	70+	ALL	MALE	FEMALE
Mental disorders	970	13.0	12.5	13.5	3.0	7.6	13.5	14.7	14.1	14.9	14.7	13.1	14.6	13.4	15.7
Schizophrenia	24	0.3	0.3	0.3			0.1	0.3	0.5	0.5	0.5	0.2	0.5	0.5	0.4
Depressive disorders ^a	280	3.8	3.0	4.5		0.1	1.1	2.8	4.0	4.8	5.8	5.4	5.0	4.0	6.0
Bipolar disorder	40	0.5	0.5	0.6		0.2	0.6	0.7	0.7	0.7	0.7	0.5	0.7	0.7	0.7
Anxiety disorders ^b	301	4.0	3.0	5.0	0.1	1.5	3.6	4.6	4.7	4.9	4.8	4.4	4.8	3.6	5.9
Eating disorders ^c	14	0.2	0.1	0.2		0.1	0.3	0.4	0.3				0.2	0.2	0.3
Autism spectrum disorders	28	0.4	0.6	0.2	0.5	0.5	0.5	0.4	0.4	0.4	0.3	0.3	0.3	0.5	0.2
Attention-deficit/hyper-activity disorder	85	1.1	1.7	0.6	0.2	2.4	3.1	2.4	1.7	0.9	0.3		0.7	0.4	1.1
Conduct disorder	40	0.5	0.7	0.4		1.1	3.6	2.1							
Developmental disorder (idiopathic) ^d	108	1.5	1.5	1.4	2.2	2.3	2.2	2.0	1.8	1.3	0.7	0.4	1.1	1.1	1.1
Other mental disorders ^e	117	1.6	1.9	1.3			0.1	0.4	1.0	2.2	2.6	2.7	2.2	2.7	1.8

Source: IHME, 2019 (96).

^a Includes major depressive disorder and dysthymia.

^b Includes all anxiety disorders and PTSD.

^c Includes anorexia and bulimia nervosa.

^d For more information on developmental disorder and autism spectrum disorders see the forthcoming WHO-UNICEF Report on *Developmental Delays and Disabilities*.

^e A residual cause within GBD which includes personality disorders.

Note. These are GBD 2019 data and do not necessarily represent ICD-11 categorization. Blank cells indicate 0.0%. Rates are adjusted for independent comorbidity but not for dependent comorbidity. All prevalence data reflect point prevalence, except for bipolar disorder for which a 12-month prevalence was calculated.

CASE STUDY

BOX 3.2

Depression and anxiety in times of COVID-19

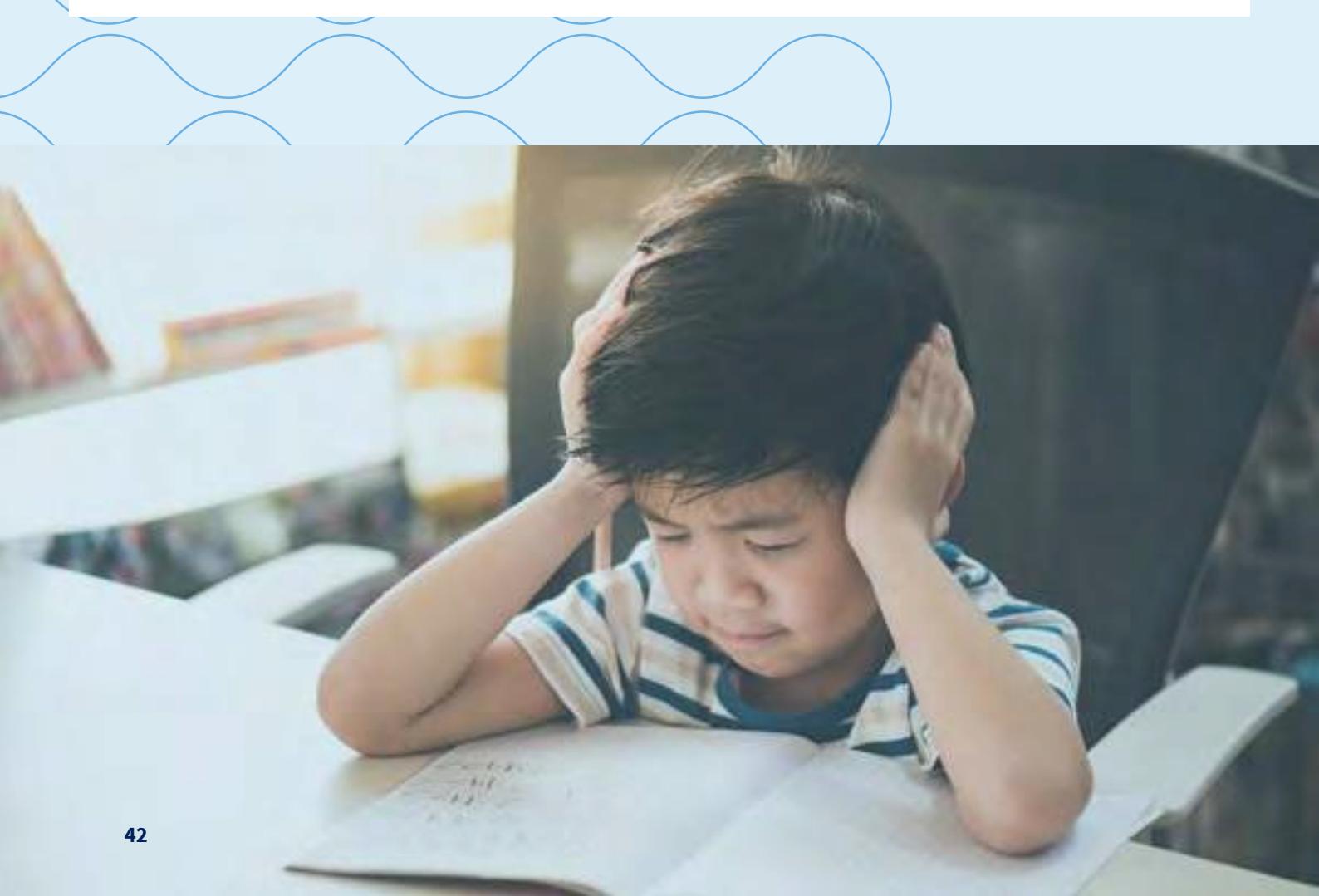
GBD 2020 estimated a substantial increase in depressive and anxiety disorders as a result of the COVID-19 pandemic, taking into account many of the uncertainties around epidemiological estimates of mental disorders in major emergencies.

Before the pandemic, an estimated 193 million people (2 471 cases per 100 000 population) had major depressive disorder; and 298 million people (3 825 cases per 100 000 population) had anxiety disorders in 2020. After adjusting for the COVID-19 pandemic, initial estimates show a jump to 246 million (3 153 cases per 100 000 population) for major depressive disorder and 374 million (4 802 per 100 000 population) for anxiety disorders.

This represents an increase of 28% and 26% for major depressive disorders and anxiety disorders, respectively in just one year.

In both cases, the countries that were hit hardest by the pandemic had the greatest increases in disorder prevalence. All over the world, there was a greater increase in disorder prevalence among females than among males, likely because females were more likely to be affected by the social and economic consequences of the pandemic. And globally there was also a greater change in prevalence among younger age groups than older ones, potentially reflecting the deep impact of school closures and social restrictions on youth mental health.

Source: COVID-19 Mental Disorders Collaborators, 2021 (68).



INSIGHT

BOX 3.3

Severity of mental health conditions and the principle of vertical equity

A key input into the WHO's Global Health Estimates (GHE) are the so-called "health state weights", which are used to adjust time spent in a particular state of health by its associated level of diminished health or impairment (on a scale of 0 to 1, where 0 denotes full health or no impairment).

The most impairing state across all health conditions – both in GHE 2019 and GBD 2019 – is acute schizophrenia, which is given a health state weight of 0.78. Put simply, this means an individual experiencing acute schizophrenia is expected to have only one fifth of the health and functioning of a fully healthy person. Severe depressive episode is considered the fifth most impairing health state; and the residual state of schizophrenia is tenth.

Estimating health state weights can also help to inform discussions around "vertical equity". This concept means giving more attention to those with greater need. It is distinct from horizontal equity, which is focused on equal access or treatment for equal need (such as ensuring equal access to care in urban and rural areas). Indeed, several countries have explicitly included the severity of a disease or condition as a key criterion for priority-setting. So, from a vertical equity perspective, care for schizophrenia and other severe mental health conditions, including severe episodes of depressive disorder, should be accorded priority because of the impairment involved.

Sources: Barra et al, 2020 (104); WHO, 2006 (103).

Prevalence in males and females

Depressive and anxiety disorders are about 50% more common among women than men throughout the life-course, while men are more likely to have a substance use disorder. As depressive and anxiety disorders account for most cases of mental disorder, overall, slightly more women (13.5% or 508 million) than men (12.5% or 462 million) live with a mental disorder (see Table 3.1).

Mental disorders are common among pregnant women and women who have just given birth, often with severe impacts for both mothers and babies. Worldwide, more than 10% of pregnant

women and women who have just given birth experience depression (105). In LMICs this figure is estimated to be substantially higher.

Women who have experienced intimate partner violence or sexual violence are particularly vulnerable to developing a mental health condition, with significant associations found between victimization and depression, anxiety, stress conditions including PTSD, and suicidal ideation (106). Women living with a severe mental disorder are much more likely to have experienced domestic and sexual violence during their life than other women (107).

Prevalence in children and adolescents

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

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

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

Prevalence in older adults

Around 13% of adults aged 70 years and over lived with a mental disorder in 2019, mainly depressive and anxiety disorders. Sex differences in rates of mental disorders increase in this age category as 14.2% of women and 11.7% of men aged over 70 years are estimated to have a mental disorder. Prevalence estimates for schizophrenia are lower in adults aged over 70 years (0.2%) compared with adults under 70 years

of age (0.3%), which in part may be explained by premature mortality (see [section 3.1.2 Mortality](#)).

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

Geographical disparities

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

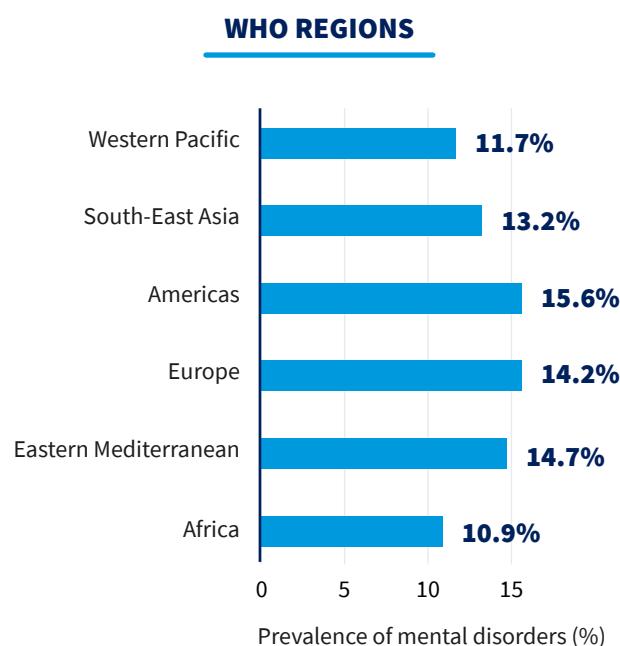
Mental disorders are somewhat more common in high-income countries (15.1%) but they are also common in low-income countries (11.6%) (see [Fig. 3.3](#)).

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

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

FIG. 3.3

Prevalence of mental disorders across WHO regions, 2019



Source: IHME, 2019 (112).

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

3.1.2 Mortality

Premature mortality

Estimating mortality from mental health conditions is complex. Both mental health conditions and suicide are rarely recorded as the cause of death on death certificates or in country mortality statistics. Yet poor mental health is often an important underlying or causative factor. Across the world, people with mental health conditions are known to experience disproportionately higher mortality rates compared with the general population (114).

People with severe mental health conditions – including schizophrenia and bipolar disorder – die on average 10 to 20 years earlier than the general population (115). Most of these deaths are due

to preventable diseases, especially cardiovascular disease, respiratory disease and infection, which are more common in people with mental health conditions. In these cases, having a mental health condition may not be the cause of death, but it is likely to be a major contributing factor.

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

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

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



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

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

Suicide

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

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

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

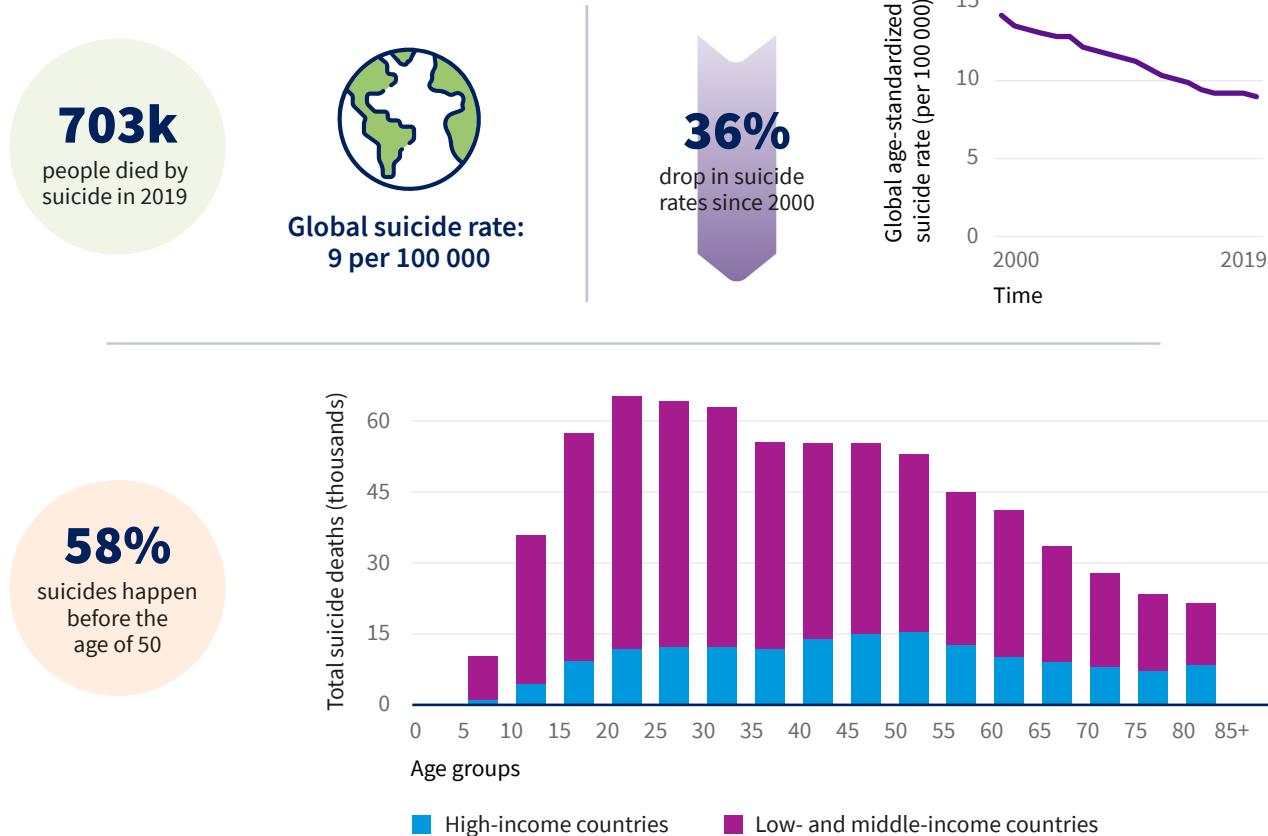
women do. In high-income countries the male-to-female ratio for death by suicide is even higher, at three men to every woman.

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

Suicide accounts for 1 in 100 deaths globally.

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

FIG. 3.4
Suicides in 2019



Source: WHO, 2021 (125).



NARRATIVE

I abandoned everything and everyone

Marie's experience

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

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



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

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

Marie Abanga, Cameroon

3.1.3 Burden

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

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

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

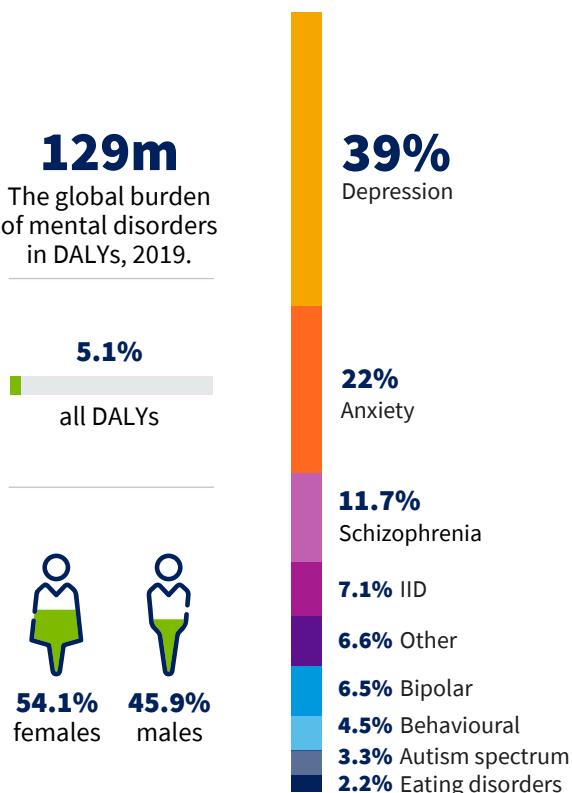
adulthood and old age, where depressive and anxiety disorders dominate. Overall, the greatest burden is carried during early adulthood.

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

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

FIG. 3.5

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



Source: WHO, 2019 (128).

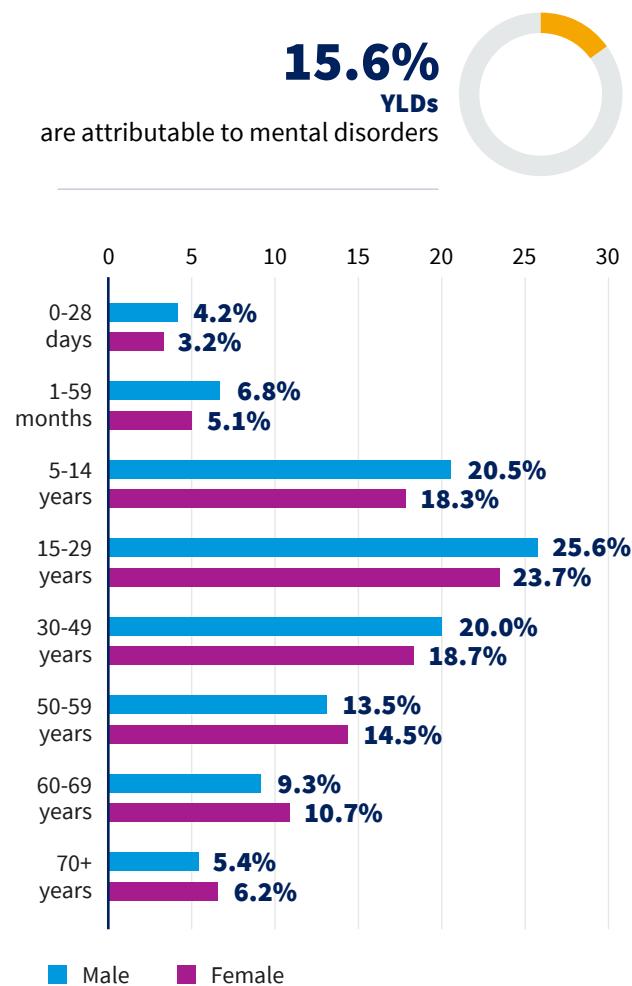
Globally, mental disorders account for **1 in 6 years** lived with disability.

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

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

FIG. 3.6

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



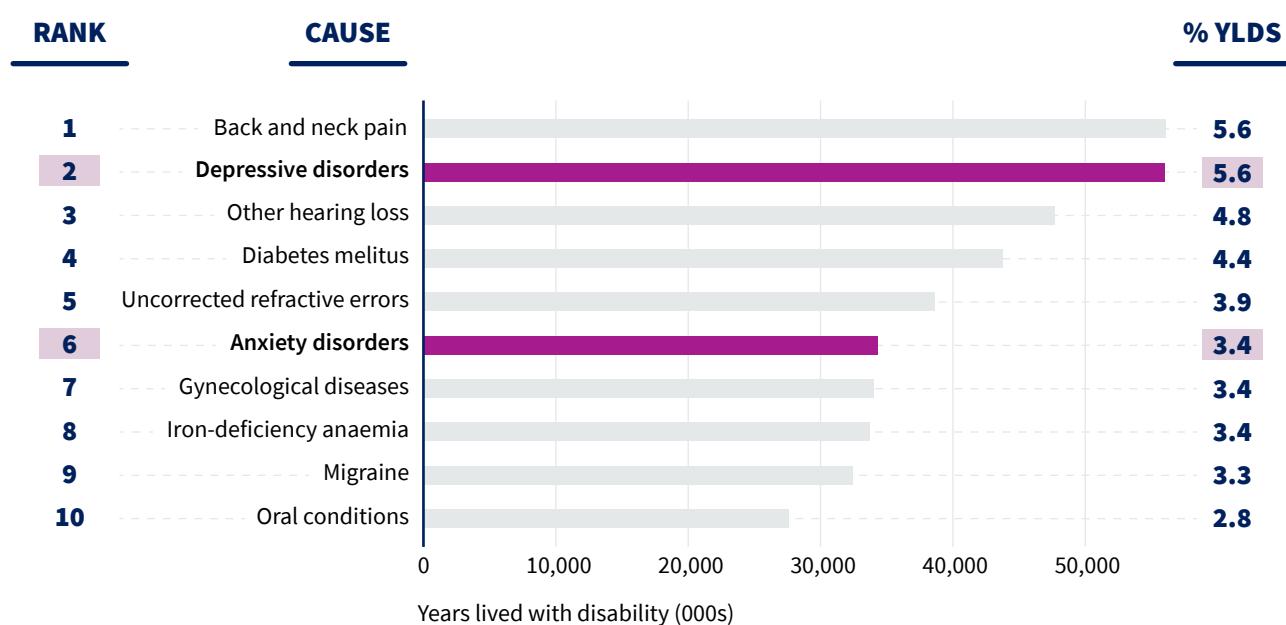
Source: WHO, 2019 (129).

Depressive disorders alone are the second leading cause of global YLDs, accounting for 5.6% of all YLDs in 2019 (see Fig. 3.7). Two important risk factors for these common mental disorders have been quantified as part of GBD 2019: childhood sexual abuse (exposure before 15 years to any unwanted sexual contact); and bullying victimization (intentional and repeated

harm of children and adolescents attending school by peers). In 2019, global age-standardized levels of lifetime exposure to childhood sexual abuse and bullying victimization in the preceding year amounted to 9.4% and 7.3%, respectively (130). Together, these modifiable risk factors accounted for 7.1% of all anxiety disorder DALYs and 9.9% of all major depressive disorder DALYs globally.

FIG. 3.7

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



Source: WHO, 2019 (129).

3.2 Economic consequences

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

These costs to society can be significant, often far outstripping health care costs. Researchers from the World Economic Forum calculated that a broadly defined set of mental health

conditions cost the world economy approximately US\$ 2.5 trillion in 2010, combining lost economic productivity (US\$ 1.7 trillion) and direct costs of care (US\$ 0.8 trillion) (131). This total cost was projected to rise to US\$ 6 trillion by 2030 alongside increased social costs. That's more than the researchers projected for the costs of cancer, diabetes and chronic respiratory disease combined. LMICs were predicted to bear 35% of the cost of these mental health conditions.

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

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

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

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

3.3 Gaps in public mental health

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

3.3.1 The information gap

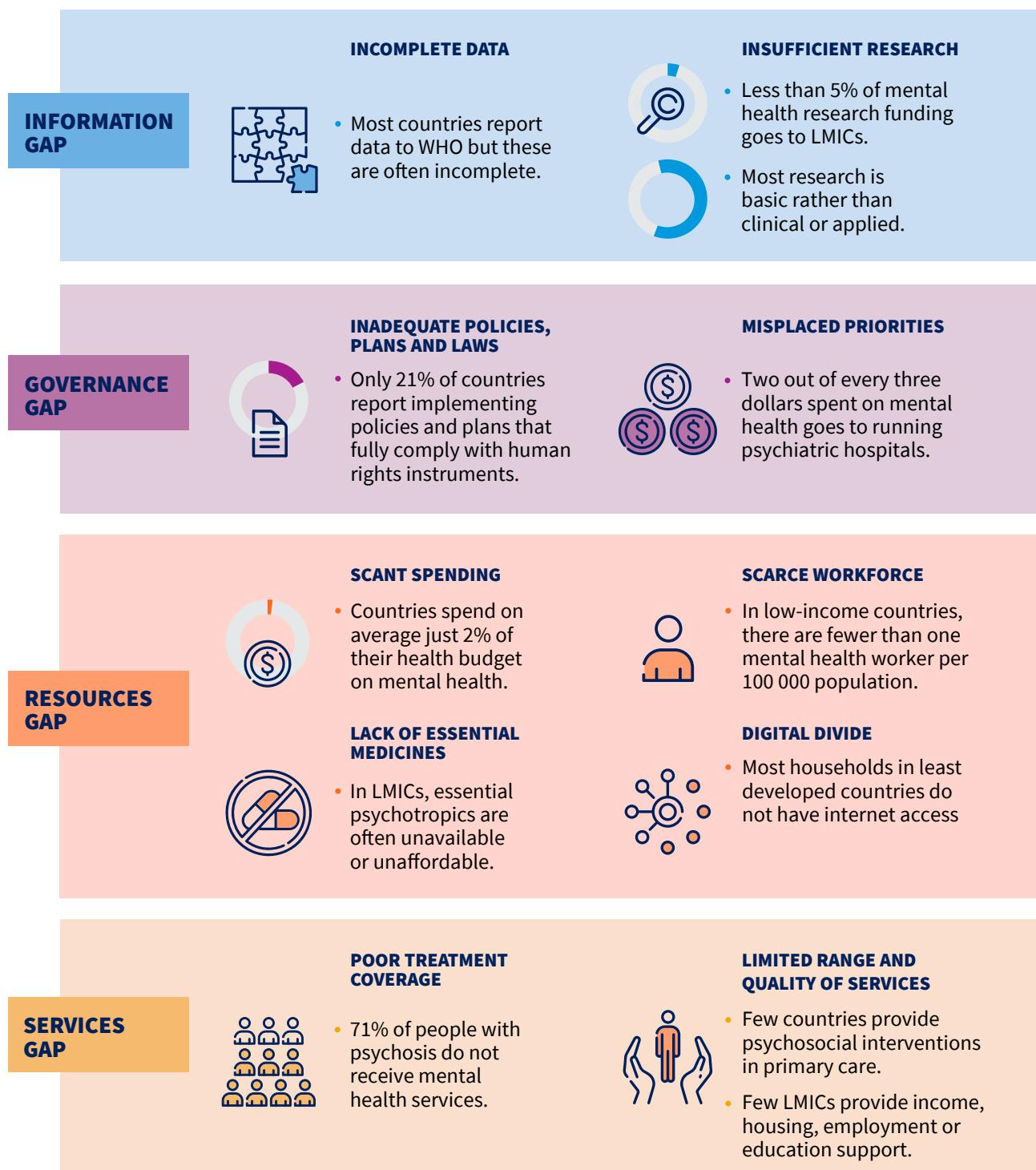
Limited mental health data

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

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

FIG. 3.8

A snapshot of key gaps in public mental health



But often the data that are reported are incomplete, particularly on service availability and use, which can be difficult to track. Nearly half of countries said they regularly compile data on

mental health service activity in the public sector for policy, planning or management. In most cases, especially among low-income countries, these data are only compiled as part of general

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

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

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

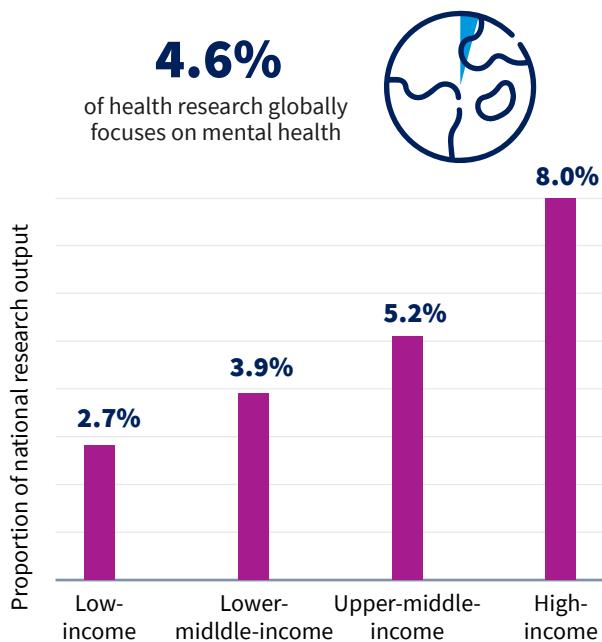
Insufficient and imbalanced research

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

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

FIG. 3.9

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



Source: WHO, 2021 (5).

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

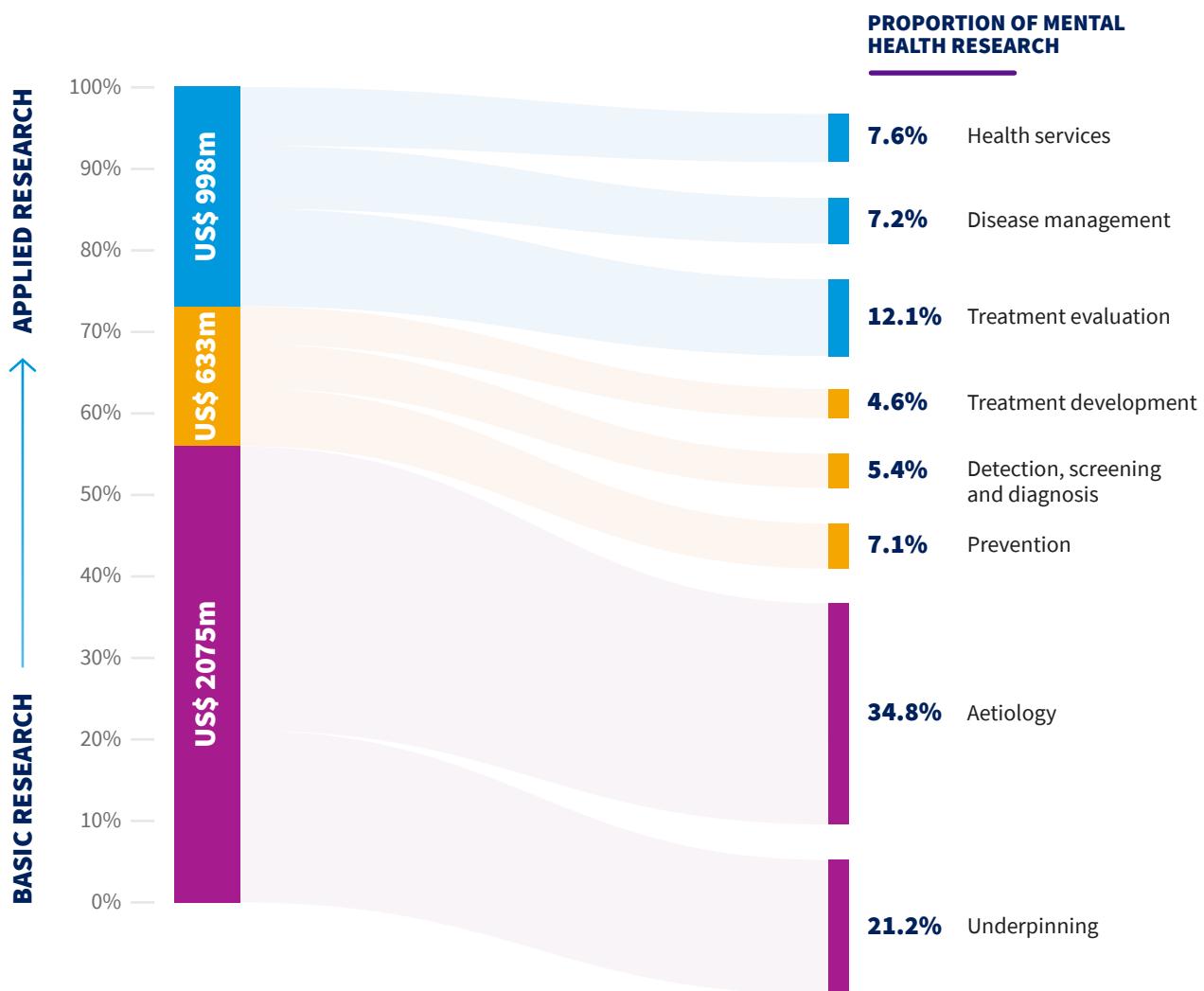
About US\$ 3.7 billion a year is spent globally on mental health research worldwide – an estimated 7% of global health research funding (137). Overall, more than half (56%) of all global funding for mental health research is spent on

basic research rather than clinical or applied research (see Fig. 3.10). Moreover, some fields of mental health are underfunded compared with others. Most notably, suicide and self-harm,

which is the subject of the only explicit SDG indicator on mental health, receives less than 1% of the overall mental health research funding.

FIG. 3.10

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



Source: Woelbert et al, 2020 (137).

3.3.2 The governance gap

Inadequate policies, plans and laws

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

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

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

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

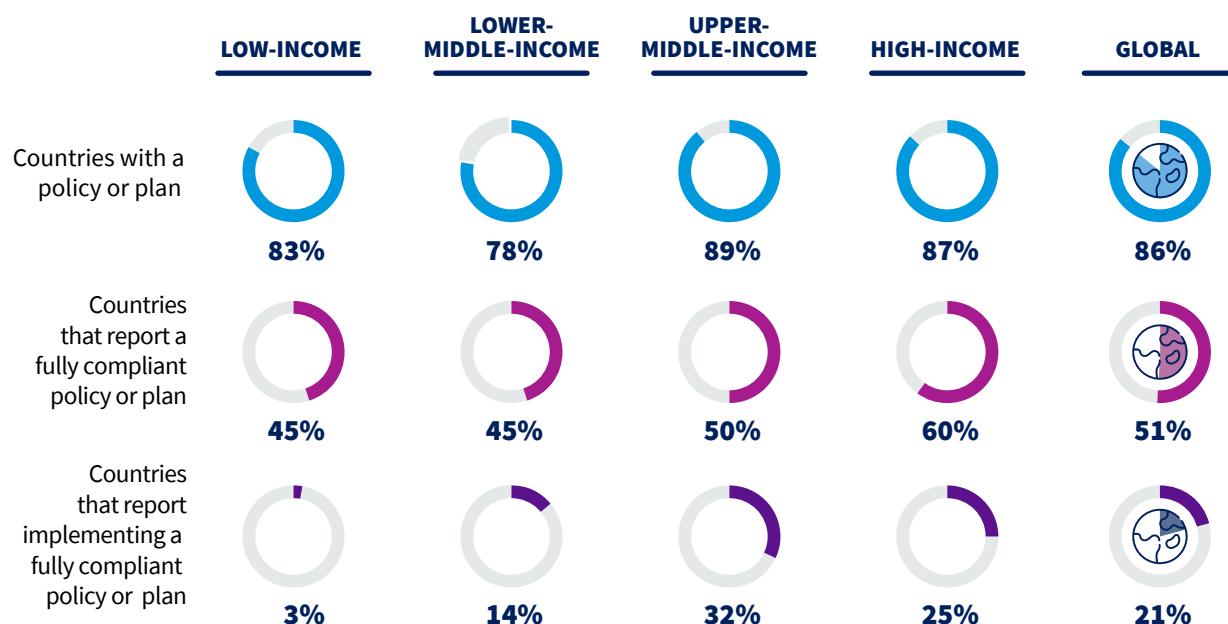
Only half (51%) of WHO Member States reported that their mental health policies or plans fully complied with human rights instruments. About a third (31%) reported plans that were being implemented. And only 21% of WHO Member States reported policies

or plans that were being implemented and fully compliant with human rights instruments. This proportion varied significantly across income groups, from 32% for upper-middle-income countries to just 3% for low-income countries (see Fig. 3.11).

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

FIG. 3.11

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



Source: WHO, 2021 (5).

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

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

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

Disparities and misplaced priorities

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

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

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

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

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

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

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

3.3.3 The resources gap

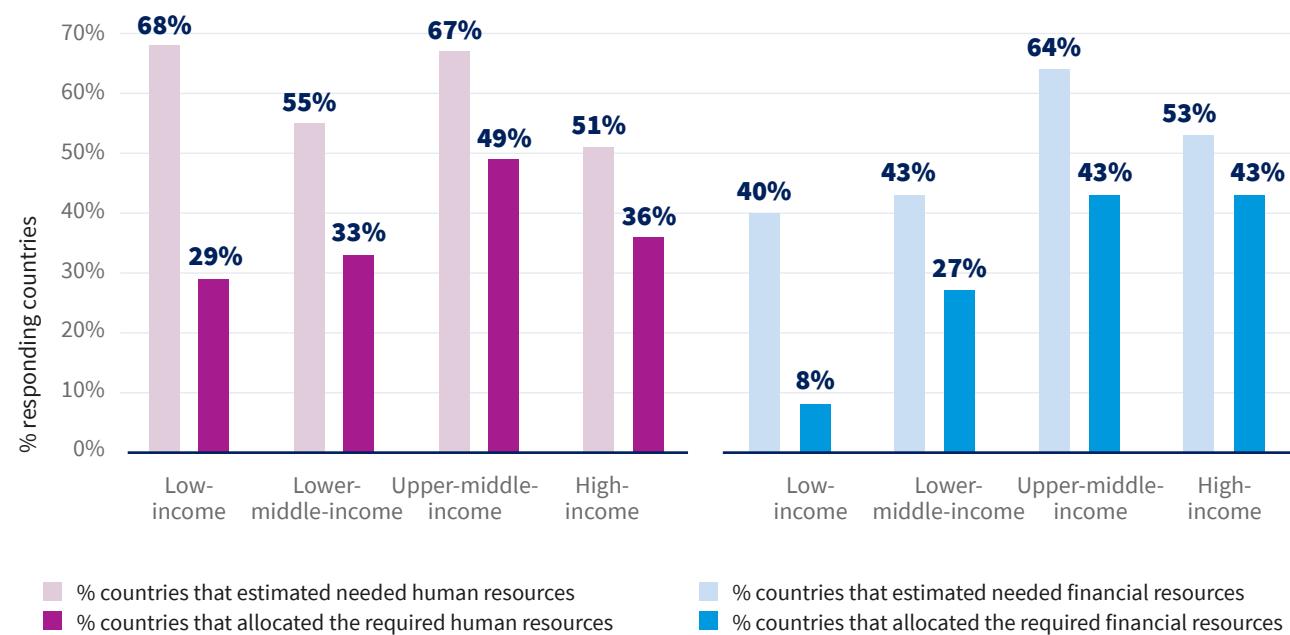
The limited implementation of mental health plans, policies and legislation is, in part, due to a lack of resources – both human and

financial – available for mental health. The *Mental health atlas 2020* shows that only half of countries with a mental health policy or plan have also estimated the financial resources they need to implement it (60% include an estimate of human resources required). And only around a third of countries have actually allocated financial and human resources to

implement their mental health policy or plan. The gap between estimating resources and allocating them is particularly stark among low-income countries. For example, while 40% of these countries have estimated the funding they need, only 8% have actually allocated the requisite resources (see Fig. 3.12).

FIG. 3.12

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



Source: WHO, 2021 (5).

Scant spending

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

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

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

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

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

Scarce workforce for mental health

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

Around half the world's population lives in countries where there is just one psychiatrist to serve 200 000 or more people. Other mental health care providers who are trained to use psychosocial interventions are even scarcer (5). In low-income countries there are fewer than one mental health worker of any kind per

100 000 population, compared with more than 60 in high-income countries (see Fig. 3.13; the median across all countries is 13 mental health workers per 100 000 population). Across all income groups, most mental health workers are nurses, who combined make up 44% of the global workforce for mental health.

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

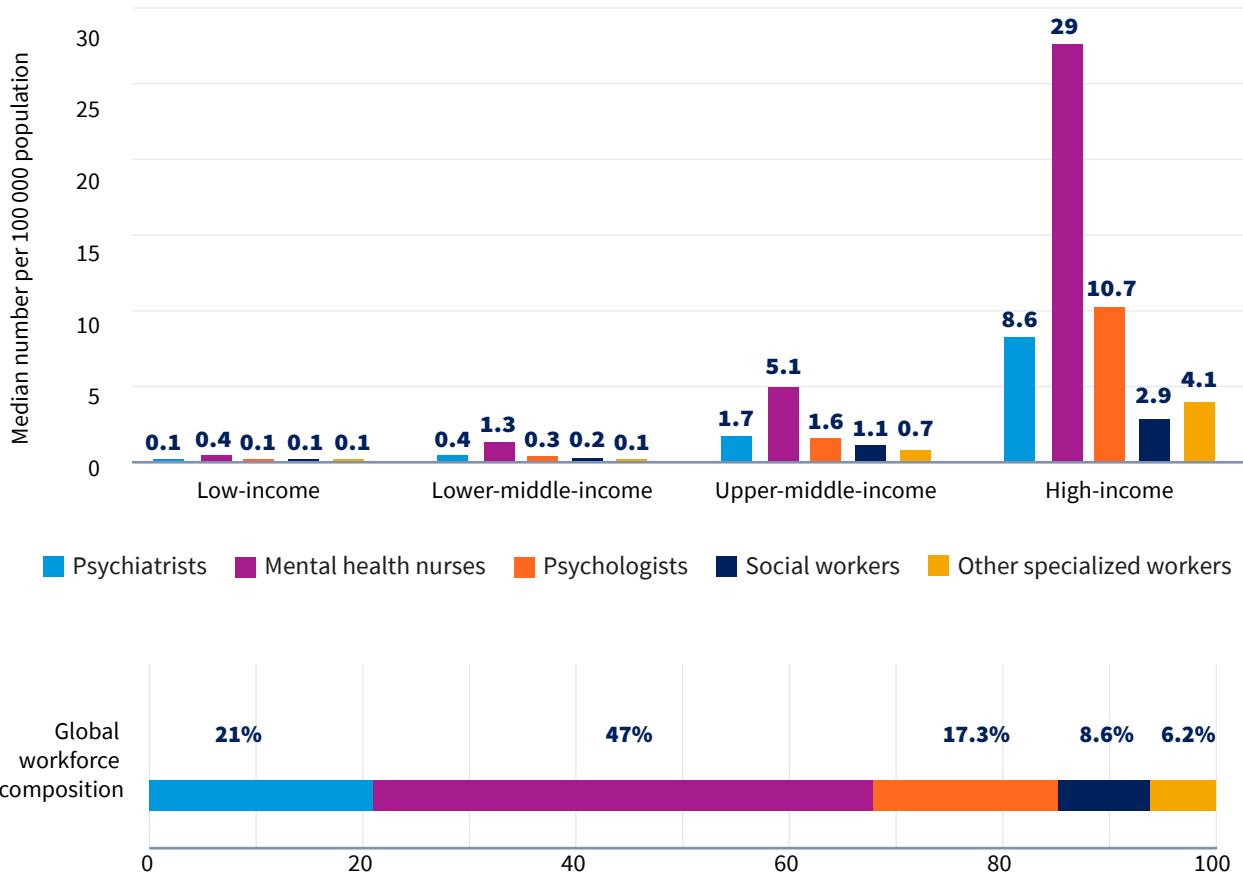
In LMICs, the mental health workforce for children and adolescents is almost non-existent.

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

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

FIG. 3.13

The specialized mental health workforce across country income groups



Source: WHO, 2021 (5).

Lack of essential medicines

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

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

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

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

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

A digital divide

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

But relying on digital technologies to deliver mental health services risks excluding some of the world's most vulnerable people from accessing the care they need and fails to address the full spectrum of mental health conditions that people experience. For many people in LMICs, mobile phones offer the only way of connecting to the internet and accessing valuable information and resources that would otherwise be out of

reach. Access to mobile phones has grown exponentially in recent years, with mobile networks now covering more than 85% of the population in every region of the world (145). But even where networks are available, not everyone has a smart phone, and even for those who do, internet access can be prohibitively expensive.

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

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

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

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

NARRATIVE

Living in a low-income country means facing disabling barriers to quality care



Eleni's experience

I struggle with bipolar disorder in Ethiopia, a low-income country. This means facing disabling barriers to access mental health care of minimum standards.

Medication supplies are scarce, irregular and expensive. Being a poor country comes with lack of hard currency to import such medications sustainably. More than often, I had to switch from a medication that enabled me live a stable life to a sub-optimal one because of unavailability in the market. Isn't it sad to report that many of my mood episodes were actually triggered by these involuntary changes in medication?

Even when the medicines are available, the prescribed dosage may not be. I remember I was prescribed a mood stabilizer with 25mg but only 100mg was available in the market. This left me with no other choice than having to split the tablet in 4

parts with a kitchen knife. Most of the time, half of the tablet will turn to powder as it does not have built-in breakable splits.

Not only medication but also laboratory tests are more than often unavailable to monitor therapeutic ranges. I was put on a mood stabilizer that required regular blood tests. I will never forget the toxic reactions I suffered because my blood level could not be monitored. Chemicals for those blood tests could not be imported at the time.

I have always covered my mental health treatment costs myself. I am privileged to have a middle-income family. But this imposed a heavy burden on our income. Health insurance schemes are not set. Sometimes, I would buy medications on the black market. They were very expensive but that was the price for a stable functional life.

Eleni Misganaw, Ethiopia



3.3.4 The services gap

Poor treatment coverage

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

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

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

Variable quality and range of services available

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

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

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

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

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

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

NARRATIVE

I am writing to you with a last hope

Mrs BN's experience

A few years ago my son, a student, fell ill and was admitted to the sanatorium of [...], which I would say has been forgotten by the world and God. The conditions there are miserable. As soon as I entered I was overwhelmed by a nightmarish atmosphere: dirty patients, dishevelled and very very skinny, surrounded me asking for some bread. As for the building, it is pitiful to look at: many broken windows, walls that haven't been painted for many years and toilets totally out of order.

There is not even one bed per patient so people have to sleep on mattresses on the floor. There is no running water and most of the cooking is done using rainwater. The worst is the food. I go there every week and see pigs' feet or heads on the inmates' plates. On several occasions I have seen mouldy margarine be served and rotten meat given to the cooks to prepare. I cannot find an explanation for why a normal man treats other people with such a lack of respect, like animals. Actually, worse than animals, since the

many dogs in the yard of the sanatorium are fed with lean, fresh meat (I've seen it myself). These dogs are allowed to run after and bite the inmates, making them so scared they won't leave the buildings to walk in the yard.

Some of the patients are exploited by the staff, either to work at their own homes or to do outdoor chores under the scorching sun. Patients are beaten or stuffed with sedatives and do not leave their beds.

Through several conversations and letters I have tried to improve the lives of those poor inmates, whose lives have already been stricken enough by their destiny and do not need to be made worse by other men. Someone has even answered me: "Why are you fighting that much? This place is but the waste of society."

This is why I am writing to you with a last hope.

Extract from a letter to WHO.



3.4 Barriers to demand for care

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

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

3.4.1 Poor supply

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

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

Locating services appropriately is key. In LMICs many mental health services are disproportionately concentrated in psychiatric

hospitals in or near major cities. This means that rural populations often cannot or choose not to use them: the journey may be too expensive; the transportation systems may be too unreliable; and the time required may be too much.

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

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

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

3.4.2 Low levels of health literacy about mental health

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

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

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

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

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

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

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

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

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

3.4.3 Stigma

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

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

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

NARRATIVE

You can achieve anything

Steven's experience

My chronic anxiety started around 15 years ago, when I was studying for my law degree. I put a lot of pressure on myself to be a high achiever and set the bar so high it was at times unachievable. I had low self-worth.

My anxiety got so bad it was hard to get out of bed some days. It stayed with me as I trained to become a lawyer. I couldn't tell management of my mental health struggles. I felt that I would be perceived as "weak" and "not able to do my job" and I felt I'd lose the respect of my colleagues.

I didn't want to go to work anymore. I felt I was changing, becoming someone I didn't recognize or like. I tried to discuss it with my family but couldn't express how I was feeling in words. It still hurts today when I cast my mind back to this difficult period of my life.

Then I had a lightbulb moment. I reached out for support from a psychologist. It was a breath of fresh air. For the first time I felt somebody understood and didn't judge me. This lifted a huge weight off my shoulders.



The psychologist showed me how I could break things down which allowed me to cope better and not become so overwhelmed with life. I have used this advice in every aspect of my life, even today, running my own company promoting mental health awareness within business and law firms.

I still suffer with my anxiety and feelings of low self-worth. But I have learned to manage them and I am in a happy place with a good mindset. I have also been successful in what I do, which I believe is because I have lived experience and can relate to the needs of my clients.

I would like to advise anyone reading this to not let your mental health struggles define who you are. Do not feel pressured to perform or rush things: you are on your own path and you will achieve your dreams and goals in your own time.

Steven Lawlor, United Kingdom

severe mental health conditions are particularly at risk of sexual violence. Violence against people with mental health conditions can be deadly.

In many communities, mental health conditions are not considered to be health issues, but are seen as a weakness of character, a punishment

for immoral behaviour or the result of illicit drug taking or supernatural forces. In all cases, the media can exacerbate misconceptions by portraying people with mental health conditions as dangerous, irresponsible or incapable of making rational decisions (156).

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

The stigma attached to mental health conditions is universal, pervading across cultures and contexts in countries everywhere. People living with mental health conditions can experience stigma from

families, neighbours, and from health professionals themselves (158). In some cases, they can internalize negative messages and stereotypes and apply them to themselves in what is known as self-stigma. In many countries stigma extends to working in mental health care and can contribute to staff shortages in mental health systems (158).

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

NARRATIVE

Stigma stifled my recovery

Odireleng's experience

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

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

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

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

Odireleng Kasale, Botswana



Benefits of change

PUBLIC HEALTH
HUMAN RIGHTS
SOCIAL AND ECONOMIC DEVELOPMENT

Chapter summary

In this chapter we make the case for investment in mental health, explaining how transforming mental health care provides a platform for advancing public health and well-being, protecting human rights and promoting social and economic development. This chapter showcases the benefits of change for individuals, families, communities and economies. And it makes clear how committing to mental health is an investment into a better life and future for all.



Key messages from this chapter are:

- Investing in mental health can greatly reduce suffering and advance public health.
- Transformation in mental health is needed to stop human rights violations that people with mental health conditions experience.
- Improving people's mental health improves educational outcomes and participation in the workforce, boosts productivity and strengthens social functioning to the benefit of all.
- Investing in mental health means investing in strategies to: ensure access to effective, quality, affordable mental health care for all; tackle stigma, discrimination and abuse; and address underlying social and economic realities that shape people's mental health.
- There is a core set of cost-effective interventions for priority mental health interventions that are feasible, affordable and appropriate.

The huge challenge posed by mental health conditions today calls for a transformation.

Rising interest in mental health over several decades has built international consensus for change and has created multiple options and opportunities for action, as described in the *Comprehensive mental health action plan 2013–2030* (3). Most recently, the COVID-19 pandemic put the value and vulnerability of mental health under the spotlight and exposed huge gaps in mental health systems and structures all over the world (see Chapter 2, *In focus: COVID-19 and mental health*). More policy-makers than ever

understand the imperative for improvement and the appetite for change has never been greater.

As this chapter shows, the evidence available today makes a compelling case for change. The inextricable links between mental health and public health, human rights and socioeconomic development mean that transforming policy and practice in mental health can deliver real, substantive benefits for individuals, communities and countries everywhere. Investment into mental health is an investment into a better life and future for all.

4.1 Advancing public health

4.1.1 Reduced suffering and improved mental health and well-being

Investment and transformation in mental health is needed because good mental health is fundamental to any individual's health and well-being, including their capacity to live a fulfilling life. Conversely, experiencing a mental health condition is associated with mental suffering and, for too many people, social exclusion (read [Zineb's experience](#)).

Mental disorders affect one in eight people around the world and exact a high toll on public health (see Chapter 3 *World mental health today*). In 2019, they were the largest contributor to global non-fatal disease burden (measured as years lived with disability YLDs). People experiencing a mental health condition are a vastly underserved group. As such, their capacity to cope, connect, function and thrive is compromised; and they face a far greater risk of suicide and physical illness. People living with severe mental health

conditions die 10–20 years earlier than the general population, most often through unrecognized and untreated physical health conditions.

Investing in mental health can greatly reduce suffering and improve the quality of life, social functioning and life expectancy of people with mental health conditions. It can both close the vast care gap that exists for mental health conditions and move significantly closer towards universal health coverage.

There is now more-than-adequate evidence upon which to act and invest, no matter the resource context.

For decades, doubt has been cast on mental health interventions' effectiveness and on their collective ability to reduce public health burden, especially in LMICs. But there is now more-than-adequate evidence upon which to act and invest, no matter the resource context (15, 159). For example, a modelling study focused on low-income countries showed that investing

**NARRATIVE**

We no longer have the capacity to bear Zineb's experience

I am the mother of Mohammed, 27, who has had schizophrenia for ten years, and his big brother Younes, may God rest his soul, who was suffering from the same.

In 2015, Younes' condition deteriorated and he died. Mohammed was deeply affected by his brother's death and since then has also severely deteriorated. There has been constant delirium, non-acceptance of treatment and severe violence towards us. We felt forced to leave our house for him and we bought a simple apartment to shelter from his violence. We feel guilty that we left him alone, but we had to.

Mohammed has repeatedly tried to end his life and it nearly happened. His condition is getting worse day by day. We no longer have the capacity to bear.

We feel psychologically and physically destroyed. We and those like us are in dire need of assistance

and facilities to save our children. We have endured the complexities of administrative procedures and expenses to no avail. There is no place in the public hospital, and the expenses of the private hospital are extremely high and we have no energy anymore.

I know Mohammed loves me so much but I live in fear of him. And now he has become depressed and lives in isolation and cannot face people.

Civil society is trying to help as much as possible. I have begun a training programme aimed at increasing the capacity of families to cope with a family member's illness, but my situation makes me unable to focus and absorb information.

A solution must be found for people to enjoy their right to care and rehabilitation so they can be part of society. This requires concerted efforts between relevant sectors and stakeholders. It is necessary and urgent.

Zineb, Morocco

just US\$ 1 per capita annually in a package of evidence-based care for priority mental health conditions could reduce YLDs by close to 5 000 per million population each year (160). For a more scaled-up package of care costing US\$ 2 per capita, the burden of mental health conditions is reduced by 13 000 YLDs per million population. So, for a country with 50 million inhabitants, this modest annual investment

of US\$ 1–2 per capita cuts 250 000 to 650 000 years-worth of disability across the population.

Promote, protect, restore

In part, public health is about promoting and protecting mental and physical health by identifying the underlying factors that influence health – the individual, social and structural

determinants – and intervening to enhance protective factors or reduce risks. This public health function includes a wide range of activities that can be targeted at individuals, groups of vulnerable people or whole populations.

Interventions where the evidence and experience of mental health benefits are particularly compelling include:

- suicide prevention strategies;
- positive parenting and preschool education and enrichment programmes;
- school-based social and emotional learning programmes; and
- mental health promotion and protection in work settings.

For more information on, and real-world examples of, evidence-based strategies for promoting and protecting mental health see [Chapter 6 Promotion and prevention for change](#).

For people experiencing mental health conditions, promotion and prevention is not enough and access to quality interventions to improve or restore mental health is essential. A range of effective and evidence-based interventions exist, yet they are unavailable to most people around the world who could benefit from them. This massive gap between the need for and uptake of care was the primary motivation behind WHO's Mental Health Gap Action Programme (mhGAP). The programme seeks to significantly expand coverage of evidence-based interventions for a range of priority conditions, with a focus on primary health care and other non-specialized health care settings in LMICs ([161](#)).

Providing essential care for everyone who needs it means not just integrating mental health care into primary health care. It also requires the development, strengthening or reorganization of mental health services to ensure a range of other community-based mental health care options

are available, including acute inpatient care at general hospitals or community mental health centers or teams. And it involves supporting a comprehensive set of interventions beyond the health sector, alongside scaling down and closing long-stay psychiatric institutions while ensuring support in the community for discharged residents. For more information on what that restructure looks like in practice see [Chapter 7 Restructuring and scaling up care for impact](#).

Working with other relevant sectors is especially important because clinical practice is just one part of the mental health care puzzle. For many people living with mental health conditions, recovery requires access to a broader programme of support that includes a range of activities specifically aimed at supporting social inclusion, including support in maintaining independence, making social connections, participating in community activities, managing complex relationships, and accessing supported housing, work or education. All these services and supports across sectors should protect and promote human rights (see [section 4.2 Promoting and protecting human rights](#)) (23).

4.1.2 Improved physical health

The intimate links between mental health conditions and physical health mean that investing in mental health does not only reduce massive population suffering but can also deliver widespread physical health benefits.

Many of the factors that influence mental health also influence other health conditions such as those related to reproductive and maternal health as well as chronic physical diseases, including NCDs such as cardiovascular diseases, diabetes, cancer and respiratory diseases; communicable diseases such as HIV/AIDS, and neglected tropical diseases (NTDs) such as leprosy and cutaneous leishmaniasis.

The four greatest risk factors for NCDs – tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol – are all linked with various mental health conditions (162). Childhood adversity, which is a major risk factor for later-life mental health conditions, is similarly related to a range of adult-onset NCDs, including heart disease, diabetes and asthma (163).

Mental health conditions affect and are affected by chronic physical diseases (see Table 4.1). They can be precursors of one another, consequences, or the result of interactive effects. For example, people with depression or anxiety experience

adverse changes in endocrine and immune functioning that increases their susceptibility to a range of chronic diseases. They are also more likely to engage in risk behaviours such as smoking and substance use. Conversely, people with chronic diseases are put under physical and psychological stress that can trigger the onset of depression or anxiety (163).

Links between some chronic diseases (including both HIV/AIDS and several NTDs) and brain health have also been found, leading to neurological consequences that can result in significant illness and death (164, 165).



TABLE 4.1

Evidence on the bidirectional links between mental health conditions and physical diseases

Chronic disease	Bidirectional links to mental health
Noncommunicable diseases	<ul style="list-style-type: none"> • People living with heart disease are more than twice as likely to also have depression or anxiety than other people. • Diabetes is significantly linked with depression, intermittent explosive disorder, binge eating disorder and bulimia nervosa. • Depression is particularly prevalent in people with cancer. • There is a strong connection between stroke and depression in both directions. • People with common mental health conditions have an excess mortality of 8–12% through smoking, diabetes, history of myocardial infarction and hypertension.
HIV/AIDS	<ul style="list-style-type: none"> • Mental health conditions are more prevalent among people living with HIV/AIDS than among the general population. • Women living with HIV experience higher rates of depression, anxiety and PTSD symptoms than either men living with HIV or women who are HIV negative. • Exposure to abuse at home increases the likelihood of adolescent mental health conditions, which in turn can make it difficult for adolescents to protect themselves from HIV risk. • Treating depression can improve adherence to care and clinical outcomes for people living with HIV/AIDS.
Tuberculosis	<ul style="list-style-type: none"> • Depression and anxiety are more prevalent among people with tuberculosis than among the general population. • Untreated depression and psychological distress in people with tuberculosis are associated with worse clinical outcomes, poorer quality of life and greater disability. • Depression is significantly linked to non-adherence to tuberculosis treatment. • Medicines for tuberculosis can have negative impacts on mental health.
Neglected Tropical Diseases	<ul style="list-style-type: none"> • Cutaneous leishmaniasis, onchocerciasis and snakebite envenoming are all linked to anxiety, depression and psychological distress. • One in two people with leprosy or lymphatic filariasis experiences depression or anxiety. • In people with lymphatic filariasis, depression has been estimated to almost double the total burden of disease.

Sources: Stein et al, 2019 (163), WHO and UNAIDS (166); Fujiwara, 2022 (167); WHO, 2020 (168).

The multiple links between mental health conditions and other chronic diseases mean they often co-occur. Children with long-term physical health conditions are twice as likely to have an emotional or behavioural condition than other children; while adults with chronic diseases are two to three times more likely to develop depression than the rest of the population. People with three or more physical health conditions are seven times more likely to have depression (169).

HIV/AIDS and tuberculosis (TB) are both similarly associated with various mental health conditions. People living with HIV are twice as likely to experience severe depression compared with other people (170). And a recent systematic review shows that the risk of death by suicide is 100 times higher in people living with HIV than in the general population (171). A study in Ethiopia similarly showed that half of people with TB had symptoms consistent with depression and that this group of people – who were much more likely to drop out of TB treatment – was half as likely to be alive at a six months follow up (172).

At a global level, comorbidity of mental and physical health conditions has become the rule rather than the exception, especially in people over 60 years of age (173).

Having both physical and mental health conditions delays recovery from both. Comorbidity makes the treatment of all conditions more difficult, often resulting in more complications. For example, people with chronic diseases who are depressed may find it harder to care for themselves, adhere to treatment or to reach out for health or social support when necessary. This leads to worse health outcomes, more hospitalizations and higher health care expenditures. For people living with HIV/AIDS or TB, dropping out of treatment also increases the risk of further transmission and multidrug-resistant disease (173).

It is clear that individuals cannot attain full physical health without mental health. All over the world, countries cannot achieve their objectives for most priority diseases without simultaneously investing in mental health.

Integrated care is good care

When people with comorbid conditions arrive in health care, they are usually treated for one or the other of their conditions but not both. As a result, many conditions go unrecognized and untreated in their early stages, increasing the risk of disability and premature death (see section 3.1.2 Mortality). Indeed, the most common cause of death among people with severe mental health conditions is cardiovascular disease (174).

An integrated approach to care ensures mental and physical health conditions are considered, managed and monitored simultaneously.

An integrated approach to care ensures mental and physical health conditions are considered, managed and monitored simultaneously. Implemented well, it can improve accessibility, reduce fragmentation and duplication of infrastructure and resources and better meet people's health needs and expectations.

Integration can be implemented in many ways and at different levels of the health system (175).

- **For service users**, integrated care is about having a person-centred approach that is coordinated across diseases, settings and time.
- **For health care organizations**, integrated care is about having common information systems and professional partnerships based on shared roles and responsibilities, for example through multidisciplinary teams, task sharing and links to social care and community services.
- **For ministries of health**, integrated care is about having joint policies, financing mechanisms and governance structures across physical and mental health.

Integrating mental health services into primary care is a key strategy at the level of health care organizations (see section 7.2.1 Mental health in primary care). Collaborative care models in particular have been shown to improve mental health outcomes, including in people with comorbid NCDs (176, 177). A proven approach is to use service delivery platforms that already exist for chronic diseases as the basis for expanding mental health services. For example, specific platforms used to support HIV care can be used as entry points for integrating harm reduction services and care for people living with mental health conditions (167).

For more information on evidence-based strategies for integrating mental and physical health care across all health care platforms, including primary care, general hospitals and disease-specific health services, see Chapter 7 Restructuring and scaling up care for impact.

4.1.3 Greater equity of access

Investment and transformation in mental health are needed because mental health and mental health care are marked by inequality. The significant influence that structural factors can have on mental health means that some groups of people in society have far poorer mental health than others. In many cases, those same people also have less access to effective and appropriate care because they are geographically distant from, or unable to pay for, services.

Particularly in lower-income settings, this means that a substantial proportion of people with mental health conditions cannot access the care they need. This can lead to worsening mental health, with adverse consequences on people's abilities to work, learn or parent. Often, people who access care have to pay for it themselves because it is excluded from essential packages of care and insurance schemes.

Direct out-of-pocket spending is an unfair way of paying for health care since poorer households end up paying a proportionately greater amount of their available income (by contrast, tax-based health insurance typically requires higher contributions from wealthier households). Cost of care is known to be a major barrier to people with mental health conditions seeking help (178).

Private purchase is an unfair and regressive way of paying for health care.

Out-of-pocket spending on mental health care often pushes people to adopt undesirable coping strategies – such as cutting household spending, using up life savings, selling assets or borrowing – which entrenches poverty and intergenerational disadvantage and can lead to poorer health outcomes (10). Importantly it is not only the costs of treatment that puts people at financial risk, but also transport costs, loss of income for individuals and their carers, and other indirect costs.

Addressing inequalities as part of mental health reform is essential to provide the right services in the right ways and places to reach everyone and anyone. Addressing people's social needs, for example through social work-type interventions, is essential as part of, or alongside, mental health care. In addition, it is crucial to address the population-level structural determinants of mental health that create social disadvantage (see section 6.1.3 Building structural capital for mental health). Other strategies focus on scaling up access to care, including by enhancing health coverage and financial protection.

Mental health for all

Including mental health conditions and interventions in UHC basic packages of essential services is a fundamental step towards closing the care gap.

Ultimately, interventions provided under UHC should ensure that all essential mental health needs are covered. This means they need to be comprehensive, including evidence-based psychosocial and pharmacological interventions, as described in WHO's UHC compendium (see section 5.1.3 Evidence to inform policy and practice) (179).

Interventions provided under UHC should ensure that all essential mental health needs are covered.

Universal public health policies that finance interventions for all can also lead to a fairer allocation of public health resources and benefit

the lowest-income groups most (see Box 4.1 Chile: including mental health conditions in UHC). In this sense, enhanced health coverage is important to protect people from the potentially catastrophic cost of paying for health services out of their own pockets.

Enhanced coverage and increased financial protection are essentially two sides of the same equity coin. Improved coverage without a corresponding rise in financial protection will lead to inequitable rates of service uptake and outcomes. But improved financial protection without expanded coverage will bring little improvement at all.





CASE STUDY

BOX 4.1

Chile: including mental health conditions in UHC

In 2005, as part of a broad process of health reform, Chile introduced Acceso Universal con Garantías Explícitas (GES), a universal health coverage package of medical and psychosocial benefits.

The package, which is periodically updated, comprises a prioritized list of diagnoses and treatments for 85 health conditions, including depression, bipolar disorder, alcohol/drug dependence, schizophrenia and dementia. GES gives equal rights to both public and private sector beneficiaries. It guarantees access to quality health care through eligibility criteria, accreditation of facilities, and professional certification. It also ensures care is timely and affordable by setting upper limits on waiting times and out-of-pocket co-payments.

Overall, GES has made the Chilean health system more efficient by emphasizing health priorities. Health services have become more accessible for all, with coverage of the lowest income quintile increasing by 20%. The proportion of people with depression who die during or shortly after admission to hospital has dropped. And, by integrating mental health into all levels of the general health care, early care for first-episode schizophrenia has improved.

People using GES say it has increased access to care, enabled diagnosis and treatment for the underprivileged, and guaranteed financial protection.

Consolidating community mental health services across the country has been critical for GES. Delivered through multisectoral teams, these services provide prevention, treatment and rehabilitation for people with severe mental health conditions. Most users can access psychotropic medicines free of charge. More than half also receive brief individual psychological treatment. And almost all users receive some other kind of individual, family or group psychosocial intervention.

These community mental health services are deeply connected to primary health care with robust systems for referral and counter referral. Every month, members of the community mental health team visit each primary care center in their catchment area to discuss complex cases and empower primary care teams in their clinical and community management. The result is that around 80% of people approaching GES for help with mental health conditions are treated by primary care professionals.

Sources: Aguilera et al, 2015 (180); Bitran, 2013 (181); Araya et al, 2018 (182).

4.2 Promoting and protecting human rights

Investment and transformation in mental health is needed to help stop the widespread human rights violations that people with mental health conditions experience worldwide.

In 2008, the Convention on the Rights of Persons with Disabilities (CRPD) came into force. Comprising 50 individual Articles, this legally binding treaty marked a major milestone in efforts to promote, protect and ensure the full and equal enjoyment of all human rights for people with disabilities, including psychosocial disabilities.

Psychosocial disabilities arise when someone's long-term mental impairments interact with societal barriers such as stigma, discrimination and exclusion, and so hinder their full and effective participation in society on an equal basis with others.

Among a range of human rights, the CRPD is designed to ensure all people have the full and equal enjoyment of the right to:

- life;
- equal recognition before the law (legal capacity);
- access to justice;
- liberty and security of the person;
- freedom from exploitation, violence and abuse;
- live independently and be included in the community;
- habitation and rehabilitation;
- health, education, work and employment;
- adequate standard of living and social protection; and
- participation in political and public life.

The CRPD is invaluable in ensuring that people experiencing mental health conditions have these rights. But despite widespread ratification of the CRPD, people with mental

health conditions worldwide continue to be denied human rights and protections through discriminatory attitudes, actions and laws. They are also often subjected to serious abuse, both in institutions and in the community. As long as these human rights violations are not fully addressed – including redressing physical, attitudinal, communication, social and legal barriers – there will be psychosocial disability.

4.2.1 Action against stigma and discrimination

Stigma, which is pervasive in the general population and in the health sector, is a major barrier to improved mental health services and self-care. It is present in homes, schools, workplaces, communities and even within the mental health care system itself (183).

Stigma leads to social isolation and discrimination, which impacts a person's ability to earn an income, have a voice, gain access to quality care, be part of their community and recover from their mental health condition. It creates the conditions for violations of multiple human rights across multiple settings (see Fig. 4.1).

Stigma can lead to social isolation, discrimination and violations of human rights across multiple settings.

In some countries, having a mental health condition provides legal grounds for divorce. In others, people with mental health conditions can lose their parental or voting rights, or may be denied a driving licence. In some countries, children with mental health conditions cannot obtain birth certificates

or other identity documents (184). Around the world, people living with mental health conditions are frequently excluded from community life and denied basic rights.

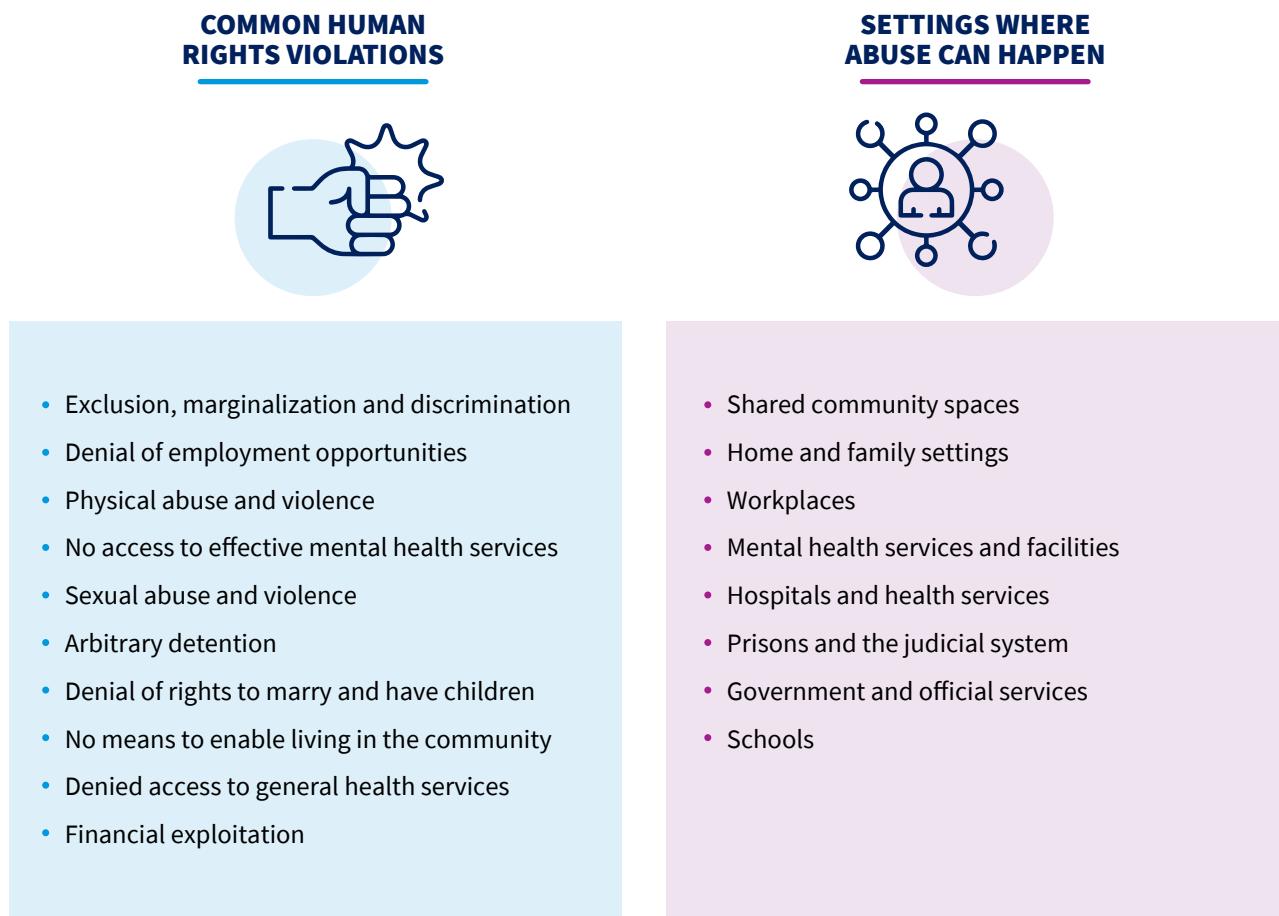
They are also discriminated against in the fields of employment, education and housing. The right to work is one of the most commonly violated rights. Even when people with a mental health condition are able to get a job, they are often underpaid (22).

And many children and adolescents living with mental health conditions are sent to segregated schools that tend to provide lower-quality education; or they are institutionalized in facilities that provide no or highly-limited education (22).

In all cases, stigma and discriminatory attitudes and directives can adversely impact mental health and hinder people's recovery (read [Lion's experience](#)).

FIG. 4.1

Common human rights violations against people with mental health conditions and the settings in which they take place



Source: Drew et al, 2011 (22).

NARRATIVE

I've encountered ignorance and stigma

Lion's experience

I've used various rehabilitation services over the years, and I have encountered ignorance and stigma. Some services were just unhelpful to me. Some actively harmed my recovery journey.

I'll never forget the nurse in the psychiatric ward who chased me around when she caught me doing yoga in my room, berating me that this type of activity was not allowed. It took me ten years to start doing yoga again: it was a trigger that kept bringing me back to that difficult experience of hospitalization.

At one point I applied for financial assistance to fund a degree in social work. I was already managing the first ever peer-support programme in a psychiatric hospital in Israel. But the social worker who helped me through the application process told me it would be immoral to let me study social work. Even when I passed my tests

with high grades, they tried to convince me to study education, saying that would be easier for me.

Today I lead the lived experience department at Enosh, the Israeli mental health association. We provide recovery resources to individuals and families coping with psychosocial disability. We work hard to promote person-oriented and trauma-aware services and practices that support recovery.

The difficult experiences I've been through and the ignorance I've encountered have also led me to lecture in therapeutic circles. At first I was begging to be heard, but slowly I have been invited to give more and more paid lectures. The need had probably existed for a long time. The therapists' desire to learn and improve the existing therapeutic services fill me with hope.

Lion Gai Meir, Israel

(see also my narrative on page 44)

Stopping stigma

Evidence from high- and low-income countries suggests that anti-stigma interventions can change public attitudes for the better, lessening experiences of discrimination among people living with mental health conditions (185). Anti-stigma strategies tend to fall into one of three categories (186).

- Education strategies use facts to address myths and misconceptions. They include literacy

campaigns, public awareness campaigns and a wide range of training and learning activities.

- Contact strategies aim to shift negative attitudes in the general population through interactions with people living with mental health conditions. They may include direct social contact, simulated contact, video contact or online contact, as well as the use of peer support services in health care settings.

- Protest strategies provide formal objections to stigma and discrimination. They include public demonstrations, letter writing, petitions, product boycotts and other advocacy campaigns.

Research on the impact of these strategies suggests that, for most groups of people, social contact is the most effective type of intervention to improve stigma-related knowledge and attitudes (185). Research findings also support active engagement and empowerment of people with lived experience across all levels of the mental health care system (see **In focus: Engaging and empowering people with lived experience**).

Several high-income countries have successfully used large-scale public awareness campaigns and

contact-based strategies to create positive changes in public attitudes to mental health (see **Table 4.2**).

Social contact is the most effective type of intervention to improve stigma-related knowledge and attitudes.

There is also much promise of broad, coordinated evidence-based programmes in LMICs (see **Box 4.2 Research to tackle stigma: The INDIGO Network**), and large-scale government-led campaigns focusing on social contact in these contexts are needed (185, 187).

Beyond direct anti-stigma campaigns, stigma can likely be reduced through work focused on improving the quality of care (see **Box 4.4 WHO QualityRights**).

CASE STUDY

BOX 4.2

Research to tackle stigma: The INDIGO Network

The INDIGO Network runs an evidence-based research and implementation programme to understand the mechanisms and consequences of stigma and discrimination in more than 40 countries; and to develop and test new ways to end stigma. Several LMICs participate in the network, including Bangladesh, Brazil, China, Egypt, Ethiopia, India, Jamaica, Malaysia, Nepal, Nigeria, South Africa, Tunisia, Türkiye and Venezuela.

The network coordinates multi-site projects, for example, to evaluate campaigns on improving referral rates to local health care services; or to investigate the potential of training medical

students in order to improve knowledge, attitudes and behaviour towards people with mental health conditions. The INDIGO website offers scales to assess stigma and discrimination.

The INDIGO Network hosts an international research programme (the INDIGO Partnership) for developing and testing evidence-based, contextually adapted interventions to tackle stigma and discrimination. This programme involves research partners at seven collaborating institutions in China, Ethiopia, India, Nepal and Tunisia, and aims to generate findings and materials that can be applied to other LMICs.

Sources: The Indigo Network, 2021 (189); Thornicroft et al, 2019 (190).

TABLE 4.2

National campaigns leading to positive changes in public attitudes towards mental health

CAMPAIGN AND COUNTRY	ACTIVITIES	KEY FINDINGS
TIME TO CHANGE Anti-stigma campaign  England	<ul style="list-style-type: none"> • Social marketing and media activity. • Local community events. • Grants for projects led by people with lived experience. • Targeted interventions for stakeholders, e.g. students, teachers, employers, and young people. • Research and evaluation. 	<ul style="list-style-type: none"> • Social marketing and media activity was most effective at influencing intended behaviour toward people with mental health conditions. • Grassroots contact-based projects were particularly effective at reducing self-stigma. • Public awareness was strongly associated with campaign activity and increased awareness was associated with more favourable attitudes.
BEYONDBLUE Mental health literacy programme  Australia	<ul style="list-style-type: none"> • Focus on depression and anxiety. • Media advertising and training. • School-based programmes. • Mental health first aid training. • Community discussion forums. • Mental health champions. • Research and evaluation. 	<ul style="list-style-type: none"> • States with more activity saw more improvement in public awareness about depression and the benefits of treatment. • Training programmes delivered moderate increases in knowledge about mental illness. • Public perception of depressed people as dangerous and unpredictable persists.
OPENING MINDS Contact-based education  Canada	<ul style="list-style-type: none"> • Targeted interventions for stakeholders (youths, health care providers, employers and employees, news media). • Mental health champions. • Research and evaluation. 	<ul style="list-style-type: none"> • Big media campaigns were not effective at changing attitudes. • Programmes that target a specific mental health condition may reduce stigma more effectively than those targeting mental ill-health in general. • The quality of the contact matters more than the duration: stories of hope and recovery were the most successful.

Source: Committee on the Science of Changing Behavioral Health Social Norms et al, 2016 (188).

4.2.2 The right to quality care

Everyone has a right to dignified, humane, responsive, acceptable, and decent care that respects their human rights. Yet too often people with mental health conditions are subject to some of the world's worst human rights abuses by the very health services responsible for their care.

From psychiatric hospitals all over the world there are reports of ill-treatment including physical, mental and sexual abuse, and neglect. People with mental health conditions may be arbitrarily confined in hospitals for years without reassessment of their medical status. They may be overmedicalized, given harmful or degrading treatments or routinely subjected to interventions without informed consent (22). In many countries, the poor conditions and infrastructure that are associated with psychiatric hospitals are also prevalent in nursing and care homes, rehabilitation centres, orphanages and overnight-stay facilities for traditional or spiritual healing of mental health conditions.

Many people in mental health institutions are shackled: locked away in small, prison-like cells with no human contact.

Many people with mental health conditions are shackled: locked away in small, prison-like cells with no human contact; or chained to their beds, unable to move for long periods of time (184). Large institutions especially are renown for degrading living conditions marked by overcrowding, unsanitary environments, unnourishing or insufficient meals and pervasive tobacco smoke (read Mrs BN's experience in Chapter 3) (22). Children are particularly vulnerable to the violence and neglect associated with institutional environments (see Box 4.3 Children in institutions). So too are older adults, with one out of ten staff in institutional settings

across high-income countries admitting to elder physical abuse over the past year (191).

Accordingly, there is a great need to transform mental health care to make it community-based (see Chapter 7 Restructuring and scaling up care for impact).

Maltreatment is not confined to institutional care. People with severe mental health conditions can find themselves hidden away by family members, chained or caged in the home, physically or sexually abused in prisons or subjected to violence in the community (192). Mental health outpatient care also often violates human rights, as evidenced by treatment that is routinely forced and purely biomedical, not addressing people's needs and rights for inclusion, social care and protection, among others. And while traditional healing can be highly supportive and meaningful to people, it can also involve abusive practices (134).

Those who experience abuse rarely have access to proper judicial mechanisms. In many countries, people with mental health conditions have little opportunity to raise complaints for ill-treatment or involuntary admission (193). Crimes committed against people with mental health conditions also frequently go undocumented because police or prosecutors have unfounded concerns about the victims' credibility as witnesses.

Ill-treatment and abuse cause psychosocial disability, impede people's recovery and often worsen their mental health condition. Any transformation towards community-based mental health care must address human rights violations.

Stronger rights in mental health care

Preventing ill-treatment and abuse in mental health services requires a mix of strategies designed to shift attitudes, strengthen rights



EVIDENCE

BOX 4.3

Children in institutions

An estimated 5.4 million children live in institutional care around the world, many of whom have mental health conditions.

Many institutions for children are unregistered, making monitoring almost impossible. They often provide environments that are neglectful and more abusive than they are caring. Children often live far from home and spend their days in overcrowded rooms, rarely interacting with staff, family members or other children. Many of the buildings are poorly maintained and have insanitary washing facilities and poor sleeping conditions. Children are often inadequately clothed, malnourished, inappropriately medicated and physically restrained. In many institutions, violence is pervasive.

Institutionalization often harms children's mental and physical health. Children in institutions are more likely to have mental health conditions than

children brought up in the community, including higher rates of aggressive behaviour, depression and anxiety, bedwetting, attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder. They are more likely to have problems with antisocial conduct, social competence and play. And they often experience attachment difficulties too.

A lack of general check-ups and immunizations also means that childhood diseases are more common among institutionalized children than in the general population; and death rates are far higher.

A transformation in mental health that shifts the care of children with psychosocial disabilities away from institutions towards community services and support will not only ensure that human rights are respected in line with the CRPD and other international frameworks but will also lead to better health and development outcomes for children in care.

Sources: Desmond et al, 2020 ([194](#)); WHO, 2015 ([195](#)); UNICEF, 2021 ([4](#)).

and reshape care environments ([23](#)). While combatting stigma is important, other tools and tactics are key to eliminate ill-treatment and uphold human rights. These include:

- rights-based laws and policies;
- development and scaling up of rights- and community-based services that are people-centred and recovery-oriented;
- monitoring and evaluation of mental health services;
- active participation of people with lived experience of mental health conditions in

decision-making processes, monitoring mechanisms, design and delivery of services;

- appropriate training for mental health professionals to address stigma and discrimination and to build capacity on the rights of persons with mental health conditions; and
- reporting on rights-based policy to global conventions (see [Box 4.4 WHO QualityRights](#)).

In all cases, providing accountability and redress mechanisms to record, prevent and respond to human rights abuses is important. In some countries, the office of the ombudsperson or

TOOL

BOX 4.4

WHO QualityRights

QualityRights is a global initiative designed to improve the quality of care in mental health and related services and to promote the rights of people with psychosocial, intellectual and cognitive disabilities. The initiative works at the ground level to directly change attitudes and practices, as well as through policy to create sustainable change.

The initiative covers the following areas of work:

- capacity building to combat stigma and discrimination and promote human rights and recovery;
- creating community-based, person-centred and recovery-oriented services that respect and promote human rights;
- improving the quality of care and human rights conditions in mental health and related services;
- supporting civil society movements and people with lived experience to undertake advocacy and influence policy-making; and
- reforming laws and policies in line with the CRPD and other international standards.

Across all areas of work, QualityRights develops and deploys a diverse range of training materials, toolkits, technical support and practical guidance to support a human rights and recovery approach to mental health. Combined, these resources are designed to help advance mental health, eliminate stigma and promote inclusion. They aim to build knowledge and

skills among mental health practitioners, service users and others, for example on how to end coercive practices such as seclusion and restraint and how to respect people's will and preferences. There is also guidance on peer support and advocacy for mental health, as well as a transformation toolkit for reshaping services to better promote human rights.

The initiative also provides QualityRights e-training on mental health, recovery and community inclusion for health workers, policy-makers, carers, community members and people with lived experience. The e-training covers how to support a person's own mental health and that of others, and how to promote human rights to help tackle stigma, discrimination, abuses and coercion experienced by people with mental health conditions. The QualityRights e-training has been launched globally, making it available to all people in all countries. In Ghana, where it has been ongoing since March 2019, more than 21 000 people had successfully completed the online QualityRights training by May 2022.

A 2019 evaluation showed important and positive shifts in attitudes towards human rights among participants completing the QualityRights e-training, including on the right to legal capacity, informed consent, ending coercive practices and community inclusion.

Sources: WHO, 2022 (196); WHO, 2019 (197); WHO, 2019 (184); Funk et al, 2021 (198).

Access the WHO QualityRights e-training at: <https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training>.



similar structure – a public official or entity appointed by, but at arm's length from, the national government or parliament – provides an important source of information, mediation and redress.

4.2.3 Autonomy in health decision-making

Being able to make decisions about one's life – including the right to choose one's own mental health care – is key to a person's autonomy and personhood.

The CRPD commits countries to recognizing that people with mental health conditions enjoy legal capacity on an equal basis with everyone else. And yet involuntary hospital admissions, and care against the wishes of someone experiencing a mental health condition, are routinely and widely practiced across the world, facilitated by laws and practices that give guardians of people with mental health conditions extensive substitute decision-making powers. Today, in all countries, decisions made by clinicians or other officials can legally supersede the preference of individuals with mental health conditions, which can lead to them being detained against their will and forced to have treatment.

The use of involuntary admission and treatment remains the subject of concern and debate among and between service users and professionals (199, 200, 201, 202). Laws on substitute decision-making and coercive care are typically intended to safeguard the interests and well-being of affected people and people in their communities. But they do restrict people's ability to choose where to live, how to manage their finances or what medical treatment to accept. Through substitute decision-making, people experiencing mental health conditions lose their rights to informed consent, confidentiality, privacy and communication with family members.

Frequently, people end up in institutions and exposed to seclusion or restraint. Involuntary admission can lead to horrific experiences (read [Sandra's experience](#)). And fear of coercion can stop people from seeking help when they experience mental health problems.

Changing the paradigm: supported decision making

Evidence and experience suggest that there are many strategies available for reducing involuntary admission and coercive treatment in mental health care. Staff training and integrated care are both effective interventions (203, 204). So too is using supported decision-making as an alternative to substitute decision-making, guardianship or other processes that exclude or go against the involvement and will of the person affected (205).

Supported decision-making is about supporting people to exercise their own choices about their lives, including about their mental health care.

In supported decision-making, the person with a mental health condition chooses someone or a network of people who they trust to serve as their supporter. The person with a mental health condition is always the decision-maker; the supporter is available to discuss the issues, options or choices when necessary and communicates the will and preferences of the person if they are unable to do so themselves.

Supported decision-making is about supporting people to exercise their own choices about their lives.

In practice, supported decision-making can take many forms and includes support organizations and networks, advanced plans and provisions, independent advocates, peer support and personal assistance. It can be done through a legal document, for example an advance directive that specifies what actions should be taken for a person if they are no longer able

NARRATIVE

Twelve hospital admissions; only one was my choice

Sandra's experience

Pinned down by policemen and paramedics. Gagged and handcuffed like a criminal as I was knocked unconscious by a medical cocktail. Waking up not knowing where I am, clothes off in what feels like a prison. My crime? At worst, being loud, antagonistic and manic. My life sentence? Bipolar disorder. This was the first of my eleven involuntary hospital admissions. I was literally stripped of any semblance of human rights or dignity. And it was terrifying.

I was given my diagnosis and some meds and sent home, confused and already falling into depression. Empty and emotionless I was also feeling the side effects of the medication – severe parkinsonism, akathisia and tremors.

A year on. Boom! Mania. I was out of control. My family was worried. Involuntary hospital admission number two. At least the staff treated me with care and compassion. No restraints this time. Human kindness and empathy go a long way. New meds and on I go.

Two years later I am in denial about having a mental health condition and default on my medication. Relapse. Involuntary admission number three. Back in restraints. I'm told this is the end of the line. If I

don't get it together here, I will go into placement where my family won't be allowed to see me. Worse than prison. Eventually I'm discharged.

Four years on. My marriage is falling apart and so am I. Involuntary admission number four. Restrained and intravenously injected with what feels like boiling water through my veins. A new side effect emerges and I get stroke-like symptoms every time I have a 'knock out' injection.

Over the next four years I was involuntarily hospitalized seven times, including three times in a single fortnight. New meds and a new side-effect: sleep paralysis.

My twelfth and last admission was different. It was my choice. Voluntary. Acceptance that I needed help. More than help, I wanted support. My psychiatrist was stern but also patient and empathetic. She believed in my life and I felt she truly had my best interests at heart. My medication is finally on point.

I fell time and again to find my own way back up. I will continue trying and learning and, for effort alone, I will always succeed.

Sandra Ferreira, South Africa

to make decisions for themselves because of illness or incapacity. Or it can be less formal, for example involving personal supporters who are trusted contacts of the person involved.

In all cases, supported decision-making:

- respects the rights and wishes of the person;
- does not advance the interests of others;
- does not attempt to influence the person to make decisions they do not want to make;
- provides the level of support requested by the person; and
- is used for as short or long a time as the person requests it.

Pockets of supported decision-making can be found all over the world, including in the Americas, Europe, South-East Asia and the Western Pacific.

In the past five years Colombia, India, Peru and the Philippines have all passed legislation to remove barriers to legal capacity and recognize the role of supported decision-making in the context of mental health services (23).

In South America, where a number of countries are making progress in supported decision-making, programmes often rely on informal support mechanisms provided through civil society organizations, including organizations of persons with lived experience (see [Box 4.5 Supported decision-making in South America](#)). While there is still much to be learned in how to implement supported decision-making in different treatment and resource situations, it is clear that investment and transformation in mental health must include advancing supported decision-making.





CASE STUDY

BOX 4.5

Supported decision-making in South America

Argentina: drawing on day-to-day life for support

In 2017–2018, Argentina’s *Persons with Disabilities: The Exercise of Their Legal Capacity and Decision-making* pilot project used participants’ daily experience of psychosocial and intellectual disabilities to identify and critically analyse support systems for decision-making. Participants used person-centred planning to identify support individuals and networks (as well as limitations) in their day-to-day life.

The project evaluation stressed the need for a flexible and dynamic toolbox of support and identified the role of organizational structures for designing supported decision-making.

Colombia: planning for life

Colombia’s *Supported Decision Making and Community Life* pilot project in 2015–2016 built a personalized support system to build capacity for decision-making, improved relationships and independent living. Participants used life-planning

tools to develop a map of networks that they could draw on for support; and created a personalized booklet describing their goals, dreams, and basic preferences.

Qualitative interviews and observation of participants revealed that some individuals were empowered to make their voices heard, and that families adjusted their approach to support.

Peru: engaging individuals, groups and whole communities

In 2016–2018, the *Support Networks for Decision Making and Community Life* pilot project used one-to-one planning and counselling as well as group workshops, peer support, family meetings and broader stakeholder mapping and outreach to promote decision-making support networks.

Participants reported feeling empowered through greater knowledge.

Source: Vásquez et al, 2021 (206).



Engaging and empowering people with lived experience

Valuing the insight of people with lived experience of mental health conditions, and giving them voice, choice and influence in multiple aspects of the mental health care system, is a vital step towards transforming mental health worldwide.

People with lived experience may have survived human rights abuses by mental health services, and as such they have much insight into how mental health services can fail people. They can be powerful advocates for people-centred, recovery-oriented, human rights-based mental health care and for policy and legislation that protects their rights.

Empowerment gives people with lived experience better understanding and control over their lives (207). It requires governments, employers, educational institutions, nongovernmental organizations and members of the public to remove barriers that may hinder full and effective participation in society for people with lived experience of mental health conditions.

Over recent decades there has been a progressive shift towards service users and their carers having greater involvement at different levels within the mental health system.

- **Personal level:** involvement in one's own health care planning, assessment and management, for example through shared decision-making, advanced planning, supported self-management and person-centred recovery approaches to care.
- **Community level:** involvement in local service planning, delivery, monitoring and evaluation, advocacy, public awareness campaigns (especially to reduce stigma), and training for mental health staff and others.
- **Strategic level:** participation in shaping mental health policy, plans and laws, service monitoring and research.

Participatory approaches are key to implementing UHC (208). Yet they are still infrequently applied to mental health care in many countries. The growth in participatory processes for people with lived experience has mainly taken place in high-income countries (209). Only a third of middle-income countries – and just 16% of low-income ones – have a formal mechanism in place for involving service user associations in the mental health system (5).

There are varying degrees of participation, from being consulted to joint decision-making; and from being involved in service-delivery to user-led services. Whatever the level of involvement, it is important that participation is not tokenistic; and that the views of people with lived experience are fully considered and

valued in policy and practice. This requires time. In all cases, provisions should be made to ensure individuals are adequately supported throughout the participatory process.

Positive partnerships for care

Empowering people to have control over their life and mental health care instils personal dignity, value and respect. It can increase self-esteem and confidence. It also gives people a level of choice and autonomy they may not have received otherwise.

At the same time, meaningful engagement of people with lived experience builds service providers' understanding of what it's like to have a mental

health condition; it can help challenge assumptions and increase the level of trust between them and service users.

The potential result is better therapeutic relationships and more equal, collaborative and effective partnerships of care. Individuals and health care providers can work together to map out the options for care and select those that are most appropriate and acceptable to the individual (see section 7.1.1 Putting people first).

All this contributes positively towards a person's recovery and quality of life (read [Alexandra's experience](#)).

NARRATIVE

Autonomy was the key to my recovery

Alexandra's experience

Receiving autonomy over my mental health care was the greatest contributor to my recovery. I was diagnosed with a mental illness when I was seven. Throughout my childhood and adolescence, I had no say in my own recovery: my own ideas of what would work well for me were often dismissed. This lack of autonomy eroded my already-low self-esteem and worsened my mental illness.

I remember walking into my current therapist's office at the age of nineteen. I was a shell of an individual. Years of being forced into specific care pathways and bubble-wrapped by caring adults had shattered my confidence. I barely believed I was capable of making basic decisions, let alone helping myself. But this



therapist was different: she saw me as a person rather than my mental illness. She asked me about interests, wanted to know my work style, and was eager to work together to construct a pathway to mental well-being.

We started small, but with her guidance, I gradually gained the confidence to make complex decisions about my health and well-being. Her willingness to collaborate with me, create care plans that suited me as an individual, while still giving me the space to make autonomous decisions, helped me build the confidence to thrive not only mentally, but in all other areas of my life. To this day, I attribute my recovery to her collaborative nature.

Alexandra M Schuster, United Kingdom

Social contact for better care

Social contact strategies that engage people with lived experience are the evidence-based way of reducing stigma in the community (see [section 4.2.1 Action against stigma and discrimination: Stopping stigma](#)). They are also important for reducing stigma among service providers. Stigma among primary care providers likely contributes to low rates of detection of mental health conditions in primary care.

A pilot study in Nepal suggests that involving people with lived experience as co-facilitators in mhGAP training programmes for primary care workers may be effective in reducing stigma ([210](#)). Interestingly, the study also found that primary care workers who are co-trained by people with lived experience may be more likely to diagnose mental health conditions accurately.

Networks to enable engagement

Peer-led networks and organizations have a key role in enabling people with lived experience to engage with their care. Networks can be a vital source of mutual support for mental health service users. And they often also supply encouragement, resources and formal infrastructure for the systemic advocacy and self-advocacy that is needed to facilitate change.

Through peer-led organizations, people with lived experience have helped educate communities,

inform and influence policy-makers, denounce stigma and discrimination and fight for improved services and legal rights ([211](#)).

During the COVID-19 pandemic, peer-led organizations have been particularly valuable in giving voice to people with lived experience. The Global Mental Health Peer Network (GMHPN) and partners, for example, surveyed people with lived experience on the psychosocial consequences of the pandemic and advocated for greater equality and equity in the pandemic response ([212](#)). At a national level, user organizations have stepped in to provide extra support services: for example, the Psychiatric Disability Organization Kenya offers psychosocial support for prison staff ([7](#)).

The *Comprehensive mental health action plan 2013–2030* calls for action that helps organizations of persons with mental health conditions to participate in reorganizing, delivering, and evaluating and monitoring services. In practice, supporting these organizations may include, for example, efforts to:

- encourage their creation;
- build their capacity to effectively advocate for human rights;
- establish mechanisms to ensure their full participation in policy-making;
- involve them in monitoring and evaluating mental health services; and
- include them in capacity-building efforts for stakeholders.

For more information on supporting the participation of people with lived experience in directing and delivering services, see:
www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools.

4.3 Enabling social and economic development

Mental health is an essential, if often neglected, issue in social policy and economic development. Poor mental health puts a brake on development by reducing productivity, straining social relationships and compounding cycles of poverty and disadvantage. Conversely, when people are physically and mentally healthy, and reside or work in mentally healthy environments, they can study or work productively and contribute to their communities, to the benefit of all.

Growing evidence shows that transforming the mental health agenda requires not only enhanced access to quality services and care. It also

requires greater attention to, and investment in addressing, the underlying social and economic realities of life that shape people's mental health. Countries are already committed to addressing these realities through the SDGs of the 2030 Agenda for Sustainable Development. The links between mental health and the SDGs are complex and, in many cases, bidirectional (see Table 4.3). Progress towards achieving the SDGs has the potential to promote and protect mental health (15). At the same time, improved health outcomes, including mental health outcomes, are important to realizing the SDGs' full ambition.





TABLE 4.3

Mental health is linked to each of the SDGs

SDG	LINKS WITH MENTAL HEALTH
1 No poverty	<ul style="list-style-type: none"> Mental health conditions are closely linked to poverty in a vicious cycle of disadvantage.
2 Zero hunger	<ul style="list-style-type: none"> Poor nutrition impairs cognitive and emotional development in children. Food insecurity increases the risk of mental health conditions in adults.
3 Good health and well-being	<ul style="list-style-type: none"> Mental health is an integral part of general health and well-being.
4 Quality education	<ul style="list-style-type: none"> Mental health is important for learning; and learning environments are key determinants of mental health. People with mental health conditions experience barriers in accessing education.
5 Gender equality	<ul style="list-style-type: none"> Inequity and gender-based violence are risk factors for mental health conditions.
6 Clean water and sanitation	<ul style="list-style-type: none"> Socioeconomic deprivation and poor access to facilities creates multiple life stressors and is linked with a range of mental health conditions.
7 Affordable and clean energy	
8 Decent work and economic growth	<ul style="list-style-type: none"> Work practices and environments are determinants of mental health. People with mental health conditions experience barriers in accessing decent work.
9 Industry, innovation and infrastructure	<ul style="list-style-type: none"> Employment and economic growth is an important protective factor against mental health conditions.
10 Reduced inequalities	<ul style="list-style-type: none"> Discrimination and inequitable treatment of people with mental health conditions is pervasive and causes psychological stress.
11 Sustainable cities and communities	<ul style="list-style-type: none"> Well-planned urbanization can benefit mental health through improved access to work, education and housing as well as safe environments and green spaces. Exposure to community-level violence is a risk factor for mental health conditions.
12 Responsible consumption and production	<ul style="list-style-type: none"> Socioeconomic deprivation and poor access to resources are linked to a range of mental health conditions.
13 Climate action	<ul style="list-style-type: none"> Climate change and environmental events cause human suffering and can undermine mental health.
14 Life below water	<ul style="list-style-type: none"> The availability of natural resources on land and at sea impacts people's health, including their mental health.
15 Life on land	
16 Peace, justice, and strong institutions	<ul style="list-style-type: none"> Conflict and violence is a major threat to mental health, while mental health may contribute to reduced violence.
17 Partnerships for the goals	<ul style="list-style-type: none"> Mental health is a universal concern. Lessons from mental health partnerships can be applied to the SDG agenda.

Source: Lund et al, 2018 (52).

A holistic approach to mental health promotion, protection, care and recovery provides for greater equality of opportunity (with respect to education, income and social inclusion) as well as service access, especially for those exposed to or living in precarious or vulnerable situations.

In short, the benefits of better mental health extend beyond psychological well-being itself, from social equity and inclusion to economic growth and prosperity.

4.3.1 Social equality and inclusion

As discussed in [Chapter 2 Principles and drivers in public mental health](#), our mental well-being is constantly being shaped and re-shaped by the environment in which we find ourselves. Someone whose life is marked by diminishing opportunities, social exclusion and economic insecurity will have a different mental health trajectory to that of someone who grew up in, and continues to have, a stable, supportive home, work and social environment. Analyses in Europe reveal that, on average, men and women living on the lowest incomes are twice as likely to report poor mental health compared with those with the highest incomes ([213](#)).

Accordingly, a key requirement for successful mental health transformation at the population level is to reduce or eliminate local and national disparities or inequalities as they relate to mental health. This is a goal in itself and the benefits of successful action against such inequalities can be added to the case for investing in mental health.

The [Comprehensive mental health action plan 2013–2030](#) identifies implementation options for addressing disparities; and these were further highlighted by the World Mental Health Day in 2021, the theme of which was “Mental Health in an Unequal World” ([214](#)). Proposed strategies include actions against interpersonal violence, inimical immigration policies and

racism; and actions for child protection, decent working conditions and social inclusion.

Addressing disparities requires a major step up in multisectoral action to address the social and structural determinants of mental health to achieve social justice (see [section 6.1.3 Making structural changes for mental health](#)). It requires a transformation in the social exclusion of people with mental health conditions, who are often denied basic social and civil rights (see [section 4.2.1 Action against stigma and discrimination](#)).

It also requires a transformation in access to care to ensure that mental health services are available to all people in society, at all stages of life. Too often, services focus on adults to the neglect of services for children, adolescents and older people. Gender differences need to be considered in every area of mental health intervention, with special attention paid to survivors of gender-based violence and to gender-identity minorities, who often find mental health services discriminatory (read [Kat’s experience](#)).

Other priority groups identified by the [Comprehensive mental health action plan 2013–2030](#) include homeless people and people in the criminal justice system or in detention, as well as: asylum seekers, refugees and irregular migrants; marginalized ethnic groups, including indigenous people; people with physical and intellectual disabilities; and people affected by complex emergencies. Interventions and support targeted at these groups can help reduce existing inequalities and promote social inclusion, thereby contributing to ensuring interventions to support mental health are universal, yet are calibrated proportionately to the level of disadvantage (proportionate universalism) ([215](#)).

In all cases, reaching people living in vulnerable conditions requires mental health (and other) services to be more accessible, closely coordinated with social care and widely known about. Experience suggests that



NARRATIVE

Reforming mental health care for the LGBTIQ+ community



Kat's experience

When I engage with my country's mental health system, I apply filters to my sexuality. Each time I filter out my sexuality, I feel like I've taken several steps backward in my recovery. But I do it because I have experienced homophobic comments and lack of understanding.

My experiences of discrimination have made me outspoken about the need to reform our mental health systems for the LGBTIQ+ community. Our mental health systems must acknowledge the harm they caused, for reformation to begin. The decision to include certain sexualities in international disease classifications, for example, created untold damage. Many countries, including my own, have continued to embrace these classifications. Although some no longer exist in updated publications, the effects of international discriminating policies and diagnoses still linger, particularly in countries where LGBTIQ+ persons have few or no rights.

Beyond acknowledging the harm done, we need equitable action that removes stigma, for example updating Trinidad and Tobago's Mental Health Act of 1975 to include the need for equitable service delivery for LGBTIQ+ persons. Developing and enforcing zero discrimination policies that help the mental health workforce unpack biases will also help bring about much-needed change.

Additionally, investing in the mental health workforce so that more people in the LGBTIQ+ community are educated in mental health and hired as mental health professionals can help foster a safer mental health system. Further, reshaping our systems to include peer supporters, especially from the LGBTIQ+ community, can ensure that those on their recovery journey are supported by others with similar experiences.

Most importantly, it is time to truly practice the words "nothing for us without us" and give the LGBTIQ+ community – especially those with lived experience of mental health conditions – an equal role in shaping our mental health system from policy development to service delivery. Those with lived experiences can point out what works in our systems because we have engaged with these systems for years. We can also point practitioners towards better solutions. We need to encourage meaningful collaboration between LGBTIQ+ persons with mental health conditions and traditional mental health professionals.

Lived experiences must begin taking priority, especially LGBTIQ+ experiences.

Kat McIntosh, Trinidad and Tobago

reaching marginalized groups of long-term unemployed, street sex workers, refugees, irregular migrants, and homeless people can be achieved by establishing outreach programmes, integrating mental health into general health care, coordinating social and health care and disseminating information to both individuals and practitioners (47). A sound organization of mental health services – as described in Chapter 7 Restructuring and scaling up care for impact – is instrumental in reaching marginalized people.

4.3.2 Economic benefits

The economic implications of diminished mental health are enormous and extend far beyond the direct costs of treatment (see section 3.2 Economic consequences).

Good mental health enables people to work productively and realize their full potential. Conversely, poor mental health interferes with people's ability to work, study and learn new skills. It holds back children's educational attainment which can impact future employment prospects. Meanwhile, adults living with mental health conditions may find that they are not able to work, or cannot work as well as usual, often for extended periods of time. Carers may be similarly affected.

A survey on household costs associated with mental health conditions in six countries across sub-Saharan Africa and South Asia found that households where someone had a mental health condition were economically worse off than control households. For example, they had lower housing standards, lower household income, fewer assets, and higher health care expenditures (216).

Work losses not only affect individual and household abilities to earn a living but also contribute to wider societal costs through increased unemployment and welfare needs, lost productivity, workplace accidents and reduced taxation revenue.

Researchers estimate that 12 billion productive work days are lost every year to depression and anxiety alone, at a cost of nearly US\$ 1 trillion (217). This includes days lost to absenteeism, presenteeism (when people go to work but underperform) and staff turnover.

Reducing individual, community and structural risks to mental health while simultaneously increasing access to effective care not only improves well-being and social functioning but also leads to a range of economic benefits for affected individuals and their households. Such action can improve participation in, and productivity at, work and school, reduce time spent on informal caregiving, reduce demand for health and welfare services, and increase the potential for savings or investment (see Fig. 4.2). A recent systematic review found that most of the mental health interventions assessed led to improved economic outcomes, mainly in relation to education and employment (218).

Businesses and the wider economy also stand to benefit from investment in improved mental health through greater participation in the labour market and higher productivity, both of which serve to improve a company's bottom line. A study with ten companies in Canada showed that workplace mental health programmes can deliver a positive return on investment within three years (219). For governments too, investing in the population's mental health can lead to savings in welfare support: a recent analysis from Denmark showed that an increase in mental well-being was associated with lower health care costs and sickness benefit transfers (220).

12 billion work days
are lost every year to
depression and anxiety.

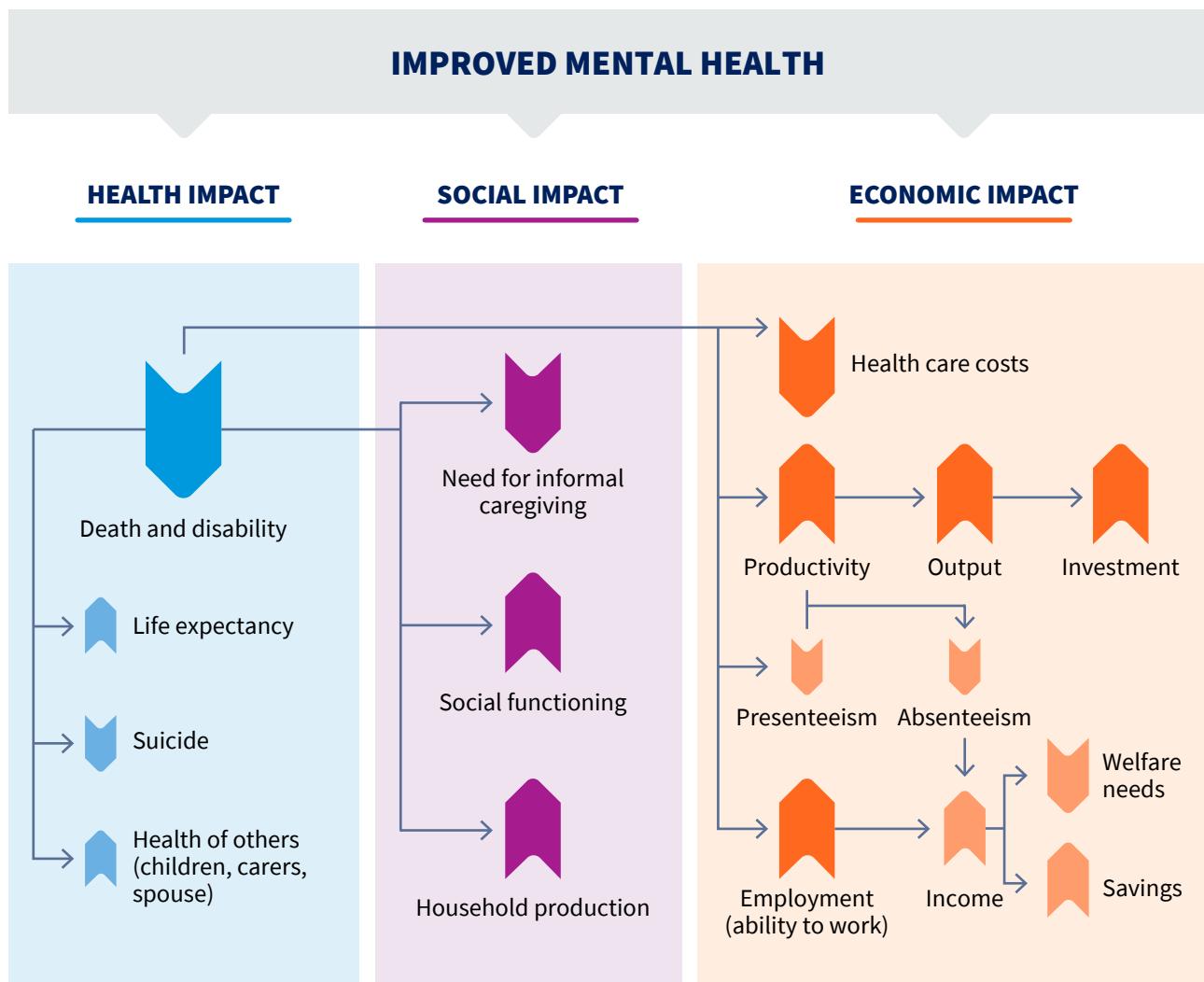
Economic value and efficiency

The costs and cost-effectiveness of treating mental health conditions have become a very important part of discussions about whether and why countries should invest in mental health.

Accumulated evidence shows that there is a core set of cost-effective interventions for priority conditions that are also feasible, affordable and appropriate even for resource-poor settings.

FIG. 4.2

Some of the potential social and economic benefits of investing in mental health



Source: adapted from WHO and UNDP, 2021 (221).

WHO's menu of cost-effective interventions for mental health identifies a selection of mental health interventions for which cost-effectiveness information is available (222). At a population level, the menu identifies universal and indicated school-based social and emotional learning programmes and regulatory bans on highly

hazardous pesticides (which are commonly used in suicides in several LMICs) as cost-effective and affordable population-based interventions (see Chapter 6 Promotion and prevention for change) (222). At the individual level, the menu lists a range of cost-effective clinical interventions, which are also included in the WHO

5 to 1 benefit to cost ratio for scaling up treatment for depression and anxiety

UHC compendium (see section 5.1.3 Evidence to inform policy and practice). Of course, cost-effectiveness alone cannot provide the basis for priority setting and WHO's menu stresses the importance of human rights and equity when selecting mental health interventions.

The returns on investment for clinical interventions can be substantial, especially for depression and anxiety. For example, one global modelling study carried out for 36 large countries indicates that a linear increase in treatment coverage between 2016 and 2030 could secure 43 million extra years of healthy life, at a value of US\$ 310 billion, and generate a further US\$ 399 billion in productivity gains (217). With the cost of scaling up treatment estimated at US\$ 147 billion, this provides a benefit cost ratio of five to one (see Fig. 4.3). The highest rewards for investing in depression are predicted in lower-middle-income countries (217).

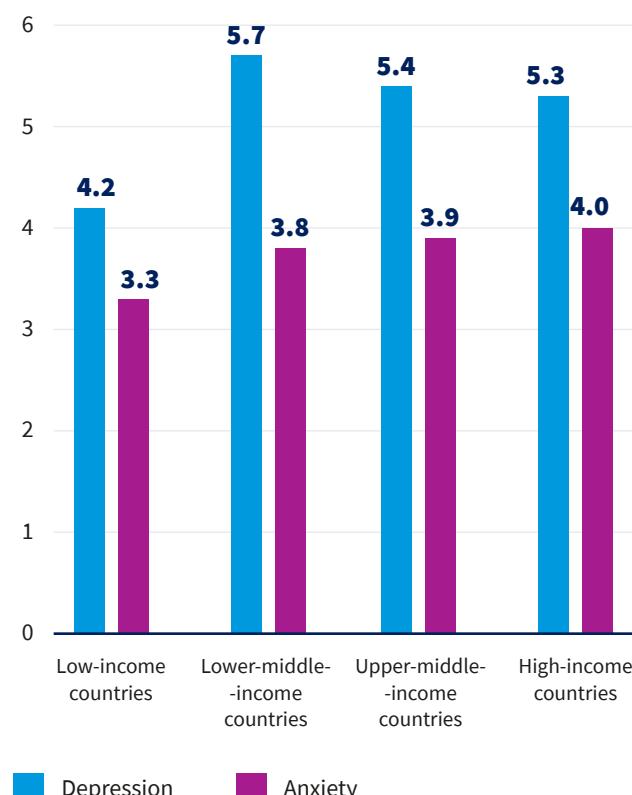
Other modelling studies show that integrated mental health packages that combine multiple interventions for promotion, prevention and care can bring significant and large-scale returns, especially when productivity gains and the value of wider social benefits are considered (see Table 4.4).

In South Asia and sub-Saharan Africa, the cost of scaling up delivery of an integrated package for epilepsy, depression, bipolar disorder, schizophrenia and heavy alcohol use has been calculated at US\$ 3–4 per capita. The return on that investment is estimated at 500–1 000 healthy years of life for every million dollars spent (223).

Elsewhere, the cost of implementing a care package in non-specialist settings has been estimated to be even lower. Studies in Ethiopia, India, Nepal, South Africa and Uganda calculate it to be less than US\$ 1 per capita. These studies suggest that, over a ten-year scale-up period, the additional amount that would need to be invested each year is less than US\$ 0.10 per capita (224).

FIG. 4.3.

Returns to investment in scaling up treatment for depression and anxiety (benefit to cost ratios)



Source: Chisholm et al, 2016 (217).

TABLE 4.4

Investing in mental health delivers significant returns

CASE STUDY	MODELED BENEFITS OF INVESTMENT
 JAMAICA Investment: US\$ 115 million to scale up treatment for depression, anxiety and psychosis 2015–2030	<ul style="list-style-type: none"> Increased coverage of psychosocial treatment from 15% to 50%. Overall benefits of more than US\$ 434 million to the economy, including productivity gains and the value of wider social benefits. Return on investment of more than five to one for clinical treatment of anxiety and depression.
 PHILIPPINES Investment: US\$ 2.7 billion (US\$ 2.57 per capita per year) for integrated package of promotion, prevention and care over ten years	<ul style="list-style-type: none"> Universal school-based social and emotional learning interventions to prevent depression and suicide are predicted to have the highest return on investment, resulting in US\$ 9.5 for every US\$ 1 invested. Other predicted high return investments include scaled-up treatment of epilepsy (6.6 to 1) and depression (5.3 to 1).
 SOUTH AFRICA Investment: 9% of projected budget in 2035 to scale up interventions for common and severe mental health conditions, epilepsy, dementia, and alcohol and drug use disorders	<ul style="list-style-type: none"> Highest returns predicted for scaled-up treatment of perinatal, adult and childhood depression, with returns of 4.7, 4 and 3.6 respectively. By the end of the scale-up period, approximately 2.2 million years of healthy life would be restored, with close to 2.5 million prevalent cases averted and more than 44 000 deaths avoided. Overall savings for psychosis and dementia did not exceed costs of scale up, but health and human rights benefits were enormous.
 UZBEKISTAN Investment: US\$ 398 million 2021–2030 to scale up evidence-based interventions for common and severe mental health conditions as well as epilepsy and alcohol use disorders	<ul style="list-style-type: none"> Projected benefits of US\$ 382 million in restored productivity plus improvements in health itself that were valued at US\$ 701 million. Scaled-up treatment of epilepsy, treatment of depression, and universal, school-based social and emotional learning interventions to prevent depression and suicide, offer the highest returns on investment in terms of restored productivity, and a gain of US\$ 8.7, 3.4, 3.0 respectively, for every US\$ 1 invested.

Sources: PAHO, 2019 (225); WHO Regional Office for the Western Pacific, 2021 (226); Besada et al, 2021 (227); WHO Regional Office for Europe, 2021 (228).



5

Foundations for change

FRAMEWORKS
KNOWLEDGE AND COMMITMENT
FINANCE
COMPETENCIES

Chapter summary

In this chapter we explore foundations for change towards improved mental health. We focus on four particular components required to secure well-functioning mental health systems and services: effective policy and planning frameworks; public and political knowledge and commitment; sufficient finance and resources, and widespread competencies for mental health care. This chapter also highlights the growing role of digital technologies in strengthening mental health systems and services.



Key messages from this chapter are:

- Key targets for transformation include: plans and policies; leadership and governance; information systems and research; finance; public awareness; and competencies in mental health care.
- Global instruments, ranging from joint action plans to legally binding conventions, are critical to guide action on mental health and provide an enabling context for transformation.
- Three types of political commitment – expressed, institutional and budgetary – are needed to drive the mental health agenda forward and effect meaningful change.
- People with lived experience are important agents of change to improve public awareness of mental health and acceptance of people with mental health conditions.
- Including psychosocial interventions and psychotropic medicines in UHC packages of essential services and financial protection schemes is vital to close the mental health care gap.
- All countries need to expand their specialist workforce and build mental health care competencies among general health care and community providers as well as individuals in the community.
- Digital technologies can strengthen mental health systems by providing tools to inform and educate the public, train and support health care workers, deliver remote care, and enable self-help.

[Chapter 4 Benefits of change](#) provided the case for transforming mental health systems, highlighting the potential benefits to be gained. Pockets of progress achieved over the past decade prove that change is possible. The *Comprehensive mental health action plan 2013–2030* provides a roadmap for action by all stakeholders.

In many ways, transforming mental health is about system strengthening: ensuring that each of the core components of a mental health system are fit for purpose. A well-functioning mental health system is built on having trained and motivated mental health workers, well-functioning

information systems, and a reliable supply of medical products and technologies, backed by adequate funding, strong leadership and evidence-based plans and policies ([229](#)).

Strengthening mental health systems provides the foundations for change. It enables reorganization and scaling up of services and supports. In the sections that follow, we consider what it will take to secure four key foundations for change: effective policy and information frameworks, public and political understanding and commitment, sufficient finance and resources, and widespread competencies for mental health care.

5.1 Frameworks for policy and practice

National and international policy frameworks are used to set out countries' principles, values and objectives for mental health; and they serve to help transformation.

5.1.1 International frameworks

Various international frameworks – ranging from joint agendas and action plans to political declarations and legally binding conventions – have been developed and are being used to guide action on mental health. These include regional frameworks such as: *Scaling up mental health care: a framework for action*, which was adopted by the 68th Regional Committee for the Eastern Mediterranean in 2015; the 2021–2025 *European Framework for Action on Mental Health*, adopted by the 71st Regional Committee for Europe in 2021; and forthcoming frameworks by WHO's African Region, WHO's Western Pacific Region and WHO's Region for the Americas.

International frameworks also include global instruments, such as the *Comprehensive mental health action plan 2013–2030*, which provides a roadmap to transforming mental health globally and is central to WHO's work ([3](#)). Updated in 2019, this plan is structured around four key objectives (see [Chapter 1 Introduction](#)). It outlines actions for Member States, WHO and partners and sets out diverse options for how such actions could be implemented. Delivering on the action plan targets would go a considerable way towards improving mental health worldwide.

Delivering on the Comprehensive mental health action plan 2013–2030 would go a considerable way towards improving global mental health.

Another key global framework is the CRPD, which came into force in 2008. Ratified by 182 countries, the CRPD is a legally binding convention to promote, protect and ensure the full and equal enjoyment of all human



TOOL

BOX 5.1

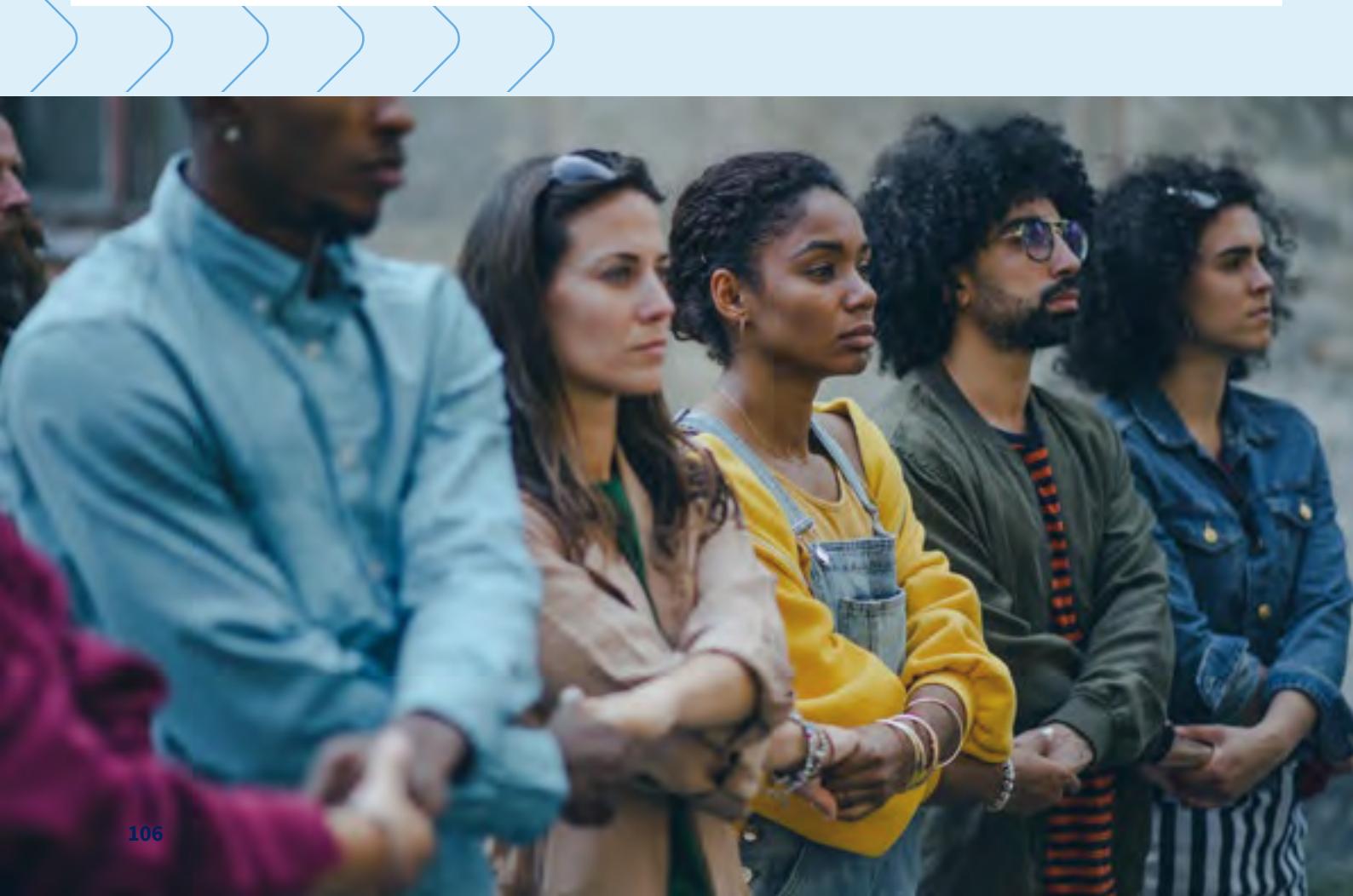
International instruments for human rights

Human rights instruments adopted by UN Member States with relevance to the rights to mental health and the rights of people with mental health conditions include:

- Universal Declaration on Human Rights (1948);
- International Covenant on Economic, Social and Cultural Rights (1966);
- International Covenant on Civil and Political Rights (1966);
- Convention on the Elimination of All Forms of Discrimination against Women (1979);
- Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1982);

- Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1987);
- Convention on the Rights of the Child (1989);
- ILO Indigenous and Tribal Peoples Convention (1989);
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990);
- The United Nations Principles of Older Persons (1991);
- Declaration on the Elimination of Violence against Women (1993); and
- Convention on the Rights of Persons with Disabilities (2006).

Source: OHCHR, 2021 (230).



rights for people with disabilities, including psychosocial disabilities (see section 4.2 Promoting and protecting human rights).

Various other global human rights instruments also promote the rights of people with mental health conditions, both directly and indirectly (see Box 5.1 International instruments for human rights). Together, these international instruments provide powerful tools for legal and social advocacy to transform mental health.

The 2030 Agenda for Sustainable Development, and its 17 SDGs, is another important global framework for mental health (231). SDG3 focuses specifically on health and includes target 3.4 to reduce by one third premature mortality from NCDs through prevention and treatment, and to promote mental health and well-being. Suicide mortality rate is an indicator for this target (indicator 3.4.2).

A major implication of SDG3 for mental health policy and practice is a requirement for a strong public health approach to the needs of those with mental health conditions. But, as detailed by the Lancet Commission on Global Mental Health and Sustainable Development, the SDGs provide a broader framework for transforming mental health because many other SDGs explicitly address the social and structural determinants of mental health (see section 4.3 Enabling social and economic development) (15).

Just as the links between development priorities and mental health are increasingly acknowledged, so too are the links between mental health and other health priorities. In 2018 UN heads of state and governments signed a political declaration on the prevention and control of NCDs (covering cardiovascular diseases, diabetes, cancer and chronic respiratory diseases) that acknowledges the bidirectional links between these NCDs and mental health conditions (232). Accordingly, it provides a

new level of political commitment to also prioritize mental health when implementing the NCD agenda. It also provides new impetus to manage mental health conditions alongside NCDs, both within primary health care and within specific NCD programmes (see section 7.2 Mental health integrated in health services).

Universal health coverage (UHC) for mental health

UHC means that everyone everywhere can get the health care they need without suffering financial hardship. Achieving UHC by 2030 is one of the SDGs. Importantly, UHC does not mean free access to every possible health service for every person. Every country has a different path to achieving UHC and deciding what to cover, based on their people's needs and the resources at hand. UHC does however emphasize the importance of access to health services and information as a basic human right.

In 2019, the UN General Assembly made specific mention of "people with mental health problems" in its resolution on UHC (233). That same year, with the launch of the WHO Special Initiative for Mental Health, WHO firmly embedded mental health into its own strategic efforts to expand UHC (see Box 5.2 WHO Special Initiative for Mental Health).

Embedding mental health in UHC is critical to close the huge mental health care gap that exists in many countries.

Embedding mental health in UHC is critical to close the huge mental health care gap that exists in many countries. And it is a fundamental step on the road to mental health reform. In practice, it comprises activities to include mental health needs in parity with physical health needs in all plans and processes developed to achieve UHC.



CASE STUDY

BOX 5.2

WHO Special Initiative for Mental Health

In 2019, the WHO Special Initiative for Mental Health was established to accelerate access to mental health services through UHC. The goal is to ensure 100 million more people have access to quality and affordable mental health care.

The initiative will initially be implemented in 12 countries to demonstrate what is possible. Eight countries have already been selected: Bangladesh, Ghana, Jordan, Nepal, Paraguay, Philippines, Ukraine and Zimbabwe. In each country, the Special Initiative will be anchored in two broad types of strategic action:

- advancing mental health policies, advocacy and human rights; and
- scaling up interventions and services across community-based, general health and specialist settings.

Source: WHO, 2021 (234).

Importantly, the initiative takes a case-by-case approach to embedding mental health in UHC and mental health reform, using detailed country assessments and consultations to develop a plan that builds on existing strengths and responds to national priorities so that support can be targeted where it is needed most. Ministries of Health are supported to lead national-level transformation with emphasis on scaling up services to districts and regions. In this way, the initiative hopes to secure sustainable scale up.

Priorities across several countries focus on the building blocks for health system strengthening, for example governance, access to services and information systems. Some countries, such as Paraguay, are also focusing their efforts on the mental health aspects of COVID-19 recovery.

This means including both social and psychological interventions, as well as basic medicines, for mental health conditions in UHC basic packages of essential services and financial protection schemes (see section 5.1.3 Evidence to inform policy and practice). It means ensuring that mental health care is available and accessible through a broad range of health and social care services, including primary health care (235). And it means expanding training throughout the health care system to ensure staff are competent to deal with mental health conditions.

5.1.2 National policy and legislative frameworks

Global frameworks are important and useful in directing efforts to improve mental health. But ultimately it is national policies, plans and laws that shape local action on mental health and enable change. At this level, governments have the lead responsibility to develop and implement frameworks to meet all the mental health needs in their country, to protect the rights of those with mental health conditions, and to promote the mental health and well-being of all.



According to WHO's *Mental health atlas 2020*, the number of countries with established policies, plans and laws in place for mental health is steadily growing (see [section 3.3.2 The governance gap](#) (5)). These are important to articulate clear objectives for mental health and to direct practice and implementation.

Mental health legislation that complies with international human rights instruments, whether independent or integrated into other laws, is specifically needed to protect and promote human rights, for example by establishing legal and oversight mechanisms and enabling the development of accessible health and social services in the community.

Human rights-oriented laws and policies are needed to guide transformation in mental health, including shifting from institutional to community-based services. They protect against discrimination and abuse. They emphasize the importance of liberty and enable dedicated community-based mental health services – such as community mental health centres or mental health teams – to be developed and to function, so that those with mental health conditions can avoid hospitalization in custodial institutions. And they can help ensure mental health is included within primary care and other priority health programmes and partnerships, for example for HIV/AIDS, women's health, children and adolescent health, communicable and noncommunicable diseases.

Given the multisectoral nature of mental health determinants, and the importance of mental health programmes in areas such as education, employment, disability, the judicial system, human rights protection, social protection, poverty reduction and development it is essential that laws and policies aimed at improved mental health should be developed beyond the health sector. This includes, for example, developing legislation to protect children from abuse or to protect workers' rights to mental health.

In all cases, identifying and involving stakeholders in the development of mental health laws and policies is important to ensure they are fit for purpose.

Detailed plans of how laws and policies will be implemented are vital. This means:

- establishing timeframes for developing and delivering specific elements of the law and policy;
- allocating budgets;
- estimating human resource needs (both specialist and non-specialist) and making a plan for how these will be trained and placed;
- identifying all activities that need to be done and establishing clear roles and responsibilities for each one; and
- establishing how monitoring and evaluation will be done to assess progress and performance (including on rights compliance) and to enable continuous improvement.

WHO suggests setting up a functional mental health unit or coordination mechanism in the ministry of health, with an allocated budget and responsibility for strategic planning (including situational analysis, needs assessment and inter-ministerial and multi-sectoral coordination and collaboration) to help ensure the development and implementation of effective national policy and legal frameworks (3).

5.1.3 Evidence to inform policy and practice

Relevant and reliable information and research are needed to ensure that transformative policies, plans and evaluations for mental health reform are informed by evidence.

Making a case for investing in mental health relies in part on having evidence that mental health conditions are prevalent and pose a serious threat to public health (see [Box 5.3 WHO World Mental Health Surveys](#)). Putting evidence into context is



particularly important. National and local data on the impact of mental health conditions on health, education, employment, welfare and other sectors, and the effectiveness of community-based care can help place the case for investment within relevant political contexts that drive policy-makers to act (see section 4.3.2 Economic benefits) (236). In Belize, for example, evidence on the specific problems in the national mental health system, and on the effective strategies available for overcoming them, was a key factor in persuading policy-makers and donors to back a radical reform of mental health services in the country over 20 years (237).

In addition to robust data on the prevalence and impact of mental health conditions, evidence that there are effective solutions is essential to counter misconceptions that investing in mental health is not worthwhile.

The UHC Compendium

In every area of health, but perhaps especially in mental health – where resources are usually scarce – it is essential that every intervention is backed by evidence, grounded in analyses of carefully chosen and collected routine data, and sensitive to cultural contexts and local conditions.

TOOL

BOX 5.3

WHO World Mental Health Surveys

For more than 20 years, WHO World Mental Health Surveys Initiative has coordinated and carried out rigorous general population epidemiologic surveys to provide information on the global prevalence, burden and unmet need for treatment of mental disorders; and to support policy decisions.

The initiative operates in 29 countries that, when combined, represent all regions of the world and include a total sample size of more than 160 000. All surveys use a common methodology that includes a WHO structured diagnostic interview to assess conditions and treatment, consistent interviewer

training and procedures, and standard quality control protocols.

The World Mental Health Surveys have been variously used to estimate the prevalence of mental disorders, evaluate risk factors, study patterns of and barriers to service use, and validate estimates of disease burden. Together, they have been crucial in establishing that mental disorders are very common around the world. In almost all cases, they have given countries their first ever national representative data on the epidemiology of mental disorders.

Sources: Harvard University, 2021 (238); Demyttenaere et al, 2004 (239); Kessler et al, 2007 (240).



WHO guidelines and recommendations identify a range of interventions for managing mental health conditions, whose efficacy and appropriateness has been established through systematic reviews of the best available evidence and consideration of values, preferences, and feasibility issues from an international perspective (241).

- **Psychosocial interventions** involve interpersonal or informational activities, techniques, or strategies to improve health functioning and well-being (242). For mental health, these include psychoeducation, stress management (including relaxation training and mindfulness), emotional or practical social support (including psychological first aid), and various other social and rehabilitative activities, including peer support and supported employment and housing (203). These also include psychological treatments such as behavioural activation, problem-solving therapy, cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and eye movement desensitization and reprocessing (EMDR).
- **Psychotropic medicines** can, where appropriate, be used to reduce the symptoms of priority mental health conditions and improve functioning. Psychotropic medicines on the *WHO model list of essential medicines* include medicines for psychosis, bipolar disorder, anxiety disorders, depression and obsessive-compulsive disorder (243).

Based on extensive reviews of research, WHO has compiled the UHC Compendium to help countries decide what to include in UHC service packages. This global repository includes more than 3 500 evidence-based interventions across all areas of health, including more than 200 health actions for mental health conditions (179).

Mental health actions listed in the compendium address the spectrum of promotive, preventive, diagnostic, curative, and rehabilitative interventions. They are largely based on the

mhGAP Evidence Resource Centre, which contains the background material, process documents, and the evidence profiles and recommendations for WHO guidelines for mental, neurological, and substance use disorders (159). Most of the clinical interventions listed in the compendium are included in the widely used mhGAP Intervention Guide (mhGAP-IG) for non-specialized health care settings (see Box 5.4 mhGAP Intervention Guide: eight steps in clinical practice).

For many people living with mental health conditions, being able to choose and access psychological treatment and other psychosocial support is essential.

Importantly, clinical recommendations listed in the UHC Compendium and in the mhGAP-IG include a mix of psychosocial and pharmacological interventions. Too often, discussions on mental health in UHC coverage packages focus exclusively on medicines. But for many people living with mental health conditions, being able to also choose and access psychological treatment and other psychosocial support is essential.

For each intervention and health action listed in the UHC Compendium, information is given on relevant health programmes, life-course stage and SDG goals.

Many of the mental health interventions in the compendium are not only effective but also cost-effective and are on the *WHO menu of cost-effective interventions for mental health* (see section 4.3.2 Economic benefits) (222).

In practice, the choice of intervention and how it is implemented should be based on the type of mental health problem being experienced and, in the case of children and adolescents, on the developmental stage of the person experiencing it. And even though mental health

TOOL

BOX 5.4

mhGAP Intervention Guide: eight steps in clinical practice

Priority mental, neurological and substance use conditions currently targeted by WHO's mhGAP are: depression, psychosis (including schizophrenia and bipolar disorder), epilepsy, dementia, disorders due to alcohol or drug use, child and adolescent mental and behavioural disorders and conditions related to stress (for example, PTSD) as well as self-harm/suicide. For each of these, WHO has developed (and continues to update) management recommendations using the well-established Grading of Recommendations Assessment, Development and Evaluation (GRADE) method. The recommendations cover both psychosocial and pharmacological interventions.

The mhGAP Intervention Guide (mhGAP-IG) turns these evidence-based guidelines into simple clinical protocols that can support decision making on the ground in non-specialized health care settings. Additionally, a broader programme of action builds partnerships across all stakeholders to adapt and adopt the protocols at scale.

The mhGAP-IG describes the essentials of mental health clinical practice, including assessing the person's physical health and assessing and managing mental, neurological and substance use disorders. In particular, it identifies eight steps in clinical practice.

- 1.** Develop a treatment plan in collaboration with the person and their carer.
- 2.** Always offer psychosocial interventions for the person and their carers.
- 3.** Use pharmacological interventions when indicated.
- 4.** Refer to a specialist or hospital when indicated and available.
- 5.** Ensure that an appropriate plan for follow up is in place.
- 6.** Work with carers and families to support the person.
- 7.** Foster strong links with employment, education, social services and other relevant sectors.
- 8.** Modify treatment plans for special populations, including children and adolescents, women who are pregnant or breast-feeding and older adults.

Sources: Dua, 2011 (241); WHO, 2016 (244).





conditions exist on a continuum (see section 2.1.2 Mental health exists on a continuum), health care providers need a diagnostic framework to clinically assess, treat and ensure payment for the care of mental health conditions.

International Classification of Diseases, 11th Revision (ICD-11)

Using medical nosology is important to ensure that mental health is included in health statistics and in health services planning and implementation. For example, if a country is developing a UHC basic package of services, it must be able to list clearly defined mental health conditions to decide what intervention to include for what condition. And in many countries, both public and private health insurance providers usually require a diagnosis before covering the costs.

WHO's ICD-11 is the gold-standard global tool for coding diseases, causes of death, injuries and health conditions, informed by an extensive review of the evidence (245). It includes a fully revised chapter on mental, behavioural and neurodevelopmental disorders that has been designed to make mental health diagnoses more accessible, also in non-specialist settings (246).

Unlike most other diagnostic systems in mental health, this ICD-11 chapter is especially designed to ensure it is clinically useful and globally applicable, in addition to being valid and reliable (247).

Mental health information systems

Health management information systems, including those for mental health, provide valuable data on needs, services use and resource demands. These can be used to track trends and clusters of cases, identify at-risk groups and measure mental health outputs and outcomes (including coverage). They can also

be vital to inform service provision, resource deployment and management guidelines (248).

For mental health information systems to be useful in informing policy and planning and improving mental health outcomes:

- the indicators must be relevant and feasible to collect;
- the data must be regularly reviewed and used to identify trends; and
- the health system must allow for practical changes to be made on the basis of data collected.

Where these conditions are manifest, health information systems can enable decision-making in all aspects of the health system and ensure the delivery of equitable, effective, efficient and good quality interventions.

But despite an appetite for using information systems to support decision-making around service planning, this rarely happens in LMICs (see Box 5.5 Mental health management information systems in LMICs) (249).

ICD-11 is designed to ensure it is valid, clinically useful and globally applicable.

The *Comprehensive mental health action plan 2013–2030* commits countries to strengthen their surveillance systems for monitoring mental health, self-harm and suicide. It suggests that countries disaggregate data by facility, sex, age, disability, method and other relevant variables; and that they use these data to inform plans, budgets and programmes.



CASE STUDY

BOX 5.5

Mental health management information systems in LMICs

A survey of mental health management information systems in six African and Asian countries (Ethiopia, India, Nepal, Nigeria, South Africa and Uganda) found that all countries collected some mental health indicators through their routine health management information system, but that these data were limited in scope and variable in their categorization of mental health conditions.

In general, the information systems surveyed focused on reporting mental health diagnoses rather than providing system level indicators on quality and use of services. Where data on mental health were

collected and reported they took too long to reach policy-makers to be able to influence decisions.

Introducing a separate mental health information system is unrealistic and undesirable in many LMICs where mental health is still largely neglected and resources remain in short supply. But routine information systems can be strengthened to deliver better quality mental health data. For example by providing better support and training in mental health information management, including selecting relevant standardized indicators for mental health.

Source: Upadhyaya et al, 2016 (250).

Research for mental health

In addition to robust information systems, evidence-based mental health policies and services also require locally relevant research that is timely, relevant, reliable, well-designed and conducted, accessible and innovative.

Various initiatives have established research priorities for mental health at a global level. For example, the 2011 Grand Challenges in Global Mental Health, which established 25 research priorities for mental health involved researchers, advocates, programme implementers and clinicians from more than 60 countries and was instrumental in directing substantial research funding for mental health (251).

Global prioritization initiatives for mental health research such as the Grand Challenges highlight the importance of research aimed at finding better interventions, methods of care or even cures for mental health conditions. But they also identify other areas of importance, including research on: the determinants of mental health; the prevalence and global burden of mental health conditions; the feasibility and affordability of interventions; and the effectiveness and appropriateness of different interventions in different contexts.

At a national level, the *Comprehensive mental health action plan 2013–2030* emphasizes the importance of developing a prioritized and funded research agenda that is based on consultation and cooperation with all stakeholders and sectors; and that includes robust mechanisms for translating knowledge into practice.

Of course, not all research is done to specifically inform a given policy or with the intention of being directly applied in practice. And it is often the accumulation and replication of data that eventually gets adapted and adopted into policy or into clinical guidelines or recommendations, rather than a single piece of research. Notwithstanding, where research starts with the intention of practical application, there is much that researchers can do to support the translation of knowledge into practice and guide mental health transformation.

They can, for example, ensure that their research reflects local and national realities. Data collected for the *Mental health atlas 2020* shows that less than 5% of health research outputs globally focused on mental health; and most of that was concentrated in high-income countries (see [section 3.3.1 The data gap](#)). Addressing global research imbalances and helping to close the data gap is important to ensure LMICs have the information they need to identify and target their own mental health needs and priorities. That means conducting clinical research in LMICs and ensuring a central role for LMIC researchers in designing and managing the research. It also means paying greater attention

to mental health systems research, rather than basic or clinical research, to better understand how to transform services so they meet the mental health needs of all those who need care ([252](#)).

Researchers can do much more to involve people with lived experience in research design and delivery. People with lived experience and their organizations can facilitate global networks for research collaboration. They can help design and carry out culturally-validated research. And they can help evaluate services to ensure research is credible and genuinely useful to service users and carers ([253](#)).

Ensuring that mental health research evidence can be put to use – including by policy-makers, managers, clinicians and mental health planners – is essential ([254](#)). Planning research collaboratively with stakeholders, sharing regular updates and findings, assessing potential implications and jointly considering how to use evidence as it emerges, holds enormous potential for translating knowledge into practice, including by conducting implementation science.

5.2 Understanding and commitment

Mental health is underserved for many different reasons. One of the most important is that it tends to be ignored and undervalued – by individuals, families, businesses, communities and countries. The result is that people at all levels of society and government take insufficient action to promote mental health, prevent mental ill-health, or to provide comprehensive, rights-based, quality care to those in need. A deep appreciation of the real value of mental health is not in itself enough to transform mental health; but it is a fundamental step in the right direction.

5.2.1 Strengthening political will and engagement

Transforming mental health cannot be achieved without reallocating limited resources, developing new policies, building new skills, establishing new partnerships and engaging new stakeholders. In doing these things it is common to encounter strong resistance to change, driven, for example, by logistical challenges, vested interests and competing priorities ([237](#)). Strong political will and commitment are essential to overcome the barriers.

Political will for an issue typically includes three types of commitment: how widely decision-makers publicly support the issue (expressed commitment); the extent to which policies, plans and programmes are established to implement the stated intent (institutional commitment); and whether or not the necessary funds are allocated (budgetary commitment) (see Fig. 5.1) (255).

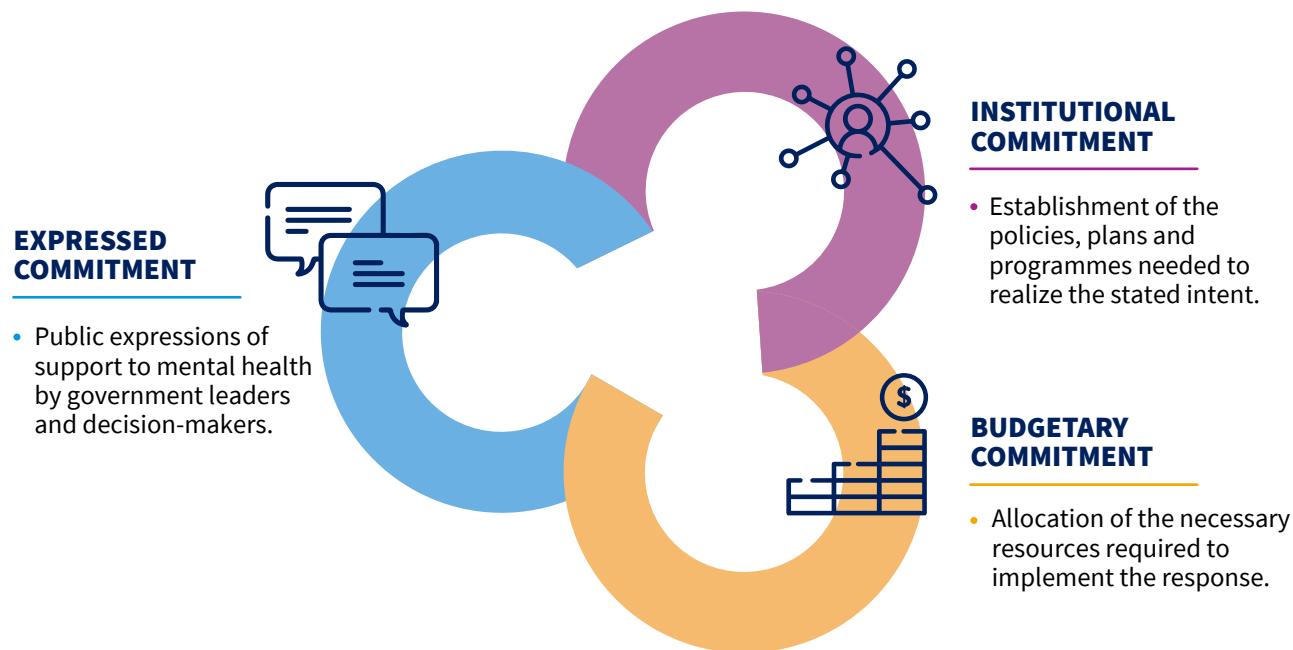
All three types are needed to drive the mental health agenda forward and effect meaningful change. Indeed, a 2007 analysis of LMICs suggested that many of the barriers to improved mental health services could be overcome by generating political will for accessible and humane mental health care (252). Since then, growth in global advocacy and action has focused political attention on the need for quality mental health care and built an appetite for change.

Globally, expressed commitment is significantly stronger than it was a decade ago. Institutional commitment has similarly grown, with 146 countries now reporting stand-alone policies and plans in place for mental health. But still, countries remain reluctant to make change happen and budgetary commitment is rare: only 67 countries reported data on mental health spending in 2020 and those that did still only spent on average 2% of their total health budget on mental health (see section 3.3.2 The governance gap) (5).

Each type of political commitment can be influenced by a range of national and international factors, including national leadership, domestic advocacy, international public health and development agendas, and public opinion. In all countries, identifying and engaging key agencies and stakeholders in the overall process so that there is shared ownership of the vision and its implementation is important.

FIG. 5.1.

Political will is made up of three types of commitment



Source: Fox et al, 2011 (255).



In low-income countries, where mental health budgets are particularly limited, there is potentially also a catalytic role for external donors in initiating and enabling a transformation in mental health. And political will in source countries as well as recipient ones can have a large influence over whether or not international organizations choose to invest in mental health in LMICs (256).

All over the world, advocacy, evidence and political context can also be hugely influential in fostering political commitment and leadership.

Advocacy movements

Advocacy at all levels – global, regional, national and within communities – is needed to advance mental health policies and practice. And at all levels, there are a growing number of organizations that advocate for better mental health policies, more financing for mental health systems, and an end to stigma and discrimination against people living with mental health conditions.

Advocacy at all levels is needed to advance mental health policies and practice.

Advocacy also increasingly combines different types of stakeholders to achieve change. Ensuring representation from different stakeholders in advocacy movements is important to their success and is recommended by the *Comprehensive mental health action plan 2013–2030*.

WHO has developed guidance and works with a wide variety of organizations to deliver successful mental health advocacy (257). International institutions can be key agents of change in encouraging and supporting policy-makers to improve mental health services, ensure equity in care and promote human rights. Leading figures from these organizations – such as the WHO Director-General and the UN Secretary General – have a critical role as champions for better mental health.

Member States in global decision-making bodies, such as the World Health Assembly or the UN General Assembly, or in coalitions of nations such as the G77, G20 or G7, can be strong advocates among their peers to include mental health in deliberations and to deliver shared commitments to change (as expressed, for example, in the *Comprehensive mental health action plan 2013–2030* or the *UN political declaration on NCDs*). Mental health advocacy by national governments is equally important in influencing the policies and priorities of international organizations such as the World Bank or Global Fund to Fight AIDS, TB and Malaria.

Mental health professionals and people with lived experience of mental health conditions have an important role in advocacy. Mental health professionals can help influence policy-makers and advance progress through peer to peer influencing within and between countries. And participation by people with lived experience is important to help change attitudes and build awareness about mental health conditions, to articulate the value of improved access to effective and humane mental health care, and to provide peer support services, among other things (read Sahar's experience and see Chapter 4, In focus: Engaging and empowering people with lived experience) (23).

Increasingly these stakeholders are joined by other influential groups including parliamentarians, businesses and media and communications organizations who also advocate for better mental health. More broadly, a growing range of stakeholders are acknowledging mental health as a cross-cutting issue and working to better integrate it in multisectoral services and programmes targeted at, for example, improving physical health, strengthening educational attainment, upholding human rights, and supporting people affected by conflict and disaster.

NARRATIVE

Giving people hope is my greatest pleasure



Sahar's experience

I was 16 when my life was turned upside down by an invisible illness. I spent what should have been my senior year in high school on a couch, too depressed to move, eat, or think, in a maelstrom of internal terror that I hoped would go away. It never did.

I spent years living with an undiagnosed mental illness. All I knew was I was hurting and terrified that people would find out about my mental struggle. I didn't know anyone who was open about having a mental illness. I turned to drugs and alcohol to numb my pain. My life didn't matter to me and I had a suicide attempt.

It has been eleven years since my world fell apart. In that time I have been diagnosed with borderline personality disorder, major depressive disorder, and obsessive compulsive disorder. I have dealt with the perils of addiction. Today I am taking prescribed medication, attending therapy sessions, and putting in the work to be mentally healthy.

Over those eleven years I also broke out of my bubble of shame and realized that my illness was a superpower I could use to help others. I cofounded a non-profit organization aimed at bringing awareness

to mental health and used my story to create awareness and help others. I am proud to be a mental health advocate. Giving people hope by sharing my story has been the greatest pleasure of my life. Maybe that is what all the heart ache and suffering is for – to help others.

As much as my illness is a superpower I have days where I am crippled by my illness. I am lucky to have an incredible support system that helps me through the darkness. This is not something I take for granted. Many people have no support and no access to good mental health care. They are left to suffer and in some cases perish from something that is treatable.

To move forward we must ensure that mental health care is accessible to all. We must ensure that our kids are taught that it is ok not to be ok and help is just a conversation away. Mental illness is not a death sentence nor a sign of weakness.

My name is Sahar. I am a proud mentally ill teacher, advocate, daughter, niece, friend, aunt, dog-mom, and human, finding my way in the world like everyone else.

Sahar Vasquez, Belize



In all cases, ensuring consensus and clarity in communications is important. Fragmentation in advocacy, where different stakeholders argue against each other to highlight different aspects of mental health, has been identified as a major barrier to progress (258). But overall, there has been a rise in coordinated national and global advocacy campaigns, events, forums and platforms in recent years (for example, see Chapter 4, In focus: Engaging and empowering people with mental health conditions). These can serve as vehicles for strengthening political commitment. For example, World Mental Health Day (celebrated on 10 October each year) is increasingly used all over the world to raise awareness of mental health issues, garner public expressions of commitment from national decision-makers and mobilize efforts in support of mental health (259).

Windows of opportunity

Some political contexts offer particularly favourable opportunities for securing commitment from political leaders and moving the mental health agenda forward. This includes, for example, the launch of a landmark report or international agreement. In 2001, the WHO flagship report on mental health captured the attention of political leaders all over the world and provided the momentum for a number of national and international mental health initiatives to take root and flourish (237).

Humanitarian emergencies and natural disasters offer unparalleled platforms for change to develop better care systems for the long term.

In the Americas, it was the signing of the Caracas Declaration in 1990 that paved the way for mental health reform. The declaration called for mental health to be integrated into primary care, and for the human rights of people with mental health conditions to be protected. It was informed by a combination of epidemiological studies that showed the extent of mental

ill-health in the region; but also political and social innovation following the end of several dictatorships. It provided the basis for policy and legislative initiatives and successful and innovative reform in many countries, including Brazil, Chile, Cuba, El Salvador, Guatemala, Nicaragua and Panama, among others (260).

Humanitarian emergencies arising from natural disasters and conflict, despite their tragic nature and adverse effects on mental health, offer unparalleled platforms for change. They represent an obligation and opportunity for countries to invest in mental health. A surge of national and international aid, combined with sudden, focused attention on people's mental health, can galvanize political support and action and create opportunities for developing better care systems for the long term.

In Syria, for example, before the conflict, there was scarcely any mental health care available outside the psychiatric hospitals in Aleppo and Damascus. Now, thanks to a growing recognition of the need for support, and increasing humanitarian aid, mental health and psychosocial support has been introduced in primary and secondary health facilities, in community and women's centres, and in school-based programmes. Today, despite the ongoing conflict, at least one of every four functioning general health care facilities in Syria has one person trained in mental health, who is supervised and works within a system to provide mental health care.

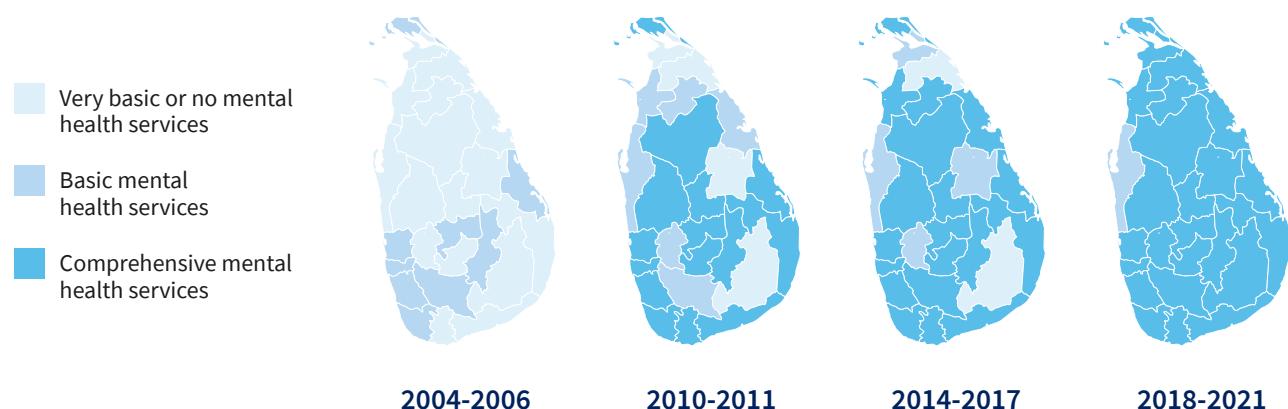
Many countries have already capitalized on emergency situations to build better mental health systems (261). For example, in Sri Lanka, the impacts of the Asian tsunami in 2004 dramatically increased the political interest in mental health and facilitated the mobilization of immediate resources for emergency mental health care, which then provided a platform for broader national mental health reform. Supported by WHO, the Sri Lankan Ministry of Health worked

with stakeholders to develop a national mental health policy focused on decentralizing care and ensuring the local availability of mental health services in all districts of the country. The plan was implemented through multiple

programmes at national and district levels. Today, every district in the country has mental health services infrastructure, compared with a third before the tsunami (see Fig. 5.2).

FIG. 5.2

The expansion of mental health services in Sri Lanka, 2004–2021



SERVICES	2004 → 2021		HUMAN RESOURCES		2004 → 2021	
• Acute inpatient units	10	25	• Psychiatrists	36	136	
• Outpatient clinics at hospitals	10	26	• Child psychiatrists	1	10	
• Intermediate care rehabilitation unit	5	21	• Forensic psychiatrists	-	2	
• Alcohol rehabilitation centres	1	11	• Medical officers of mental health (MOMH)	40	223	
• Outreach clinics	55	287	• Medical officers with one year diploma in psychiatry	-	47	
• Child mental health clinics in general hospitals	2	26	• Psychiatric nurses	-	71	
• Child mental health units	-	2	• Psychiatric social workers	9	78	
• Mental health helpline	-	1	• Occupational therapists	6	58	

Source: Ministry of Health Sri Lanka et al, 2021 (262); Directorate of Mental Health, Sri Lanka, unpublished data, June 2022.

In Albania, the 1999 crisis of refugees from Kosovo¹ created an interest in mental health and an appetite – backed with finances – for mental health reform. A new mental health plan was approved and services were decentralized from a hospital-only and biologically-oriented system of care to a wide range of community-based services (see Fig. 5.3).

FIG. 5.3
Change in mental health facilities in Albania 2000–2020



Source: Ministry of Health, Albania, unpublished data, March 2022.

Most recently, the COVID-19 pandemic has made strengthening mental health systems more urgent all over the world, but especially in LMICs. It has prompted swift and diverse responses through, for example, national COVID-19 response plans for mental health services, implementation of WHO and Inter-agency Standing Committee (IASC)

guidance and a WHO Executive Board decision urging Member State action on, and resources for, mental health (see Chapter 2, *In focus: COVID-19 and mental health*) (7, 263). Building on the growing interest in using new technologies in mental health care over recent years, the pandemic has also spurred development and deployment of a swathe of digital tools and tactics to support mental health in the face of deep uncertainty, stress and change (see *In focus: Harnessing digital technologies for mental health*).

Whether it is a new report, a change in government, a disaster or a public health emergency, all opportunities must be used to transform mental health.

5.2.2 Building public awareness and interest

Building public awareness and interest is essential to transform and scale mental health care. Mental health is everybody's business. Intrinsic to our quality of life and our potential for prosperity, it is something that all people should value for themselves and others. If the general public does not know about or is not interested in mental health issues, they are less likely to take responsibility for self-care, to seek appropriate help when they aren't well, or to prioritize access to quality mental health care for all (see *section 3.4.2 Low levels of health literacy about mental health*). Governments are also unlikely to invest in mental health promotion or commit to mental health care reform if the general public is not knowledgeable and interested in mental health issues.

Building public interest in mental health, shifting attitudes and tackling stigma is not easy. But experience shows it is possible, most notably through education, contact and protest anti-stigma strategies such as those outlined in *section 4.2.1 Stopping stigma*. Approaches based on social contact with people with mental health conditions

¹ The reference to Kosovo in this report should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

NARRATIVE

Knowledge is power

Angelica's experience

In my country there are 17 psychiatrists for 16 million people. The mental health budget is very small and conditions like mine – obsessive compulsive disorder (OCD) – are simply ignored.

For years I thought that maybe I was bewitched, or cursed, or possessed by evil spirits. I had to go through this alone, because of fear of stigmatization. I could not even tell my husband. I was scared my loved ones would desert me. My church could not help. No priest understood what I was going through. There were no support groups in the whole country.

I finally found out about OCD online. Even then it took me nearly a year to get the courage to visit a health care worker. I remember once telling a friend that the government was letting people with OCD down because no one was talking about it. They replied that we only have ourselves to blame: we need to speak up.

In 2018 I set up a nongovernmental organization called Zimbabwe OCD Trust to raise awareness of and provide support to people with OCD. I started a support group. We used to meet face-to-face once a month before COVID-19; now we meet online. I gave talks on the radio and at local events. Our work was featured in newspapers and magazines. People started to notice me, they started listening to what I was saying and then they started coming forward and inviting me to talk about this highly stigmatized disorder.

Knowledge is power. Just knowing that their distress was caused by a mental health condition and not some evil spirit was a relief to most people. I am not a psychiatrist, so once someone is comfortable talking about their disorder I ask them to seek professional help.

I feel that this is just the beginning of my work in raising awareness of OCD, ending stigma towards it and supporting people with lived experience to be treated as equal partners in this world.

Angelica Mkorongo, Zimbabwe



CASE STUDY

BOX 5.6

VISHRAM: a community initiative to reduce suicides in rural India

The Vidarbha Stress and Health Program (VISHRAM) was a community-based programme run over 18 months in 2014 and 2015. It was designed to address the mental health risk factors for suicide in the rural Amravati district of Vidarbha, central India. By the end of the project, the prevalence of suicidal thoughts among VISHRAM's target population had halved, and the prevalence of depression had fallen by 22%. There was also a six-fold increase in the percentage of people seeking mental health care.

VISHRAM used a tiered model of collaborative care, in which community health workers provided the first point of contact. They visited households and held small meetings to increase awareness of mental

health conditions and the services available to treat them. They also helped identify people with symptoms of depression, persuading them to talk to a lay counsellor for psychological first aid; or, for people with more severe symptoms, to visit an outreach clinic and see a psychiatrist.

As a legacy of VISHRAM, each of the 30 villages involved in the programme has a community health worker who is trained to detect depression, provide frontline support and refer people to the public health system for further management. The increased awareness among community members also triggered 26 village councils to pass resolutions to the State Government demanding mental health services.

Source: Shidhaye et al, 2017 (264).

are particularly effective. People with lived experience, including in peer-led organizations, can be important agents of change. They can increase awareness and acceptance among the general public and so build health literacy in mental health (read [Angelica's experience](#)).

In practice, awareness-building programmes can vary widely from country to country, reflecting differences in culture, context and resources available. In many cases they are embedded in other community-based mental health services and infrastructure designed to increase the demand for care (see Box 5.6 VISHRAM: a community initiative to reduce suicides in rural India).

Improving awareness and help-seeking is a key requirement to scale up much needed mental health care. If people do not know that some of their mental health difficulties can be addressed by locally available services, they will not seek care.

Awareness building also includes proactive case detection. Research in rural Nepal showed that community volunteers trained to use a vignette and picture based case detection tool can identify people with mental health conditions and so inform them about available care (265). The Nepal study found that proactive community case detection led to nearly 50% more people starting mental health care compared with general awareness-raising and self-referral.



Harnessing digital technologies for mental health

Digital technologies – from websites and online platforms to smartphones and mobile applications – have long been able to help people achieve better mental health (266). But until recently it has mostly been people in higher-income countries using them. Now, these technologies are becoming more available and affordable in many countries and settings, and they are increasingly being harnessed to improve mental health, especially in remote areas where people are more likely to have access to a mobile phone than mental health care.

This trend was amplified during the COVID-19 pandemic as service users and providers searched for ways to deliver and access mental health care amid social restrictions.

Of course, digital technologies for mental health are not without their risks. In all cases, digital interventions should be guided by ethical principles and implemented in line with professional codes of conduct. Key areas of concern are: privacy, data protection, safety and accountability (267). Availability and fairness are also important issues, especially as many people – especially those with fewer resources – may not be able to access digital technologies (see [section 3.3.3 The resources gap: a digital divide](#)).

And digital technologies more broadly can adversely impact mental health. Various studies suggest that exposure to social media in particular has been linked with mental health conditions in young people (although there are caveats due to methodological limitations in the research). Time spent online, types of activities and addictive use have all been associated with depression, anxiety and psychological distress in adolescents.

Extensive screen time and frequent use of digital technology may possibly heighten attention-deficit symptoms, disrupt sleep, and hinder brain development (268, 269). They can lead to technology addiction and social isolation. Gaming disorder, which is a new condition in ICD-11, is an increasing concern (270). It is more common among men than women and it can result in marked distress and significant impairment in personal, family, social, educational or occupational functioning.

Overall, digital technologies have the potential to contribute substantially to national efforts to achieve universal mental health coverage. They reduce travel time and expense. They provide flexibility to fit around people's daily schedules. And their anonymity can help avoid barriers created by stigma. Indeed, the evidence for digital approaches supporting mental health is compelling, with self-help approaches and telemedicine in particular showing strong benefits, including in middle-income countries (271).

The sections that follow describe five areas of great promise, where digital technologies are already being used to effectively improve the availability, reach and quality of mental health care (we have not considered their use in mental health information systems).

The examples provided are far from exhaustive: this is a fast-evolving field and new approaches and applications are constantly emerging.

Digital technologies to inform and educate the public

Having information about mental health and how to deal with one's own mental health can be extremely useful to people experiencing psychological distress or living with a mental health condition; or indeed to anyone who simply wants to improve their well-being.

WHO online resources. WHO provides extensive digital resources to the public through various media including videos, booklets, manuals and webpages (272). Key topics include: managing stress, mental health during COVID-19, dealing with depression, and preventing suicide.

Global experts by experience. The Global Mental Health Peer Network publishes podcasts, interviews, academic papers and online articles to share information aimed at empowering people with lived experience (273). By sharing recovery stories, the network hopes to help break down stigma and remind others that recovery is possible.

Health literacy in China. In response to a rise in mental health problems during the COVID-19 pandemic, mental health professionals and health authorities in China developed a range of online mental health education and awareness programmes (274). These include using social media to provide information to medical staff and the public; and free e-books to educate people about COVID-19 prevention, control, and mental health.

Digital technologies to train health care workers

Across multiple settings, WHO and other institutions use e-learning courses with remote support and supervision to train health care workers in various aspects of mental health care, including clinical management, rights-based care (see Box 4.4 [WHO QualityRights](#)), and delivering psychological interventions (see Box 5.12 EQUIP: assessing and building competencies for psychological interventions).

WHO Academy. Using a mix of online, in-person and blended learning programmes, the WHO Academy plans to expand access to learning for health workers, managers, public health officials, educators, researchers and policy-makers around the world. When it opens, it will offer training on all aspects of global health, including mental health. The academy will offer multilingual, personalized programmes featuring innovations such as artificial intelligence and virtual reality technology. All courses will be suitable for low-bandwidth settings. Both mhGAP and QualityRights core training packages for primary health care workers will be available through the new academy.

EMPOWER. EMPOWER is an online, interactive training programme that teaches supervised community health workers to deliver mental health interventions for different conditions. It is being simultaneously developed in India and the United States. The programme is digitizing the content of existing, evidence-based, psychosocial treatments that have been shown to be effective when delivered by non-specialists. Online learning will involve digital leaning, a remote coach, peer supervision moderated by an expert and competency assessment (275).

Virtual Campus for Public Health (VCPH). VCPH is the learning platform of the Pan American Health Organization (PAHO) (276). Through the VCPH, health practitioners can access online courses and interactive materials on a variety of public health topics, including

public mental health topics such as prevention of self-harm and suicide, mental health and psychosocial support in humanitarian emergencies, and stigma reduction. The platform includes content in four languages, contributed from 21 countries across the Americas. The VCPH has supported public health training since 2008 and now has more than a million people enrolled in its courses (277).

Digital technologies to support non-specialist providers

Digital tools can help non-specialist providers to assess mental health conditions and provide treatment.

Electronic mhGAP Intervention Guide

(e-mhGAP-IG). The original mhGAP-IG provides clinical protocols to support non-specialist providers in assessing and managing priority mental health conditions. The mobile tool offers the same materials, reformulated for use with a smart phone and available in several languages.

e-health in Afghanistan. In Afghanistan, an e-health initiative in Badakhshan province supported community health workers and facility-based health care providers through a tailor-made mobile application (278). Like the e-mhGAP-IG, the Afghan application included interactive mhGAP-based guidelines for screening and management. It could also register mental health service users in the community and provided a platform for teleconsultation. Preliminary evaluation suggested remote communities had enhanced access to care, stigma was reduced, and the quality of health services improved.

Digital technologies for remote care

Tele-mental health is a way of putting service users and mental health professionals in touch remotely. Sessions held through videoconferencing, online messaging or by telephone enable the professional to make evaluations, provide therapy (individual, group

or family therapy), prescribe medication, educate about mental health and support self-management. Research shows that psychological treatment through videoconferencing can be particularly useful in treating depression and anxiety (279).

Tele-mental health can also involve mental health professionals supporting pharmacists to deliver prescriptions or primary care providers to deliver consultations, either live or using a record-and-forward format in which information is pre-recorded and sent for review. Or it can involve providing advice and guidance remotely.

In remote rural areas, tele-mental health may be more convenient for logistical purposes. During the COVID-19 pandemic it was the only practical option available for most people (see [Chapter 2, In focus: COVID-19 and mental health](#)). People often prefer tele-mental health because it avoids the stigma of attending a physical consultation and the time and cost of travel to the appointment.

Counselling through chat in China. During the COVID-19 pandemic, mental health professionals in medical institutions, universities and academic societies across all regions of China established online 24-hour psychological counselling services through free messaging applications (274).

e-prescriptions in the Philippines. In the Philippines, doctors used teleconsultations to liaise with pharmacies and issue e-prescriptions as a way of improving access to prescription medication during COVID-19 lockdowns (280).

Digital technologies for self-help

Self-help interventions have a strong evidence base, especially for depression and anxiety (281). But when it comes to digital self-help for mental health, there are thousands of online and mobile applications available and only a few have been well tested and evaluated. Examples of well evaluated tools include Step-by-Step



(read Nour's experience and see Box 7.7 Step-by-Step: guided self-help for depression in Lebanon).

Smartphones for stress management. In Viet Nam, a smartphone-based stress management programme has been found to improve work engagement among hospital nurses. The programme was developed in consultation with Vietnamese nurses to consider their work cultures and stressors and was provided in two formats: one where any module could be picked by the user; and one where the modules had to be followed in sequential order. The fixed-order programme, which included CBT-based stress management skill training,

was found to significantly improve work engagement at three-month follow up; but its effectiveness did not endure at seven-month follow up (282).

WHO Alcohol e-Health. WHO Alcohol e-Health is an evidence-based interactive self-help tool for people seeking to reduce or discontinue their use of alcohol. Alcohol e-health has been tested in Belarus, Brazil, India and Mexico, where it was found to reduce harmful or hazardous alcohol use within six months, suggesting that this could be an important model for other LMICs to follow (283).

NARRATIVE

I can actually feel a difference

Nour's experience

Since birth, I have suffered with brittle bone disease. When I was young I went to a school that cares about integrating children with special needs and I did not feel different, although outside school I was subjected to bullying that bothered me and made me cry a lot.

Then, in my last year of school, my family moved. My new school did not even meet the lowest standards to support people with my condition. I started skipping school a lot and after years of being at the top of my class, my grades started to drop. When I failed my exams I experienced a great shock and I developed a constant fear of failing. I started having more psychological disturbances but did not have the awareness to express myself or to ask help from anyone.

I tried therapy but I couldn't always afford the fees. Then I found Step-by-Step on social media. Step-by-Step is a free, online mental health programme that gives me a space to express my emotions and tools to help me overcome the problems I face. At first I felt that the tools were not that helpful, but using them again and again I can actually feel a difference.

Today I can express my mood when I need to and I use tools like breathing and grounding exercises to help me decrease my psychological pain. Through Step-by-Step I have learned to get things done even when I'm feeling down and powerless, by splitting them up into simple tasks. Step-by-Step is also helping me strengthen my social relationships. I feel that I belong to a circle of support. And I have gained skills that make me think more positively and gratefully.

Nour Awad, Lebanon

5.3 Financing for mental health

Strengthening information, evidence and understanding can only go so far in facilitating mental health reform. To transform mental health services, plans and policies must be translated into action through financing that allocates resources as and where they are needed. Adequate financing provides the basis for establishing administration and governance mechanisms, developing and deploying a trained workforce and installing relevant infrastructure and technology to scale up delivery of sustainable mental health services.

Achieving adequate financing requires policy-makers and planners to devote more funds for mental health, either by getting additional resources from the state treasury or external funders, or by redistributing resources towards mental health, both within the health budget as well as across government (for example in education budgets).

Either way, budgetary restrictions and human resource constraints invariably limit what is possible. Achieving UHC requires rational and carefully considered decisions about where, how and to whom health services should be provided. In all contexts, in-depth processes to weigh up needs, resources, evidence of impact and models of intervention can help ensure that resources are allocated, and services provided, appropriately and efficiently.

Financial constraints have led to some highly innovative solutions that use minimal resources but achieve important outcomes. Such innovations, borne of necessity, may be the most favourable option in LMICs; they may also provide models that are appropriate for high-income countries. For example, both

Problem Management Plus and the Friendship Bench involve brief, simplified versions of psychological interventions that were originally developed for LMIC communities but which have now been adapted for use in New York (see section 7.1.4 Scaling up care for people with common conditions) (284, 285).

Mental health services generally rely entirely on health and social care budgets for resources. Resource allocation tends to follow historical convention rather than being based on ongoing evaluation of need. Budgets are usually refocused only when health care is being reformed.

There are ways that countries can increase the efficiency and equity of existing resources for mental health services, including by deinstitutionalizing mental health care and by tackling any misuse of resources. Nonetheless, no country will be able to meet the mental health needs of their populations without mobilizing additional funds and human resources and allocating increased amounts for mental health.

No country will be able to meet the mental health needs of their populations without mobilizing additional funds and human resources for mental health.

Most funding for mental health should come from domestic sources, to ensure sustainability (219). But there is a role for external funders, for example through direct assistance, foreign direct investment, corporate social responsibility or philanthropy (286).

CASE STUDY

BOX 5.7

Peru: innovative financing for sustainable improvement

Since 2013, a process of mental health reform in Peru has been closing the care gap for people in need. The reform is focused on shifting care for mental health conditions from specialized psychiatric hospitals to community-based care. Analysis suggests that the reform has supported a gradual but significant expansion in mental health services: in 2009, 9% of people who needed care were covered; by 2018 this figure had risen to 26%.

The successful mental health reform in Peru would not have been possible without an innovative financing model to mobilize new resources and leverage existing funding streams for mental health. In 2014, the Ministry of Economy and Finance approved a ten-year results-based budget exclusively to support community-based mental health services.

By 2020, the number of community mental health centres in the county had grown ninefold (see Box 7.13 Peru: comprehensive community-based mental health care).

Mental health services were included as part of the benefits package offered under Peru's national health insurance scheme, which marked a crucial step towards achieving mental health parity in the health system. This was complemented by a revised reimbursement fee schedule to cover the costs of service provision at community mental health facilities and specialized psychiatric hospitals.

Combined, these measures helped reduce individuals' out-of-pocket payments for mental health services by a third from 2013 to 2016.

Sources: MINSA, 2019 (287); APEC, 2020 (288).



5.3.1 Increasing resources from domestic sources for mental health

Domestic finance for mental health services can be mobilized by advocating for funds from the state treasury; or by reallocating resources within the health budget. Either way, experience shows that when countries commit to funding mental health services themselves, transforming mental health care is possible (see [Box 5.7 Peru: innovative financing for sustainable improvement](#)).

Sourcing additional finance for mental health from the central resource pool through ministries of finance or planning is attractive in that it does not take funding from other areas of health. But any request for additional funds from the treasury also has to compete with requests from other ministries, as well as from a wide range of other organizations needing government assistance.

As countries continue to orientate and finance the move towards UHC, it is vital that mental health is incorporated into sector-wide plans for responsive and resilient health systems. The introduction of new social health insurance schemes or other health financing reforms needed for UHC provide key opportunities for mental health to be “hard wired” from inception. Beyond the health sector, mental health should be fully considered as an emerging development priority since it is linked to poverty, social inequalities, migration, and other key concerns (see [section 4.3 Enabling social and economic development](#)). In this way, mental health can be brought into development strategies that inform treasury decisions, such as medium-term budgetary frameworks.

An alternative approach is to reallocate resources within the health budget to increase the proportion that goes to mental health. Constraints related to budgetary limits and competing priorities still apply. Beyond mental health, governments

have to decide how much to spend on communicable diseases, NCDs, and maternal and child health, among other health needs. Each of these areas of health may have valid and persuasive arguments for keeping their current budgets or even increasing them. Governments also have to decide how much of the health budget should be spent on primary care services, hospitals, specialized services, and prevention and promotion, all of which include mental health.

As countries continue to cope with the economic consequences of COVID-19, government budgets all over the world are under severe strain. The competition for resources is likely to be as strong as ever, while the need to rapidly scale-up mental health support for affected populations is immense (see [Chapter 2, In focus: COVID-19 and mental health](#)).

Expert opinion is divided on how much of the health budget should be allocated to mental health, with various proposals about which criteria should be used to set health priorities ([289](#)). Feasibility, affordability, cost-effectiveness, human rights and equity are all important considerations. There is also the need to understand broad health care financing contexts, tie budgets to nationally-agreed mental health goals and targets and use financing as a tool to introduce innovations and facilitate mental health reform ([284](#)).

Whether or not countries adopt a specific target percentage of the health budget to spend on mental health, the road to UHC requires sufficient resources to make quality affordable care equally accessible for physical and mental health care. This requires all sectors, not just health, to allocate resources to mental health. For example, people with mental health conditions should have access to comprehensive support and employment programmes run by social development and labour ministries.

TOOL

BOX 5.8

Health4Life Fund on NCDs and mental health

Health4Life Fund is a UN-wide multi-partner trust fund devoted to NCDs and mental health that was established in 2021 under the auspices of the United Nations Inter Agency NCD Task Force.

It is designed to support LMICs with catalytic grants, in order to stimulate multi-stakeholder and cross-sectoral action at country level, increase domestic funding, and improve policies, legislation and regulation.

H4LF seeks to enable governments and civil society to address national priorities and achieve scale for innovative actions that strengthen the health system. This includes implementing recommended interventions for preventing and managing NCDs and mental health conditions across the life-course while enhancing a broader multisectoral response to underlying social and structural determinants.

Source: WHO, 2021 (290).

5.3.2 External investors in mental health

Even if countries scale up domestic finance for mental health services, external investors still have an important role, for example, in sourcing catalytic funds (see Box 5.8 Health4Life Fund on NCDs and mental health).

External resources are particularly important in low-income countries, where budgetary pressures are often greatest. In these countries, a large and complex ecosystem of external investors exists across the public, private and third sectors, including aid agencies, development banks, corporations, small- and medium-sized enterprises, nongovernmental organization, corporations and private foundations.

External resources may also be important for middle-income countries, especially as they scale down institutional care and temporarily require a “double budget” to build up community mental health services.

In many cases, external funding can successfully catalyse positive change (see Box 5.9 Pakistan: harnessing donor funding to spark change). But although the level of external investment in mental health has risen since 2000, its contribution remains limited. Mental health attracts very little donor funding. (291) Philanthropic contributions are particularly important in funding mental health improvements in LMICs, but these are still marginal compared with external investment in other areas of health (292).



CASE STUDY

BOX 5.9

Pakistan: harnessing donor funding to spark change

Using a series of external grants since 2014, Interactive Research and Development in Pakistan has established and scaled up the *Pursukoon Zindagi* (Peaceful Life) programme to increase access to mental health services in low-resource communities.

The programme combines community engagement and capacity building activities to increase awareness of mental health conditions and services. Its lay counsellors also provide brief community-based psychological treatment, or referrals. From 2018, the programme started integrating its services within some primary care networks, as well as within specific disease programmes for TB, HIV, lung health and diabetes.

By December 2019, the programme reported that it had screened more than 100 000 people for anxiety and depression; and given free mental health counselling to more than 9 000 people. It

now operates in 19 primary care centres, with more than 140 lay counsellors trained and deployed in communities. It plans to extend the model to three additional primary care providers with a combined network of 75 clinics in Karachi.

When the programme started, lay counsellors were grant funded; but after the programme's success the primary care facilities covered staff costs, so ensuring sustainability.

During COVID-19, the programme has also trained lay counsellors to provide mental health services through proactive calls to people tested for COVID-19; has organized support groups for frontline workers; and a crisis helpline for anyone suffering from anxiety or depression. The programme trained at least 25 health workers to provide integrated physical and mental health care remotely; and supported more than 20 000 people.

Sources: MHIN, 2021 (293); Innovations in Healthcare, 2021 (294).

5.4 Competencies and human resources

Alongside evidence, understanding and funding, widespread competencies in mental health are a vital component of a well-functioning mental health system. In tiered systems of care, diverse providers adopt different but complementary roles that use resources efficiently and make care more widely available. This means that competencies in mental health need to be achieved and maintained by care providers at each tier, ranging from individuals and community providers to general and specialist health care workers (see Fig. 5.4).

Mental health staff working in psychiatric hospitals may have to learn how to work in community-based settings. At the same time, primary care staff will have to develop new skills in detecting mental health conditions and providing care. A broad range of providers who are not mental health specialists, including community workers, lay volunteers, teachers, police officers and prison staff, similarly need specific skills to deliver basic mental health interventions (295). Providers in all settings, including both mental health specialists and non-specialists, need to develop competencies to effectively support the social inclusion of people living with mental health conditions and ensure rights-based, person-centred, recovery-oriented care and support.

Beyond the mental health workforce, everyone in the community has a role in reducing the treatment gap by developing their individual skills and competencies in understanding and looking after their mental health, including managing their own mental health conditions where possible.

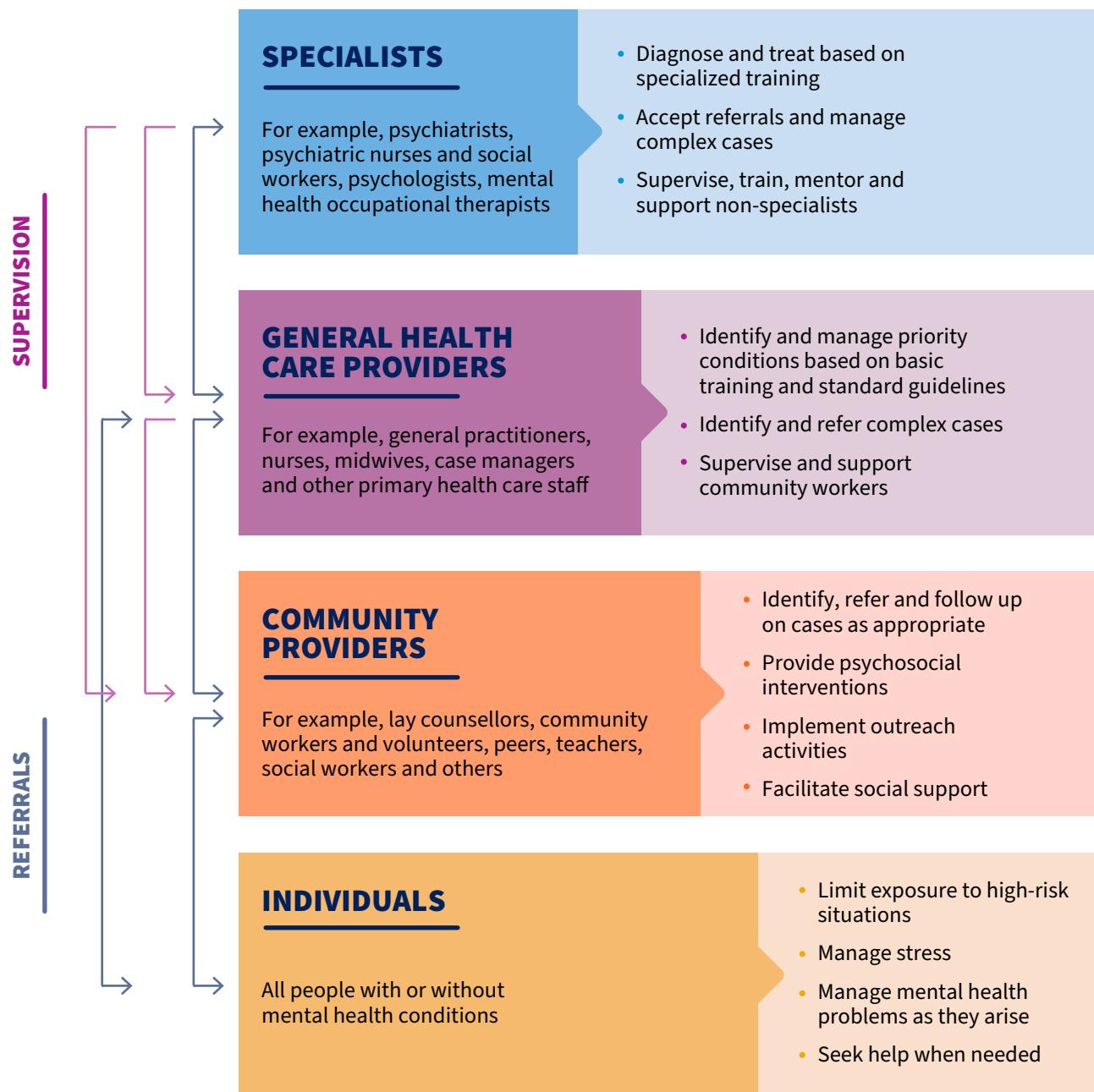
In comprehensive care systems, evidence shows that task-sharing can improve health and social outcomes for people living with mental health conditions, especially in LMICs (296). Task-sharing is also cost-effective. One modelling study in KwaZulu-Natal, South Africa, concluded that task-sharing with competent non-specialists could substantially reduce the number of health care providers needed to close mental health care gaps at primary level, at minimal additional cost (297).

Task-sharing can improve health and social outcomes for people living with mental health conditions, especially in LMICs.

Researchers suggest that task-sharing works best when practitioners:

- belong to the same community as the people served and adapt treatment to incorporate local cultural aspects and beliefs (cultural competency);
- are supervised and have completed basic training in relevant skills to deliver the intervention, either full- or part-time;
- combine psychological and social components of care; and
- have trainers and supervisors who follow a structured supervision protocol to assure quality, as well as providing mentoring, guidance and support (15).

FIG. 5.4

Tiered care allocates different but complementary tasks to workers at different levels of the health system

Source: Ryan et al, 2019 (134).

5.4.1 Expanding the specialist workforce

A competent specialist workforce forms the backbone of any mental health system. As described in [Chapter 3 World mental health today](#), the lower the income of countries, the fewer the mental health specialists. In LMICs, mental health systems – particularly services for children and adolescents – are grossly understaffed. The shortage is partly because in LMICs there are too few health specialists overall. Other contributing factors include the stigma associated with working in mental health and a lack of training opportunities ([298](#)). Professional isolation, poor remuneration and job dissatisfaction, for example, all help drive high levels of emigration among psychiatrists from LMICs ([299](#)).

The specialist workforce that does exist is often unequally distributed, with most staff concentrated in cities and large institutions, and too few in rural areas. This lack and imbalance of trained personnel is a huge barrier to care and puts services out of reach for many people, especially when a large proportion of specialists work in private practice, which in many countries is not covered by health insurance.

Most specialists are clinicians at heart, motivated by providing care to those experiencing mental health conditions. But if they are to help transform mental health systems, they must also deploy diverse competencies. They must work as experts within multidisciplinary teams; as teachers strengthening the skills of students and other staff; as supervisors and mentors to general health care and community providers who are task-sharing on mental health; as researchers contributing to the evidence base on mental health; as public health specialists developing

service infrastructure; and as advocates increasing awareness around key issues ([300](#)).

They must also be able to work with diverse populations to assure that care is equitable for racial and ethnic minorities, LGBTIQ+ persons, migrants and refugees, and persons experiencing poverty and homelessness. The risk of not recognizing mental health conditions or misdiagnosing them is greater with these populations.

Specialist health professionals have multiple roles and so require diverse competencies.

Many countries do not have training programmes for psychiatry, clinical psychology and mental health nursing. Even fewer have training programmes in child psychiatry or child mental health. In some cases, cooperation with universities in high-income countries can offer a potential solution to these challenges (see [Box 5.10 The Toronto Addis Ababa Psychiatry Project \(TAAPP\)](#)).

In all cases, it takes time and substantial resources to train and deploy mental health specialists. But since they are urgently needed to develop and support nationwide networks of community-based care, innovative and flexible training may be necessary. Some countries have found alternative routes by introducing new cadres of mental health professionals who can substitute for psychiatrists, clinical psychologists or psychiatric nurses, especially in rural areas where the gap in expertise is often most severe (see [Box 5.11 Innovations in human resources to develop specialist expertise](#)). These innovations in human resources have proved critical for the nationwide development of a functioning mental health system and serve as potential examples to other countries.



CASE STUDY

BOX 5.10

The Toronto Addis Ababa Psychiatry Project (TAAPP)

The TAAPP is an educational collaboration between Addis Ababa University and the University of Toronto set up to help Ethiopia's newly established psychiatry residency programme. It was designed to supplement the department of psychiatry at Addis Ababa University with external expertise, helping the department to teach, provide clinical supervision, and develop educational capacity.

Established in 2003, the TAAPP involves various faculty and staff from University of Toronto travelling to Addis Ababa to teach a jointly-set curriculum. At the same time, selected faculty from Addis Ababa University are invited to complete year-long clinical fellowships at a hospital in Toronto.

A total of 100 Ethiopian psychiatrists have been trained with the help of TAAPP, bringing the number of psychiatrists in Ethiopia up to 113. The TAAPP programme has recognized that medical faculty staff need not only clinical competencies but also educational capabilities. So the programme has focused on building teaching and training skills among Ethiopia's mental health professionals.

Since TAAPP began, eight new departments of psychiatry have opened outside Addis Ababa; and four new psychiatry residency programmes have been established across the country. Mental health services are also now being integrated into all levels of the national care system.

Sources: Wondimagegn et al, 2021 (301); University of Toronto, 2021 (302).

Expanding the specialist workforce also relies on attracting more people to enter mental health as a profession, retaining them once they are qualified, and ensuring they are equitably distributed across a country. Improving recruitment and retention requires, among other things, action to:

- **tackle stigma** and promote positive attitudes towards mental health as a profession, for example by marketing it as a challenging and rewarding area of the health sector;
- **support ongoing education** by providing opportunities for skills development and knowledge exchange; and

- **enable career progression** by, for example, developing a promotion strategy for staff, providing opportunities for personal growth and professional development and fostering motivation.

Improving remuneration, using flexible job descriptions, and improving social ties among staff can also help retain mental health staff. In all cases, salaries and working conditions for mental health workers should be comparable to those of other health workers.



CASE STUDY

BOX 5.11

Innovations in human resources to develop specialist expertise

Experiences from three low- and lower-middle-income countries show how innovations in human resources can expand specialist expertise, and so support the development of a functioning mental health system that extends nationwide, including hard-to-reach rural areas.

Bhutan. In 2015, Bhutan introduced a four-year undergraduate degree clinical counselling course. As a result of this initiative, more than half of the 30 district and general hospitals now have clinical counsellors on staff. Their main responsibility is identifying common conditions – such as depression, alcohol and substance use disorder, and self-harm – and managing these through psychoeducation and psychological counselling. Clinical counsellors work closely with district doctors and nurses to support any person who is on psychotropic medications and refer or follow up as necessary.

Liberia. Starting in 2010, in partnership with the Carter Center's Mental Health Program, Liberia has trained 306 primary health workers (registered nurses, physician assistants and midwives) in mental health through a six-month training programme. These include 166 specialists in general mental health care and 140 specialists in child

and adolescent mental health care, with a focus on practical application. Graduates are known as Mental Health Clinicians and are licensed by the Liberian Board of Nursing and Midwifery to practice independently. While many do not work full time on mental health, most work in health care settings across the country and treat people with mental, neurological and substance use conditions.

Sri Lanka. Over the past 20 years in Sri Lanka, various training programmes have been launched for medical professionals, including a one-year diploma in psychiatry for doctors and a one-year diploma in basic mental health nursing. The government also created the position of Medical Officer of Mental Health (MOMH), which acts as a district focal point for mental health. Each MOMH receives three months of pre-service training in mental health after having completed their first medical degree. In many districts, the psychiatry diploma holders and MOMHs work under the supervision of Colombo-based psychiatrists and in effect lead and scale up mental health care in districts. Their role has been instrumental in ensuring that mental health care is available in all districts of the country (see Fig. 5.2).

Sources: Chencho Dorji, WHO, personal communication, 25 January 2022; Gwaikolo et al, 2017 (303); Fernando et al, 2017 (304).



5.4.2 Strengthening general health care providers' competencies

General health care providers have a major role in enabling comprehensive mental health services and scaling up mental health care, especially where mental health specialists are rare. In Chile, for example, the National Depression Detection and Treatment Programme scaled up mental health services through the primary care system (271). Introduced in 2001, the programme now encompasses more than 500 primary care centres throughout the country, each of which hosts a general clinical team made up of primary care doctors, nurses and auxiliary nurses, with individual therapy and supervision by a specialist for the most severe cases.

Scaling up mental health care through general health providers means equipping them with the skills to detect mental health conditions, provide basic care, and refer people to specialized care where necessary (305). For individuals, receiving mental health care from competent and compassionate general health care providers can be very rewarding (read *Anders' experience*).

In practice, strengthening the skills of primary care doctors, clinical officers, nurses and other general health workers means training followed by ongoing supervision, mentoring and support.

Quality training of general health care providers in mental health care should be part of pre-service education. Compared with in-service training, pre-service training is more sustainable because

NARRATIVE

My GPs were my saviours

Anders' experience

Without the direct intervention of my general practitioners (GP) at critical stages of my life, my mental health problems could have been more serious. For 15 years, I have seen mental health professionals. Every appointment saw me talking to a different person, repeating my case history time and time again and receiving at best, a medicine review – so frustrating and lacking any obvious desire to give me a good quality of life.

My experience with the GP service couldn't be more different. Over time, I found two GPs who truly listened to my needs, who gave me the time I needed

“

to explain my status and who took extraordinary steps to make sure my needs were met.

Their dedication, kindness and compassion has helped me time and again over the past few years. In late 2019, when I was severely ill with depression and thinking about suicide a lot, it was my GP, not my psychiatrist, that gave me the kind of help I needed at the time and my health started to improve. He was my saviour.

I really don't know if I would be alive today without the beautiful support of my GPs.

Anders Timms, United Kingdom

its organization is integrated in teaching curricula and is typically less costly per trainee. Trainees' motivation is often relatively high because pre-service training – unlike most in-service training – is evaluated through examinations that must be passed. Yet in many countries any mental health training provided during medical or professional schooling is brief and mostly theoretical, while clinical internships are too often limited to rotations in psychiatric hospitals that do not reflect clinical practice within general health care (306).

Quality training of general health care providers in mental health care should be part of pre-service education.

Despite the strategic value of investing in mental health pre-service training, there is an urgent need to train the existing general health workforce, whether face to face, online or through a combination of both. Such training should be used to familiarize trainees with clinical assessment and management of priority mental health conditions. The training should also reduce stigma and discrimination in health care. This can be done by giving people with mental health conditions co-facilitation roles during training (210). In all cases, training should include supervised practice in general health care settings.

It is important to build confidence of general health care providers in psychosocial approaches, which are a necessary part of holistic mental health care, but which are often not prominent in primary health care. Many general health care providers feel more familiar and comfortable with a purely biomedical approach in which a diagnosis is followed with medication or another biomedical intervention (for example surgery or dialysis). But psychotropic medication is not the first line of treatment for many mental health conditions.

Moreover, even when psychotropic medicines are indicated, general health care providers need

to understand how to provide or arrange for psychosocial support alongside medications.

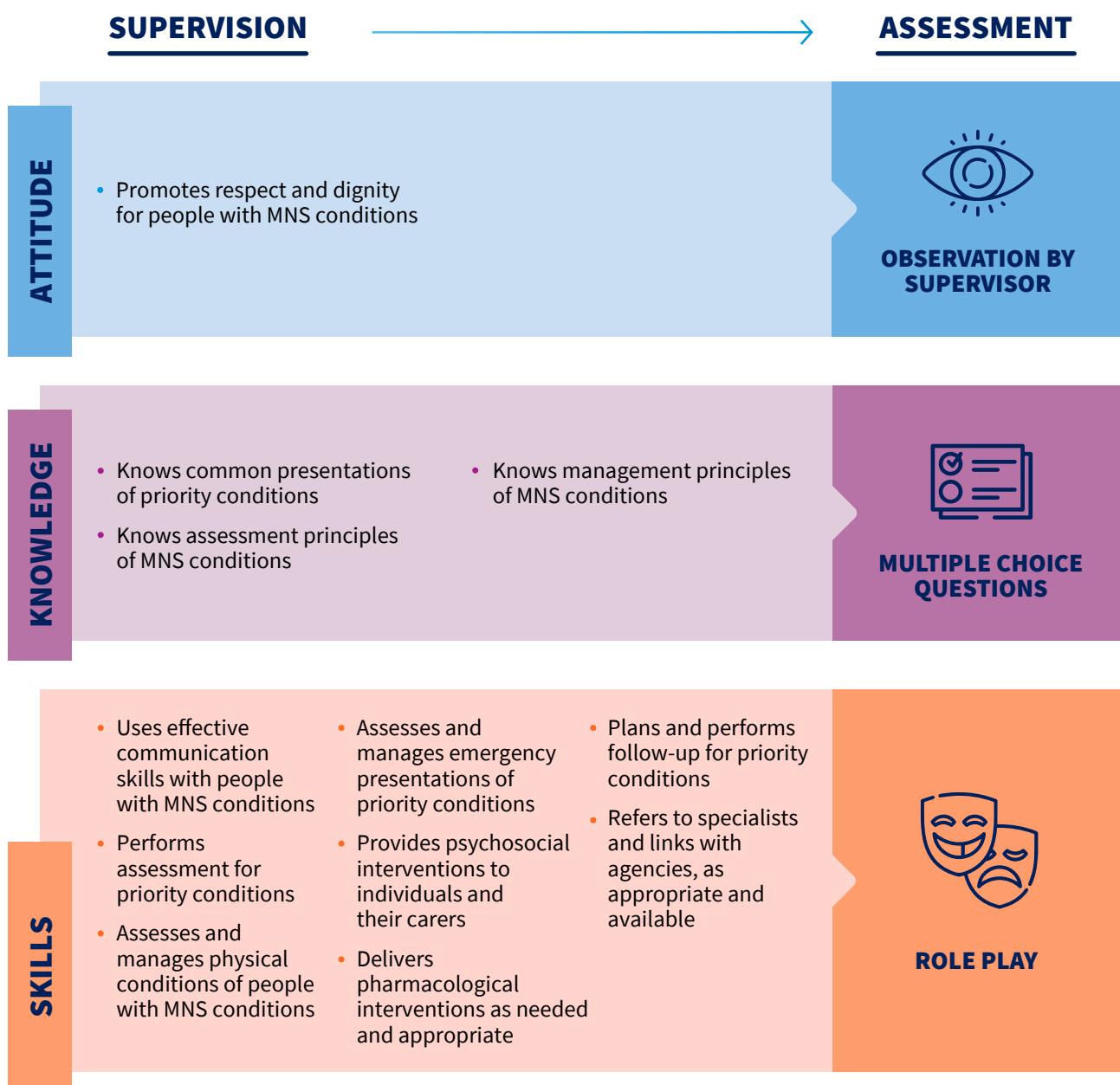
Although most primary health care providers may have too limited time to personally deliver multi-session psychological treatments for depression or anxiety, they should appreciate the relative value of such care and link, where available, to relevant providers, whether specialist or community providers skilled in psychological counselling. In addition, all primary health care providers can make time to encourage and guide people to use evidence-based self-help books or digital self-help interventions as part of depression and anxiety management (see section 7.1.4 Scaling up care for people with common conditions: self-help and In focus: Harnessing digital technologies for mental health).

To help countries implement training, supervision and support for general health care workers, WHO's mhGAP has developed a set of task-sharing training packages and implementation tools (307). These are designed to teach 12 core competencies relevant to assessing, managing and following up people with depression, psychoses, epilepsy, child and adolescent mental and behavioural disorders, dementia, disorders due to substance use, and self-harming or suicidal thoughts or behaviours (see Fig. 5.5). All mhGAP training is designed to be followed up with ongoing supervision and support.

Since it was introduced in 2010, mhGAP training and supervision has been carried out in more than 100 countries, helping to improve competencies in, and access to, mental health care all over the world (308). This is important as a global review of short mental health training that is based on WHO guidelines found that such training improves knowledge attitudes, skills and confidence among a wide range of general health care providers, including community health care workers, trained doctors, nurses, counsellors, paramedics and other non-medical staff (309). These changes lead to improved clinical practice with better outcomes.

FIG. 5.5

Core competencies targeted by the mhGAP training of health care providers



Source: WHO, 2017 (307). Note: MNS = mental health, neurological and substance use.

5.4.3 Equipping community providers with mental health care competencies

Comprehensive mental health care extends beyond health professionals to include other

care providers based in the community. These potentially include people with lived experience, lay volunteers, community workers, coordinators of user groups, religious counsellors, teachers, hairdressers, lawyers, police officials, prison guards and family and friends among others.

These providers, who are not mental health specialists, are often acceptable to users because they tend to have a more direct knowledge of local attitudes, customs and languages. This makes them well placed to identify and provide timely, culturally-appropriate first-line care. They can also help access support across social, education and justice spheres. And they can provide a source of practical and emotional help with the activities of daily living in the community. Community providers also have a role in delivering preventive and promotive services and in providing crisis support to individuals and families in distress.

*People with lived experience
can be important first line
providers of support.*

Given the diversity in potential tasks fulfilled by community providers, training for this group can vary significantly (310). Emergency field workers need to be oriented in the principles of psychological first aid (311). Caregivers need to be equipped with skills to support children with mental health conditions or behavioural problems. Community health workers need to be at the very least trained in identifying people with mental health conditions and referring them, where necessary, to the relevant level of care (see section 7.1.4 Scaling up care for people with common conditions: non-specialist counselling). All providers of mental health services, including community providers, need an understanding of human rights (184).

Many community providers – including emergency workers and family caregivers – may face significant stress themselves. Training for these groups should also focus on strengthening competencies in self-care (see section 5.4.4 Competencies for self-care).

People with lived experience will also need to be prepared to support others (312). Peer experts are living proof that recovery is possible; and they have a vital role in supporting other people with mental health conditions in their recovery journey (read Benjamin's experience). Peer experts in mental health also have a role within support groups for other health conditions, such as HIV, NTDs or Zika. In these cases, acknowledging and building skills in how to address emotional elements of the group members' needs is a good way of integrating mental health support.

Peer expertise, informed by the experience of mental ill-health, can be regarded as a third domain of expertise in mental health care, in addition to scientific evidence and practical knowledge and skills (313). Becoming a peer expert comprises a three-step process (313). It begins with the lived experience of suffering and recovering from a mental health condition. Reflection on this experience – including analysis and learning about the experience of others – turns lived experience into peer knowledge, or knowledge by experience. The third step is training in skills and attitudes to become a designated peer expert. From then on, as for all care providers, an ongoing learning process through practice is required to deepen peer experts' competencies.

All types of care providers, including community providers, can play a key role in scaling up care for depression and anxiety through psychological interventions; but their competencies should be ensured (see Box 5.12 EQUIP: Assessing and building competencies for psychological interventions). Experience shows that integrating community providers in teams with mental health professionals using a task-sharing approach can also help support people with severe conditions such as schizophrenia (see section 7.3.3 Psychosocial rehabilitation).

NARRATIVE

We can all contribute meaningfully to the world

Benjamin's experience

I became depressed as a child at the age of 14 growing up in the rural north of Liberia. The first line of treatment was traditional medicine and I was taken to a traditional healer in Guinea who reduced my anxiety by giving me traditional medicine. This helped to stabilize me to continue my secondary education and become a high school graduate.

A few years later, I relapsed. Again I was treated by faith-based healers but this time, it did not help. For many years both me and my parents struggled with my mental health. Eventually, my older brother took me to a mental health treatment facility.

I started receiving medication and it has helped me a lot. It enabled me to complete my university studies

and now I work as a school teacher. I have a wife, we are blessed with three boys and I am living happily and doing great.

I am the national Secretary for the Cultivation for Users' Hope (CFUH), which is the only organization established and run by health service users in Liberia. We work in the interest of people living with mental health conditions through advocacy, capacity building, empowerment and stigma reduction.

If people with psychosocial disabilities receive the attention and services they need and are treated with respect, they too can contribute meaningfully to the world and societies at large.

Benjamin Ballah, Liberia

TOOL

BOX 5.12

EQUIP: Assessing and building competencies for psychological interventions

Research has repeatedly shown that people who are not mental health specialists can effectively provide brief psychological interventions, based on established psychotherapies, such as CBT and IPT, as long as they are trained and supervised.

But how can governments or any other stakeholder know whether these care providers deliver competent care, given that they are not licensed by professional organizations? Ensuring Quality in Psychological Support (EQUIP) is a WHO initiative to assess and build competencies for a range of interventions.

EQUIP develops and disseminates competency-based training materials and guidance and competency

assessment tools. As such, EQUIP offers a mechanism to ensure and improve quality. EQUIP resources have been field tested in Ethiopia, Jordan, Kenya, Lebanon, Nepal, Peru, Uganda and Zambia and are available through an on-line platform (<https://whoequip.org/en-gb>). The EQUIP platform has been used for competency-driven training in psychological interventions for non-specialists, in mhGAP training for primary care workers, and in basic skills training for teachers, nurses, and community health workers.

It has been proven that use of EQUIP reduces harmful behaviour and increases competencies of trainees compared to conventional training methods.

Sources: Singla et al, 2017 (314); Kohrt et al, 2020 (315); Kohrt et al, 2015 (316).

5.4.4 Competencies for self-care

Boosting competencies to enable a transformation in mental health care is not simply about expanding the workforce for delivering services; it is also about strengthening individuals' skills in self-care.

In WHO's optimal mix of mental health services, self-care provides a base for mental health care that, when combined with community-based mental health care, will meet the mental health needs of a population (317).

Self-care is important to people. A recent survey across 113 countries found that among people with self-reported anxiety or

depression, the most-endorsed methods for feeling better were improving healthy lifestyle behaviours, spending time in nature or outdoors and talking to friends or family (150).

For self-care, all people should, as far as possible, know how to (318):

- limit exposure to 'high risk' situations that may adversely impact mental health;
- manage stress;
- discuss and manage mental health problems as they arise; and
- seek help when it's needed.

For people living with mental health conditions, self-care also requires skills and confidence to manage one's own mental health conditions



NARRATIVE

I play an active role in my recovery

Tamira's experience

My experience with our health care system highlighted the importance of a holistic approach to well-being that incorporates physical, mental and emotional health; and how difficult it is to be well in the absence of health in any of these categories.

My drive for holistic well-being was fuelled in part by the words ‘apprehension’ and ‘detention’ on my Form 1 (the form that a physician submits to authorize involuntary admission to a psychiatric facility for up to 72 hours). This language made me feel incredibly inferior and showed me how little our mental health care system attempts to disguise the atrocities of what passes for ‘care’. It set me on a search for recovery outside the formal system.

My search for answers to support my mental health included researching eastern, naturopathic and functional medicine. I also looked to exercise,

religion, spirituality, meditation and mindfulness and forms of positive psychology. I found being outdoors and in nature was a great support tool.

I also looked inside myself, reflecting on my life, my values and my purpose. And I explored communities, online via blogs and social media, which I then used as a tool to find my voice and share my experiences.

I’m not prepared to say I have ‘recovered’. And I recognize that some avenues of my search have been more fruitful than others. But what I’ve learned is that for myself and my mental health nothing is more valuable than the belief that I have the power within me to change myself. Consent is still not considered necessary in our mental health care system; but now I have the power not to give the system consent to make me feel inferior.

Tamira Loewen, Canada

outside of formal services (read [Tamira’s experience](#)). That might be achieved by oneself, or with the help of family and friends (see section [7.1.1 Putting people first: recovery-oriented care](#)). The development of self-care skills can start early. For example, from early childhood we learn from our parents how to deal with difficult emotions. Within schools, life skills training can teach emotional and social competencies such as emotional regulation, problem-solving, interpersonal skills and stress management (see section [6.3.2 Protecting and promoting child and adolescent health: school-based programmes](#)).

For adults, self-care competencies are usually supported through self-help materials and interventions that draw on evidence-based psychological treatment principles (see section [7.1.4 Scaling up care for people with common conditions: self-help](#)). Such materials can be provided in multiple formats, including one-to-one and group self-help interventions, facilitated or not. They can also be delivered through multiple media, including self-help books, audio-visual materials, and online or app-based interventions (see [Box 5.13 Living with the times: a toolkit for older adults](#)). In all cases, resources designed

CASE STUDY

BOX 5.13

Living with the times: a toolkit for older adults

Living with the Times is a psychosocial support toolkit designed to address the information and coping needs of older adults during the COVID-19 pandemic. As a high-risk group for severe disease and death from COVID-19, older adults have had to be especially cautious to avoid contracting it. Many have faced long periods of isolation and uncertainty.

The toolkit comprises a series of posters that address common concerns of older adults during the pandemic, such as how to stay healthy, how to lift one's mood, how to stay connected, how to seek help and how to cope with grief and loss.

Each poster combines illustrations and short texts for print or online use. Key messages require minimal reading skills, are culturally diverse and aim to engage older adults in conversations and activities. An accompanying manual shows carers how to use the posters in guided conversations to facilitate engagement.

The posters were tested with older adults from different countries and backgrounds. They have been widely translated and adapted in accessible formats for people with special needs. They have, for example, been used in Greece, Nigeria, Republic of Korea and Syria, where they have had a high degree of user acceptance.



Source: IASC, 2021 (319).

to build self-care skills should be available in languages and literacy levels that enable as many people to understand them as possible.

The use of self-help materials can be integrated in clinical care (see section 7.1.4 Scaling up care for people with common conditions: self-help). For example, facilitators can guide people to use self-help materials. This is called guided self-help, and it has been repeatedly shown to be as effective as conventional face-to-face specialist interventions for depression and anxiety (320). Guided self-help tools can be used to support people through the process of setting up a recovery plan for themselves (321). They can also be rapidly deployed at scale, making them particularly promising for mental health transformation.

Recovery colleges

Recovery colleges involve supporting people living with mental health conditions through adult education rather than treatment. Their curricula may vary, from understanding different mental health issues and treatment options to exploring what recovery means and how family and friends can help support it (see section 7.1.1 Putting people first: recovery-oriented care). They

often include courses focused on strengthening competencies for self-care and developing life skills and confidence to either rebuild life outside services or get the most out of services.

Guided self-help for depression and anxiety has been found to have comparable effects to face-to-face treatments.

A key feature of recovery colleges is that people with lived experience co-produce all aspects of the college, from curriculum development to course delivery and quality assessment. Studies show that recovery colleges can play an important role in decreasing the use of mental health services, suggesting that students develop improved agency and ability to manage their own mental health (322). These colleges can also benefit staff with key outcomes including experiencing and valuing co-production, changed perceptions of service users and increased passion and job motivation (323). At the societal level, recovery colleges provide opportunities to engage more people in learning alongside people with mental health conditions and tackle stigma through social contact.



6

Promotion and prevention for change

PROMOTION
PREVENTION
PRIORITIES FOR ACTION

Chapter summary

In this chapter we consider the multisectoral promotion and prevention strategies required at all stages of life to transform mental health. We explore some of the intervention options available to reduce risk and build resilience at individual, social and structural levels, summarizing the rationale and evidence behind these and showcasing examples of good practice from around the world. And we examine three priorities for action: suicide prevention; protecting and promoting child and adolescent mental health; and promoting and protecting mental health at work.



Key messages from this chapter are:

- Promotion and prevention in mental health work by identifying underlying factors that influence mental health and intervening on them to reduce risks and/or increase resilience and mental well-being.
- Effective strategies require multisectoral action and may involve making changes at the individual, social (family and community) or structural level.
- The health sector can contribute by embedding promotion and prevention programmes in health services and supporting initiatives in non-health settings, among other actions.
- Suicide prevention is a global priority, and much progress can be achieved using the strategies set out in WHO's LIVE LIFE initiative, including limiting access to means, responsible media reporting, social and emotional learning for adolescents and early intervention.
- Promoting child and adolescent mental health can be achieved through policies and legislation, caregiver support, school-based programmes and changes to community and online environments.
- Employers and governments have a responsibility to promote and protect all people's mental health at work and can do this through legislation and regulation, organizational strategies, manager training and interventions for workers.

Chapter 5 Foundations for change described the foundations for change towards improved mental health, highlighting the importance of enabling frameworks, public and political support, technical skills and sufficient resources. Chapters 6 and 7 will consider what that transformation looks like on the ground, in terms of the specific strategies and services that can be deployed to improve the mental health of populations. This includes strengthening multisectoral promotion and prevention strategies at all stages of life (the focus of this chapter) while simultaneously building up mental health and social care in the community (see Chapter 7 Restructuring and scaling up care for impact).

Effective promotion and prevention is important to enhance mental well-being and resilience, prevent the onset and burden of mental health conditions and drive down the need for mental health care. There is increasing evidence that it is often also cost-effective (324).

In essence, promotion and prevention in mental health work by identifying underlying factors that influence mental health and intervening on them (see section 2.2 Determinants of mental health). This includes efforts to tackle “distal” structural factors that shape the conditions of daily life, such as poverty inequality and environment quality. But it often also focuses on more “proximal” individual and family factors, such as individual coping skills or parenting behaviours, that have a more direct influence on mental health.

Together, promotion and prevention comprise a wide range of activities that can be targeted at individuals, specific groups or whole populations (see Table 6.1). Recalling that mental health is more than the absence of a disease or infirmity (see Chapter 2 Principles and drivers in public mental health), mental health promotion is about maintaining or enhancing people’s mental well-being, while prevention as described in this chapter (i.e. primary prevention) is about stopping the onset of mental health conditions.

TABLE 6.1

Target populations and overall objectives of promotion and primary prevention in mental health

TYPE	TARGET POPULATION	OBJECTIVE
Mental health promotion	Variable	Maintain or enhance mental well-being, or increase resilience
Primary prevention	Universal	Whole population
	Selective	Subpopulations (e.g. specific demographic groups) at an elevated risk of developing a mental health condition
	Indicated	Individuals who have signs or symptoms of a mental health condition but do not meet diagnostic criteria for mental disorder

In practice, it can be hard to make the distinction between prevention and promotion. Strategies that reshape the determinants of mental health to boost mental well-being can also work to stop mental health conditions from developing in individuals; so mental health promotion and universal prevention are often implemented as one and the same.

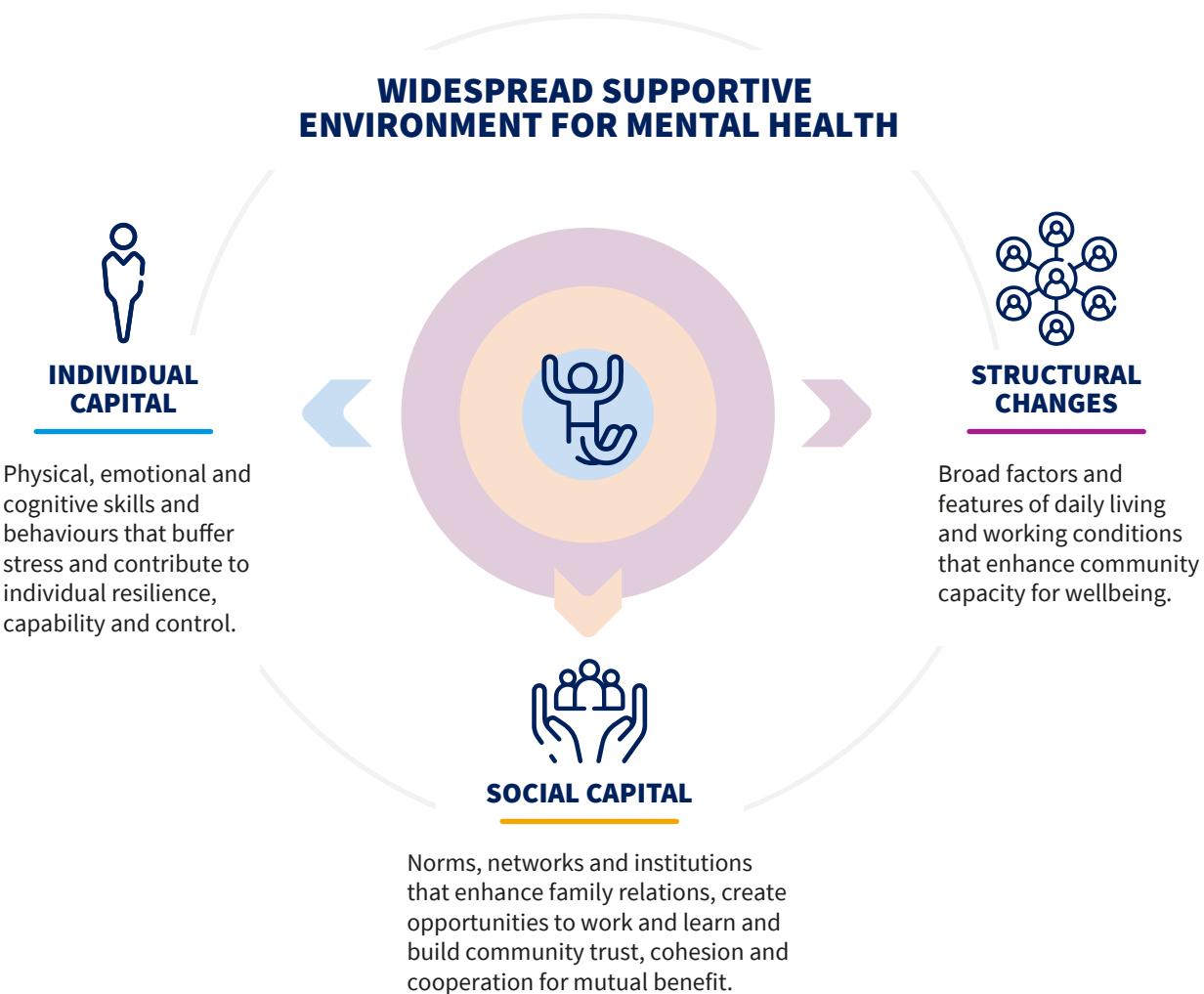
This chapter considers what it takes for countries to effectively pursue promotion and primary prevention in practice. There is no simple solution: a single intervention is rarely sufficient to effect change across all age ranges and at-risk groups. Rather, as highlighted by the *Comprehensive*

mental health action plan 2013–2030, countries need to implement a wide range of universal, selective and indicated interventions.

In the sections that follow, we explore some of the intervention options available, summarizing the rationale and evidence behind these and showcasing examples of best practice from around the world. We highlight three priorities for action where the evidence and experience of mental health benefits are particularly compelling: interventions to prevent suicide; interventions to promote and protect the mental health of children and youth; and interventions to promote and protect mental health in the workplace.

FIG. 6.1

Mental health promotion and universal prevention focus on factors that support mental health



Source: Friedli, 2009 (325).



6.1 Mental health promotion and universal prevention

Mental health promotion and universal prevention strategies are generally designed to shift the risk profile of whole populations and boost overall well-being. They do this by reshaping the determinants of mental health across individual, social and structural spheres of influence to establish supportive environments for mental health (see Fig. 6.1).

Universal strategies and interventions are highly diverse. Many interventions are delivered at the community level, for example by local leaders

or health care providers. Others are delivered at higher levels, for example through national labour laws or poverty reduction strategies.

In practice, universal interventions often combine different strategies at individual, social and structural levels. So, for example, interventions may combine life skills training (individual capital) with local events for older adults (social capital) and mass anti-stigma campaigns (structural changes) (see Box 6.1 The A-B-C campaign for good mental health).

CASE STUDY

BOX 6.1

The A-B-C campaign for good mental health

The Act-Belong-Commit (A-B-C) campaign in Australia is designed to encourage people to be proactive in becoming more mentally healthy. It is built around three simple messages:

- Do something to keep physically, socially, spiritually and cognitively active (Act).
- Do something with someone to keep connected to friends, family and community (Belong).
- Do something meaningful, important and valuable to provide a sense of purpose (Commit).

These are supported by online resources (including self-help guides, fact sheets, lists of local activities, and school curricula) and community-based programmes aimed at strengthening connections between community members and helping people

participate in diverse activities that can protect and promote their mental health.

The campaign has more than 160 community and organizational partners and collaborators in Western Australia and has also been adapted and adopted in other parts of the country as well as overseas, in Denmark, Faroe Islands, Norway and the United States of America.

By 2018, 82% of Western Australians were aware of the A-B-C campaigns, 16% of whom had taken action to improve their mental health as a result. The campaign's school-based programme for mental health promotion had also trained teachers in 51 local schools, reaching 46 000 children and adolescents (6–18 years of age).

Sources: Curtin University, 2021 (326); Anwar-McHenry et al, 2019 (327).



6.1.1 Building individual capital for mental health

Strategies to build individual resources often focus on strengthening emotional and cognitive skills, knowledge, capabilities and attitudes. They do this through, for example, parenting or learning programmes that promote:

- **Competence** to live, learn and work effectively. This includes essential life skills for communication, critical thinking, decision making, problem solving, self-awareness, empathy and care for others. It also includes the ability to self-care and choose behaviours and lifestyles that keep us healthy.

- **Resilience** to manage and adapt effectively to life stressors. Importantly, having resilience does not mean never experiencing difficulty or distress. Rather, having resilience means having the capacity to deal with stress and adversity and can “bounce back”.
- **Empowerment** to have confidence, choice and control in one’s own life. This includes having a sense of respect, hope, identity and purpose as well as having feelings of mastery, agency, hope and justice. For people experiencing a mental health condition, empowerment also includes being able to actively engage in all aspects of one’s mental health care (see Chapter 5, In focus: Engaging and empowering people with lived experience).

CASE STUDY

BOX 6.2

Using sports to promote life skills in Hong Kong youth

In China, Hong Kong SAR, a sports-based youth development programme has been found to promote life skills and empowerment among adolescents.

The programme provided weekly after-school sports mentoring sessions to a group of adolescents using a positive youth development approach that plays to the adolescents’ strengths rather than correcting problematic behaviours.

Each week, participants in the programme learned to set goals, build skills and reflect on their feelings about a specific sport. There were no teachers or

predesigned curricula. Rather, the mentors worked like facilitators, allowing the students to set their own learning goals and paths through communication. Mentors also provided tools and techniques for problem solving within the sport’s context and opportunities for putting these into practice within an environment that fostered resilience building.

A rigorous evaluation concluded that in addition to improving physical activity and fitness, the programme improved students’ mental well-being, self-efficacy, and resilience.

Source: Ho et al, 2017 (328).

Mental health promoting interventions to build individual capital often target young people, for example through school-based social and emotional skills programmes or through youth development programmes. Community youth centres, after-school clubs and community mentoring initiatives can all work to strengthen competence, resilience and empowerment and promote mental health (see Box 6.2 Using sports to promote life skills in Hong Kong youth).

Promoting healthy behaviours

Building individual competence also includes interventions designed to support people to change behaviours that undermine both physical and mental health. Low levels of physical activity, tobacco smoking, hazardous alcohol use, drug use, poor sleep and unhealthy dietary patterns are all associated with increased risks of both physical and mental health conditions (329, 100, 330).

Early childhood development programmes and schools are key platforms to not only build social and emotional skills (see section 6.3.2 Protecting and promoting child and adolescent mental health) but also to provide knowledge about physically and mentally healthy behaviours in children and adolescents.

Educating young people about the harms of using high potency cannabis should be considered to reduce the incidence of psychosis in communities.

Raising health literacy about alcohol, tobacco, physical exercise and nutrition are already

accepted public health strategies (331). In addition, major campaigns to educate young people about the harms of using high potency cannabis should be considered to reduce the incidence of psychosis in communities (332).

6.1.2 Building social resources for mental health

Building social resources for mental health involves creating opportunities to foster positive relationships and social support at different levels: within families, among peers and across the community throughout life (see Table 6.2) (333). This includes ensuring that social institutions – including preschool, school, and the labour market – recognize their role in supporting mental well-being and work to strengthen social resources.

During infancy and childhood, family relations are especially important: some of the most important sources of resilience for children living in low-income homes include parental beliefs and behaviours that promote self-esteem, social support (including from other adults), and a quality home learning environment (325). Through adolescence and adulthood social support and good interpersonal relations – at home, school, work and in the wider community – remain hugely impactful. For older adults, social connectedness is particularly important to reduce risk factors such as loneliness and social isolation. 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 (334).

TABLE 6.2

Examples of strategies and approaches that focus on strengthening social resources to promote and protect mental health

PROMOTION STRATEGY	EXAMPLES
Support caregiver mental health	<ul style="list-style-type: none"> • Identify, support and refer parents and other caregivers with mental health conditions • Peer support groups for new parents
Enable good parenting	<ul style="list-style-type: none"> • Caregiver skills training for caregivers of children and adolescents • Peer support groups for new parents • Early childhood home visits
Create protective learning environments	<ul style="list-style-type: none"> • Improve school culture and safety • Preschool education and enrichment programmes • Anti-bullying programmes • Anti-racism and anti-sexism programmes • Peer support groups and mentoring programmes within schools • Health literacy in mental health for teachers
Create protective working environments	<ul style="list-style-type: none"> • Policies to mitigate psychosocial risk factors (for example on working hours and harassment) • Mental health awareness raising and training to enable workers to provide initial support to colleagues in distress • Reasonable work accommodations for people with mental health conditions
Enable healthy personal relationships	<ul style="list-style-type: none"> • Healthy relationship programmes for youth and couples • Anti-discrimination and anti-violence empowerment and education programmes
Strengthen social support for older adults	<ul style="list-style-type: none"> • Befriending initiatives • Community clubs and social activities for the aged
Create safe and supportive neighbourhoods	<ul style="list-style-type: none"> • Physical changes to improve social interaction • Community policing

At all ages and across settings, protecting against discrimination, violence and abuse is paramount to protecting mental health. In most countries there is a huge need for greater gender equity

and women's empowerment. And in all countries, protecting women, children and older adults from violence is of particular concern. Intimate partner violence and sexual violence against women are

potent risks for depression and anxiety, eating disorders, suicide attempts and post-traumatic stress disorder (read [Lion's experience in Chapter 2](#)) (335, 45). And young people who grow up in families or communities where there is violence are at risk of a range of behavioural and emotional disturbances that undermine mental health (read [Ntokozo's experience](#)).

There is substantial evidence on what works to prevent violence against women and children, which includes: interventions for strengthening

relationship, parenting and life skills; empowering women; strengthening neighbourhood and school safety; and transforming patriarchal social norms and practices (336, 337).

In all cases, context is important: programmes that build social capital, responsibility and action to prevent discrimination and violence and other mental health-risking behaviour are particularly successful if they are driven by local risk profiles and resources (see [Box 6.3 Communities That Care](#)).

NARRATIVE

My depression stemmed from childhood experiences

Ntokozo's experience

My father passed away when I was very young, leaving me with my mother who later abandoned me at a neighbour's house. I didn't hear from her again. I was taken in by an uncle, and I faced a lot of physical abuse and bullying.

Around the age of 12, I began to experience symptoms of anxiety and depression. I remember asking my uncle if having thoughts of killing oneself was normal. His response still sticks with me: "You're too young to have suicidal thoughts; you don't know what *real* problems are."

A few weeks after this conversation I attempted suicide. Luckily a close family member was nearby

and rushed me to the clinic. I was then taken to a traditional healer by my grandfather who, due to his cultural beliefs around mental health, believed I was possessed by an evil spirit. My attempted suicide was never spoken about. Instead, it was kept a secret and my mental health condition remained undiagnosed and untreated.

My struggles with mental health continued throughout my adult life. When my symptoms became too difficult to ignore I sought professional help. It was only then, years after my first symptoms, that I was diagnosed with major depression and anxiety disorder, which were considered to be due to my childhood experiences.

Ntokozo Nyathi, Zimbabwe



CASE STUDY

BOX 6.3

Communities That Care

Communities That Care (CTC) is a community-level prevention system for decreasing risk, enhancing protection and reducing mental health-risking behaviour in youth. Tried and tested in more than 500 high-income country communities over 20 years, it has been found to effectively prevent delinquency, violence and substance use in adolescents.

The Communities That Care system trains and supports community coalitions to use data-driven, science-based prevention practices to target locally prioritized risk and protective factors. It starts with establishing a group of community stakeholders and training them in the principles of prevention science and the relationship between youth risks and behavioural disorders. A youth survey provides local epidemiological data on risk, protection and youth behaviours, which are used to develop a community risk profile and identify priorities for

action. Based on this, the community group develops an action plan, selecting prevention interventions from a compendium of evidence-based options (for example, programmes focused on parenting skills, school curricula or after-school activities).

Communities That Care interventions can operate at multiple levels, across multiple settings, and may include social media campaigns, parenting support and skills-building initiatives, changes to school curricula, management or teaching practices, and mentoring and after-school programmes.

Communities That Care's success in preventing health-risking behaviour in adolescents has been found to endure over the long term, with adolescents exposed to the system continuing to abstain from gateway drug use, antisocial behaviour and violence through to the age of 21 years.

Sources: Hawkins et al, 2014 (338); Oesterle et al, 2018 (339).

6.1.3 Making structural changes for mental health

Making structural changes for mental health involves reshaping the underlying conditions of daily life to enhance individual, family and community capacities for well-being. It is about strengthening rules and regulations, changing norms and values, and introducing adequate support mechanisms to tackle disadvantage, uphold human rights and ensure fair and equal access to infrastructure, services and opportunities for all.

A range of macro-level policies and strategic actions that enable or expedite these structural changes can be pursued; their stated aims go far beyond mental health promotion and protection, but they each have an important effect on mental health (340). Policies and strategic actions include:

- **Measures to reduce financial insecurity, poverty and income inequality.** Examples of these measures are social protection, pension systems, debt relief, economic empowerment and other poverty alleviation programmes as well as livelihood support for people with physical and psychosocial disabilities. There

is an increasing body of evidence from LMICs showing that cash transfer programmes not only alleviate financial hardship but also benefit recipients' mental health and well-being (341).

- **Measures to enable access to labour**

markets. Despite psychosocial risks such as harassment in the workplace (see [section 6.3.3 Promoting and protecting mental health at work](#)), employment has a positive influence on mental health, while unemployment is a notable risk (342). Active labour market policies and programmes – such as vocational training courses, job search assistance, wage subsidies or supported internships and work experiences – can support those looking for work, in particular the long-term unemployed, as well as those with psychosocial or other disabilities (343).

- **Measures to enhance access to education.**

Education is vitally important for physical and mental health as well as economic growth and poverty reduction. Initiatives to close the gender gap in education, mitigate early school leaving, increase school enrolment and boost adult literacy can all serve to enhance access to education.

- **Measures to improve safe and secure housing.**

Overcrowded, insecure and inadequate housing as well as homelessness all pose risks to mental health. These risks can be mitigated through supported housing programmes and by improving access to safe, affordable and good quality housing for disadvantaged groups (see also [section 7.3.4 Supported living services](#)) (344).

- **Measures to protect against discrimination.**

These include laws and regulations that promote inclusion and prevent discrimination based on ethnicity, sexual orientation, religion or age; and that cover the rights of women, children, older adults and people with physical and psychosocial disabilities (see [section 4.2.1 Action against stigma and discrimination](#)).

As detailed by the Lancet Commission on Global Mental Health and Sustainable Development, the SDGs provide a potential framework for making structural changes because many of the goals explicitly address key social and structural determinants of mental health (see [section 4.3 Enabling social and economic development](#)) (15).

Although the health sector has a clear role in prevention and promotion (see [In focus: Enabling multisectoral collaboration: what role for the health sector?](#)) most universal strategies require action beyond the health sector. This is important because any model of health promotion and universal prevention that fails to tackle the structural determinants of mental health will be limited in its reach. Moreover, the broad social and structural ills – such as abuse, exploitation and discrimination – that pervade society must be redressed not simply because they impact health but because they violate our common values in and of themselves.

6.2 Selective and indicated prevention

Unlike universal prevention, which aims to shift the risk profile of whole populations, selective and indicated prevention strategies are designed to reduce risk in one or more groups of individuals who are at higher-than-average risk of experiencing mental health conditions.

This includes priority groups as a whole, who are at higher risk of experiencing mental health conditions because of the demographics, local contexts and circumstances in which they find themselves (selective prevention). But it also includes individuals who are at

higher risk because they are already experiencing symptoms of what may be an emerging mental disorder (indicated prevention).

At-risk people may (but do not necessarily) include people living in poverty or with chronic health conditions, people with disabilities, youth exposed to violence or neglect, minority groups, indigenous peoples, refugees, older adults, LGBTIQ+ people, ex-combatants, prisoners and people exposed to humanitarian emergencies. There is large diversity of risks, problems and resources within and across each of these groups.

6.2.1 Supporting at-risk people through selective prevention

The *Comprehensive mental health action plan 2013–2030* is clear that national mental health strategies should include promotion and prevention interventions that specifically respond to locally-identified at-risk people's needs across the lifespan. Priority groups for selective prevention may vary depending on the national or local risk profile.

Selective prevention is often helpful to specific age groups across the life-course. For example, young children and adolescents may benefit from interventions as they go through developmentally sensitive periods (see section 6.3.2 Protecting and promoting child and adolescent mental health).

Interventions to expand social contacts and activities are crucial to protecting the mental well-being of older adults.

Older adults can also be supported through selective prevention. Research suggests that interventions to expand social contacts and increase participation in social activities are crucial to protecting older adults' mental well-being (345).

Another priority group for selective prevention is people experiencing humanitarian emergencies. The forthcoming Mental Health and Psychosocial Support Minimum Service Package (MHPSS MSP) (see [Box 6.4 The Mental Health and Psychosocial Support Minimum Service Package \(MHPSS MSP\)](#)) describes preventive and promotive strategies to broadly support people in these settings, including:

- disseminating information to raise mental health literacy and awareness;
- providing early childhood development and group activities for child well-being;
- supporting pre-existing community initiatives that promote mental health, including re-establishing normal cultural and religious activities, women's groups, youth networks and other interest groups;
- facilitating new community self-help initiatives; and
- supporting caregivers, teachers and other education personnel to promote children's mental health.

6.2.2 Preventing mental health conditions through indicated interventions

Indicated interventions are designed for people who present with signs and symptoms, but who do not meet the criteria for a formal diagnosis of mental disorder.

For people with elevated levels of depressive symptoms, indicated interventions include psychotherapies such as CBT and IPT, both of which have been found to delay or prevent the onset of depression (347). CBT is also an effective indicated intervention for people with anxiety symptoms (348). Given that "subthreshold" depression and anxiety are extremely common, it is particularly important that indicated interventions for this group of

TOOL

BOX 6.4

The Mental Health and Psychosocial Support Minimum Service Package (MHPSS MSP)

The inter-agency MHPSS MSP is a costed package that outlines the minimum MHPSS activities that should be implemented in emergency settings (e.g. due to war or natural disaster) across health, protection, education and other sectors. It aims to ensure humanitarian responses: are better informed by global guidelines; are evidence-based, predictable, equitable; and make more effective use of limited resources. This should lead to improved quality, scale and coordination of MHPSS programming, and substantially better mental health and well-being among affected populations.

The MHPSS MSP includes preventive, promotive and treatment interventions and covers:

- inter-agency coordination and assessments;
- essential components of MHPSS programmes, including programme design, monitoring and evaluation, staff care and staff competencies;
- MHPSS programme activities, such as orienting humanitarian workers and community members; strengthening self-help and community support; and providing extra support to people impaired by distress or mental health conditions; and
- activities and considerations for specific settings, such as infectious disease outbreaks

Source: WHO, UNICEF, UNHCR and UNFPA (346).

people are inexpensive and scalable. Self-help materials, whether through books or digital programmes, can be particularly useful (see section 5.4.4 Competencies for self-care). And early interventions by trained lay counsellors is another inexpensive and scalable approach to preventing the onset of mental disorders.

For people with signs and symptoms that indicate a high risk for psychosis, specialized early intervention can substantially improve clinical outcomes (see Box 7.14 Services for people with first-episode psychosis) (349).

Indicated prevention effectively offers support to those with the most to gain. It may also deliver significant returns on investment. The economic evidence for early intervention in psychosis indicates that it is cost-effective, and can even save money (350, 351).

Indicated interventions for people with heightened psychological distress during or after an emergency can be particularly useful. This includes facilitator-guided group-based interventions such as WHO Self-Help Plus, which has been used, with varying degrees of success, to prevent onset of mental disorders in refugees and asylum seekers in Türkiye, Uganda, and Western Europe (352, 353).



Enabling multisectoral promotion and prevention: what role for the health sector?

Reshaping the individual, social and structural factors that influence mental health often requires power, experience and expertise that lie beyond the health sector. Housing improvement schemes are typically approved and run by the housing sector. Child protection programmes are managed by social affairs. Occupational health and safety regulations are usually the labour department's responsibility. And school-based programmes for social and emotional learning are delivered through the education sector.

Effective promotion and prevention for mental health is a truly multisectoral venture. The health sector may not be able to implement every strategy or intervention required. But it can contribute significantly by embedding promotion and prevention within health services, especially for at-risk populations. The health sector also has a major role in enabling a society-wide comprehensive and joined-up approach: by advocating, initiating and, where appropriate, facilitating multisectoral collaboration and coordination.

Some of the strategies available for achieving this are outlined below. In all cases, successful multisectoral collaboration requires intelligent and appropriate information sharing, joint planning, strategic design and support, and good delivery. Multisectoral collaboration is more likely to succeed when there is transformative leadership to inspire and make the case for action, to focus efforts, and to drive through the necessary negotiations (see [section 5.2.1 Strengthening political will and engagement](#)).

Embed promotion and prevention programmes within health services

The need for a joined-up approach to promotion and prevention actions for mental health applies within the health sector as much as it does beyond it. Strategies to embed promotion and prevention programmes within health services include integrating mental health promotion into perinatal care, nutrition and child health services as well as disease-specific programmes and clinics. Primary care providers play a key part in increasing mental health literacy and advocating healthy choices around diet, exercise and sleep. Primary care providers are also well-placed to introduce people to evidence-based self-help materials for people in distress.

Support mental health promotion and protection in non-health settings

Given that many interventions to promote and protect mental health should be delivered in non-health settings, the health sector has an important role in supporting colleagues across sectors as they design and deploy effective interventions.

This involves working with schools, prisons and women's shelters among others to build competencies and resilience and empower people. It also includes working with businesses to support mental health in the workplace.

Advocate for, and provide expert opinion on, specific plans and policies

By seeking out opportunities to contribute informed opinion, mental health professionals can leverage their expertise through advocacy and thus help ensure that policies, plans and practices around structural factors are supportive of people's mental health.

For example, if a new housing settlement is being planned, mental health experts may comment on the mental health benefits of including sporting and recreational facilities (which can increase participation in community activities), and access to green space (which has benefits for mental well-being). They may further comment on the need for a community mental health centre and group home for people with mental health conditions. And they may liaise with transport sector planning to ensure that people living with mental health conditions in the new settlement can freely access mental health services when they need them.

Include mental health in “health in all policies”

“Health in all policies” is an established approach that seeks to systematically consider the health implications of public policies across sectors. It seeks synergies and aims to avoid harmful health impacts (354). It emphasizes the consequences of social and economic policies on population health and helps strengthen the accountability of policy-makers for health impacts at all levels of decision-making.

Applying this approach to mental health is essential to remodel relevant social and economic policies. By understanding where and how social and structural factors influence mental health, and embedding this in government thinking, broad policy is more likely to enhance mental health, or at the very least avoid harming it.

Establish mechanisms for collaboration

Sometimes, establishing a specific mechanism for multisectoral collaboration offers the most practical option for bringing different stakeholders together for mental health promotion and protection, especially when it comes to addressing the structural factors that influence mental health. Such mechanisms can be set up at different levels of government and with different stakeholders.

Health Promotion Foundations (HPFs), sometimes called National Health Councils or Commissions, are multisectoral organizations established through an Act of Parliament or equivalent to promote health and prevent diseases. They bring together government departments, nongovernmental organization, academics, user groups and others to investigate root causes and plan effective action. Each sector is responsible for delivering its part of the action plan. HPFs are commonly used to combat HIV, TB and NCDs; but they are under-used for mental health.

Joint authorities are similarly established through an Act of Parliament or equivalent. They typically include representatives from the ministry of health as well as high-ranking officials from other ministries, such as social welfare, justice and home affairs. They can be effective ways to enable multisectoral collaboration that tackles the social and structural factors influencing mental health.

Multisectoral task forces or coordination groups are made up of stakeholders from multiple sectors who have been convened to achieve a specific goal, such as preventing suicide or supporting humanitarian responses.

During the COVID-19 pandemic the number of MHPSS coordination groups established at national level **more than doubled.**

For example, in most large humanitarian emergencies in LMICs, mental health and psychosocial support (MHPSS) is coordinated through a multisectoral working group. MHPSS coordination groups are often co-chaired by stakeholders from both health and social sectors. These groups agree and oversee action across many of the domains that influence mental health – including health, education, social services, food, security, shelter and water and sanitation – in accordance with Inter-Agency Standing Committee guidelines. During the COVID-19 pandemic the number of MHPSS coordination groups established at national level more than doubled from 23 countries in February 2020 to 54 countries 24 months later.

Importantly, while coordination in MHPSS working groups cuts across sectors, accountability typically does not. All sectors agree on an overall action plan and on the division of labour; and then individual sectors are responsible for implementing the specific actions that fall in their domain.



6.3 Selected priorities for action

The *Comprehensive mental health action plan 2013–2030* emphasizes the need for a comprehensive approach to promotion and prevention and commits WHO Member States to develop at least two functioning national, multisectoral prevention and promotion programmes by 2030. Only 52% of WHO Member States currently meet this target (5).

As outlined above, prevention and promotion programmes can focus on numerous topics and populations. In the rest of this chapter, we will zoom in on three key priorities (see Fig. 6.2):

- actions to prevent suicide
- interventions aimed at children and adolescents
- interventions in work settings.

6.3.1 Preventing suicide

The need to prevent suicide is recognized and prioritized at the highest international levels. All UN and WHO Member States have committed – through the SDGs and *Comprehensive mental health action plan 2013–2030* – to reduce the global suicide mortality rate by one third by 2030. The global age standardized rate dropped 10% between 2013 and 2019, which shows that real progress is feasible (355). But much more action is needed to ensure that the global target will be met by 2030. This is especially so because progress varies significantly across countries and regions.

FIG. 6.2

Selected priorities for action, and associated strategies, to promote and protect mental health



- | | | |
|---|--|---|
| <ul style="list-style-type: none">• Limit access to means• Interact with media for responsible reporting• Foster social and emotional learning for adolescents• Early intervention | <ul style="list-style-type: none">• Policies and legislation• Caregiver support• School-based programmes• Community and online environments | <ul style="list-style-type: none">• Legislation and regulation• Organizational strategies• Manager mental health training• Interventions for workers |
|---|--|---|

NARRATIVE

Receiving help guided me to inner strength and self-awareness

Enoch's experience

The pain would not stop. In my head, in my mind, in my heart. I did not want to live anymore. I was about to end my life right there and then, and I was moments away from dying. But I survived. My boyfriend had come into the room in that split second and stopped me from what I was about to do. I started sobbing and wailed in rage. I was disappointed in myself that I could not kill myself and felt worse than a failure.

Depression meant failing to me. So to find myself unable to decide what to wear, unable to work, unable to get out of bed was devastating. When the doctor suggested I see a therapist, I scoffed at her. When I eventually went to see a psychologist and was told I was severely depressed, I smirked. I could not stomach the fact that I needed help. To me, that meant I was weak, incompetent.

I used to look down upon those who wanted to kill themselves, for why would anyone give up? I used to think those who mulled about life and the meaning

of it were too impractical – that earning money and climbing the corporate ladder would bring stability and happiness. I strived hard to maintain the image I thought society wanted to see. I smiled on the outside, but inside I was empty.

I started recovery slowly, through writing, therapy, playing. I started letting out the emotions I had kept suppressed. I learned to acknowledge them, and not berate myself each time I acted them out. These emotions were all part of me, but I had rejected them previously.

I started to understand that I had a part to play in the stigma against mental health conditions. The moment I understood that depression and anxiety could hit anyone, and it doesn't make us less of a person, was the moment I became open to the fact that I needed others to help me find myself again. Receiving help did not make me weaker. Rather, help guided me to ignite my inner strengths and self-awareness.

Enoch Li, China

In 20 countries, suicide attempts are a criminal offence, punishable by fines and typically one to five years in prison (356). But criminalizing attempted suicide does not stop suicides. Rather, it increases stigma and undermines suicide prevention. It prevents people from seeking life-saving help, and it creates barriers to implementing policies, delivering effective support and to getting accurate knowledge on the size of the problem (356). For countries that still criminalize suicide, a crucial step to advance mental health is to change this legal status.

All countries should develop, implement and evaluate a national strategy for suicide prevention that raises public awareness, de-stigmatizes suicidal thoughts and behaviours, encourages people to seek help, and deploys effective interventions to reduce mortality.

To help countries implement this recommendation, WHO has developed the LIVE LIFE approach to suicide prevention (357). LIVE LIFE focuses on four key prevention interventions with proven efficacy.

- Limiting access to the means of suicide.
- Interacting with the media for responsible reporting on suicide.
- Fostering social and emotional life skills in adolescents.
- Early intervention for anyone affected by suicidal behaviours (read [Enoch's experience](#)).

Limit access to the means of suicide

Although there is a complex interplay of factors that lead up to suicide attempts, the path linking an attempt to a death is simpler and depends only on the choice of method and any life-saving response after the attempt (358).

Suicide attempts are often impulsive, involving less than 30 minutes of planning. And the impulse is frequently brief. More than 90% of people who

Pesticides account for
1 in 5 suicides
globally.

present to health care services after deliberate self-harm do not die from suicide later in life. This suggests that most survivors of a suicide attempt usually do not switch to other, more lethal methods (359). This makes it crucial to reduce the chance that any suicide attempt is fatal.

Accordingly, one of the most straightforward and impactful policy-based interventions is to reduce access to lethal means and improve medical responses after a suicide attempt. This includes making laws and policies to:

- Restrict access to means, including banning highly hazardous pesticides, regulating firearms, installing barriers at potential jump sites such as high rises, bridges or metro platforms, limiting access to ligatures in prisons and hospitals, and restricting the prescription of highly toxic medicines.
- Reduce availability of means, including limiting how much of a hazardous substance someone can buy or easily access, for example by changing the packaging of toxic medicines from bottles to strip packs.
- Reduce lethality of means, including switching to low-risk alternatives, for example by replacing coal gas with natural gas in households, or replacing highly hazardous pesticides with less toxic chemicals or non-chemical approaches to crop protection.
- Improve medical treatment, including increasing the availability and effectiveness of antidotes after acute intoxication and medical management after injury.

Any regulation aiming to reduce access to means of suicide should first focus on the most common and most lethal methods used. This varies from country to country, as well as within countries and across socio-demographic groups.

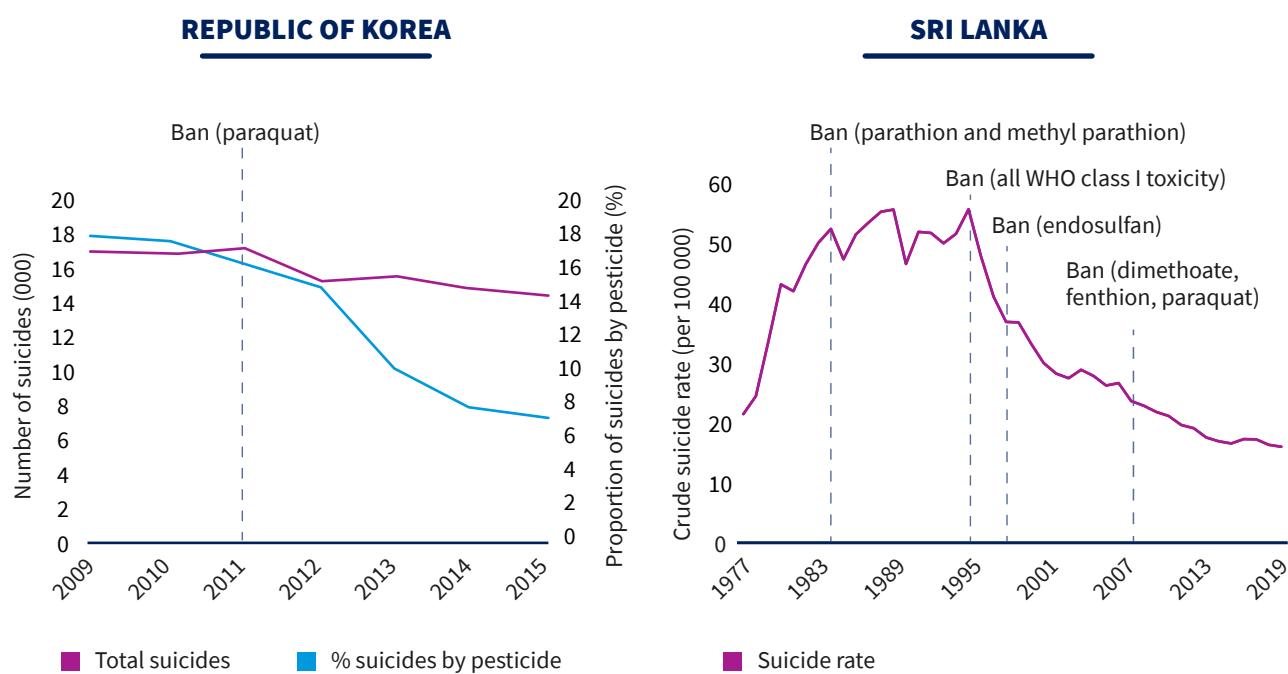
Highly hazardous pesticides

Pesticide self-poisonings account for up to one fifth of all suicides globally and are of particular concern in LMICs, where many people live in rural, agricultural communities with easy access to highly hazardous pesticides. Close to half of all suicides in LMICs in WHO's Western Pacific region have been estimated to be by pesticide poisoning (360).

Banning the sale and use of acutely toxic, highly hazardous pesticides can lead to fewer deaths by suicide. It is a low-cost intervention, which is highly cost-effective in countries with a high burden of pesticide self-poisonings (222, 361). National bans have been linked to a drop in pesticide suicides in Bangladesh, Jordan, Republic of Korea, Sri Lanka and in Taiwan, China (see Fig. 6.3 and Box 6.5 Sri Lanka: banning pesticides to prevent suicide) (362). In the Republic of Korea, a ban on the highly hazardous pesticide paraquat in 2012 resulted in an immediate and clear decline in pesticide self-poisoning suicides and contributed to a marked decline in overall suicide rates across all population groups (see Fig. 6.3). Such declines have not been associated with reductions in agricultural yield (363).

FIG. 6.3

National bans on highly hazardous pesticides and reduction in deaths by suicide



Sources: Korea: WHO, 2017 (364); Sri Lanka: Duleeka Knipe, University of Bristol, unpublished data, April 2022, updated from Knipe, 2017 (365).





CASE STUDY

BOX 6.5

Sri Lanka: banning pesticides to prevent suicide

When Sri Lanka's government drew up the Control of Pesticides Act in 1980, pesticide poisoning accounted for more than two-thirds of all suicides in the country.

In 1984, the Office of the Registrar of Pesticides began using its powers under the new Act to ban highly hazardous pesticides, starting with two organophosphorus insecticides (parathion and methyl parathion). Within ten years, all remaining highly hazardous WHO class I toxicity pesticides had been banned. In 1994, a Presidential Commission was established to draft a national policy and action plan on suicide prevention, and to coordinate action across multiple government agencies, including agriculture. Further bans in 1998 (endosulfan) and 2008 (dimethoate, fenthion and paraquat) boosted the decline. In total Sri Lanka banned 36 highly hazardous pesticides.

By 2016, the annual suicide rate had fallen more than 70% to 14 per 100 000.

The Ministry of Health continues to work on suicide prevention in multiple departments and the overall suicide rate now stands at around 25% of its peak. The national policy, and how it is implemented, is regularly reviewed by a Pesticide Technical and Advisory Committee, which is made up of many stakeholders within government. The committee also regularly engages the pesticide industry to ensure wide buy-in and cooperation.

Together, the bans are estimated to have saved 93 000 lives between 1995 and 2015, at a direct government cost of US\$ 43 for each life saved. Thousands of lives continue to be saved every year. Strong cooperation of farmers and agricultural suppliers mean that crops could be effectively grown using alternative pesticides so agricultural output has not been affected.

Sources: Knipe et al, 2017 (365); Jeyaratnam et al, 1982 (366); Pearson et al, 2015 (367).

Interact with the media for responsible reporting of suicide

Media reporting can have a major influence in shaping public opinion and attitudes about suicide. There is evidence that glamourized coverage of high-profile suicide cases or detailed descriptions of attempts can lead to imitation suicides (368). Conversely, stories that include information on where to seek help contribute to suicide prevention (369).

Working with the media for responsible reporting can include collaborations to:

- build capacity of journalists through training or guideline development; or
- regulate coverage of suicide, including identifying and correcting (or deleting) articles that fail to meet established standards.

In Lithuania, for example, journalists and psychologists have worked together to develop a code of ethics for public information to guide suicide reporting in the country. A Suicide Prevention Bureau reviews around 30 reports of suicide or suicide attempts in the online media every working day to ensure compliance with the code. For every article that is found to breach the code, the bureau contacts the editor of the publication and requests a correction (357).

Working with the media can include collaborations at all levels, from regional to local, and all platforms, including television, radio, newspapers and social media.

Foster social and emotional life skills in adolescents

The LIVE LIFE approach recommends implementing WHO and UNICEF's Helping Adolescents Thrive (HAT) guidelines, which advocate social and emotional life skills training in schools alongside a range of other initiatives to promote and protect the mental health of adolescents, including anti-bullying programmes, support on how to stay connected and safe online and offline, gatekeeper training for teachers, mental health literacy initiatives for parents and extra support to high-risk students (see section 6.3.2 Protecting and promoting child and adolescent mental health).

CASE STUDY

BOX 6.6

Guyana: building capacities for suicide prevention

Suicide prevention has been a government priority in Guyana since 2014. Action is directed by two national plans for mental health and suicide; and led by a national Mental Health Unit within the Ministry of Public Health.

Part of this action focuses on scaling up capacities for suicide prevention among primary health care providers. In 2015, the Pan American Health Organization (PAHO) began training these health care workers in identifying and managing risk for suicide and providing appropriate follow-up care. PAHO used a virtual campus to deliver an online course based on the WHO mhGAP-IG to physicians.

Since then, more than 300 health care providers have been trained to assess, manage and follow up common mental health conditions and suicide/self-harm. More than a third of these are doctors working in primary health care.

In addition, gatekeeper training is being planned and implemented to involve informal care providers in suicide prevention. This includes training teachers to recognize mental health issues in children and adolescents, and refer them to appropriate services.

Source: WHO, 2021 (357).



Early intervention for those affected by suicidal behaviours

The fourth priority intervention in the LIVE LIFE approach lies in the early identification, assessment, management and follow up of anyone affected by suicidal behaviours. This includes equipping anyone who is likely to encounter someone at risk – including all health workers and relevant community providers such as teachers – with the competencies to guide people to the support they need. It also includes providing follow up support to anyone who may have been bereaved by suicide.

Early intervention is important across the full spectrum of health services. WHO's mhGAP Intervention Guide (mhGAP-IG) includes tools and training materials to support clinical decision-making and management by non-specialized health workers (see Box 6.6 Guyana: building capacities for suicide prevention) (244).

Community-led services have an important role in supporting people affected by suicidal behaviours through survivors' groups and self-help groups facilitated by survivors with lived experience. Schools and other learning environments also have a role in providing support to those experiencing suicidal thoughts and behaviours by offering guidance on where and how to seek help. And other sectors, such as social welfare, also have a part to play in supporting survivors who may, for example, need help accessing work or benefits.

6.3.2 Protecting and promoting child and adolescent mental health

Infancy, childhood and adolescence are ages of both vulnerability and opportunity in mental health. This is a time when children acquire the cognitive, social and emotional attributes and skills they need to thrive as adults.

Childhood and adolescence is also a time of life when we are highly susceptible to environmental influences. Nurturing caregiving and supportive learning environments can be hugely protective of future mental health. On the other hand, adverse childhood experiences in homes, schools or digital spaces increase the risk of experiencing mental health conditions (see section 2.2 Determinants of mental health).

Nurturing caregiving and supportive learning environments can be hugely protective of mental health.

Informed by WHO's evidence-based guidelines the sections that follow consider the rationale and options for universal promotion and prevention across four platforms (370, 371):

- policies and legislation
- caregiver support
- school-based programmes
- environments outside school.

Policies and legislation

International frameworks such as the UN Convention on the Rights of the Child (CRC) commit all countries to promote and protect child and adolescent mental health. The CRPD complements the CRC and includes an article on protecting the rights of children with disabilities, including psychosocial disabilities. Together, they support access to care and social inclusion for children with mental health conditions.

National policies, plans and laws that align with these human rights instruments are critical to developing appropriate systems of mental health care for young people. Yet in 2020, fewer than half of WHO Member States reported having a plan or strategy for child and adolescent mental health (5).

For young children, laws and policies that support caregivers in providing nurturing care

NARRATIVE

This illness stole precious moments from me and my girls

Olivia's experience

Before becoming a mum I thought motherhood would be, yes, tiring and overwhelming at times, but mostly I expected it to be a period of joy and happiness. Not once did I think it would in fact be one of the darkest times of my life.

Both my girls were born prematurely and after giving birth to my eldest I immediately started to experience symptoms of psychosis. I felt deeply depressed and anxious, was plagued with irrational beliefs and fears, and had severe panic attacks. My symptoms went unrecognized by myself and undiagnosed by the medical staff taking care of me.

My first psychotic episode took place a few months later. I'd settled my daughter down in her nursery and then experienced the most terrifying of visions. I saw demons flying around our house, saying they were here to kill my daughter. I began living with what I came to call my "dark stranger": a shadowy figure who would appear unexpectedly telling me I was in danger and that my daughter would be better off without me. I became filled with terror. I didn't want to see family and friends and felt like I was trapped in my own horror film. My symptoms were not cared for correctly, and I experienced them again during my second pregnancy and for several months after. My recovery was slow and at times challenging and debilitating.

I've had to come to terms with the fact that this illness stole precious moments from me and my girls that I will never get back. But this realization and my acceptance of it has been my drive to help other women in the same situation. I passionately believe that every woman going into motherhood should be educated on how to take care of their mental health. All women should be informed of the symptoms and know where to get support if they need it.

Since recovering I have published a book about my experiences. I also set up The Letters of Light Project: a peer-to-peer initiative that sends handwritten letters of support from women with lived experience of maternal mental health issues to women who are receiving maternal mental health care around the world. And I have been part of the editorial team for the *World mental health report: transforming mental health for all*. These are all projects I am incredibly proud of. And I get to share them with my daughters so they know that suffering with a mental health condition is not a weakness or a source of shame. People with lived experience are courageous people whose insight and experiences are invaluable for progressing mental health care worldwide.

Olivia Gascoigne Siegl, United Kingdom



are especially important (18). For adolescents, laws and policies can also be important to reduce common risk behaviours such as self-harm, substance use and risky sexual behaviours (372).

Multiple sectors have a role in creating enabling policy and legislative environments for child and adolescent mental health. For example, health policies set the standards for mental health services and provide universal coverage. Social welfare policies protect families against economic and social adversity. And education policies secure access to learning opportunities.

Caregiver support

Caregivers have a crucial role in promoting and protecting their children's mental health by providing nurturing care throughout childhood and adolescence.

Supporting caregiver health and well-being

Even before we are born our parents' mental health can impact our own. Poor nutrition, exposure to drugs or toxins, maternal infections or stress and birth complications can all adversely affect fetal development and put a child's later mental health at risk (373). Pregnant women with untreated depression or anxiety are more likely to have birth complications or die during pregnancy, and to have a low-birthweight baby (374).

*After birth and beyond,
many caregivers experience
psychological distress.*

After birth and beyond, many caregivers experience psychological distress. Especially when this distress amounts to depression or psychosis, there can be serious consequences for both caregivers and their children (read [Olivia's experience](#)). For example, depression and anxiety can impair a mother's ability to bond with her baby.

Preventive interventions that support caregiver mental health both before and after birth can make considerable contributions to preventing mental health conditions in children (375).

One meta-analysis has suggested that, when these interventions reach caregivers who are already experiencing a mental health condition, they could reduce the risk of mental health conditions in their children by 40% (376).

Reducing caregiver stress and supporting caregiver well-being – including through home visiting interventions – is particularly valuable during pregnancy and early infancy (377). Maternal mental health care should be integrated into early childhood health and development services because of the indirect benefits on caregiving and child development outcomes (370).

Continuing support for caregiver well-being also has the potential to positively influence the development and mental health outcomes of older children and adolescents. WHO and UNICEF's HAT initiative to promote mental well-being and prevent mental health conditions among adolescents emphasizes the importance of intervening with caregivers who are more likely to experience difficulties that could adversely affect their parenting (372). This includes caregivers who live in humanitarian settings, are victims or survivors of violence or who have a mental health condition or chronic physical illness.

All caregivers who live in stressful circumstances can benefit from extra support. In 2020 the Parenting for Lifelong Health programme developed the COVID-19 Parenting Resources to reduce caregiver stress and lessen the risk of violence against children during the pandemic (378). Through tip sheets, interactive text messages, online parent support groups, phone-based counselling and more, the resources use a strategic approach to deliver messages to support caregivers and children during the pandemic. More than 210 million people accessed these resources during the first two years of the pandemic.



Skills for caregiving

Parenting programmes focus on equipping caregivers with the skills they need to provide nurturing care and a safe and stable environment for their children. Programmes for caregivers of newborns often focus on breastfeeding support, which helps establish a sense of attachment and comfort that contributes to mental health (379).

Programmes for young children's caregivers tend to focus on responsive care and learning, including preschool enrolment (370). Experience from around the world suggests that parenting programmes during early childhood can effectively reduce coercive parenting, improve children's problem-solving behaviour and social functioning at home and school, and help prevent behavioural problems, many of which have their onset in preschool periods (380).

Programmes for adolescents' caregivers may focus on (372):

- Support to promote nurturing family environments, including support to increase caregivers' involvement in parenting and ability to provide appropriate structure and supervision.
- Skills to strengthen caregiver-adolescent communication and relationships.
- Skills to strengthen positive parenting and protect adolescents from exposure to violence, including skills for setting limits and rules, promoting praise and positive reinforcements and reducing harsh punishment.
- Knowledge to increase caregivers' understanding of mental health and adolescent development, including the psychological, social, physical and sexual changes that happen during adolescence.
- Support for family social networks and community connectiveness.

Caregivers of children with developmental delays and disabilities may benefit from specific support because they are likely to experience high levels of distress. Experience shows that participating in parenting programmes such as WHO's Caregiver Skills Training (CST) can empower these caregivers to foster their children's learning, social communication and adaptive behaviour (381, 382).

Pregnant adolescents and adolescent caregivers can also benefit from parenting programmes that, for example, build awareness of the mental health challenges they may face and link them to crucial support and services (372).

School-based programmes

Schools are one of the most important settings for mental health promotion and protection among children and adolescents. They can be places that nurture well-being, equipping students with the knowledge, skills, competencies and lifestyles they need to thrive. For children whose home environment is not safe and nurturing, school can be a crucial safety net supporting basic social, emotional, and physical needs. But schools can also be places that undermine well-being, for example by exposing students to bullying, racism, discrimination, peer pressure and excessive stress about academic performance.

To be effective, each intervention in a school-based promotion and prevention programme requires active engagement and support from students, teachers, caregivers and communities. To develop a positive school climate, a whole-school health-promoting approach is needed (372). In turn, such an approach supports better health and educational outcomes and influences health behaviours, to the benefit of students, school personnel and the broader community (383).

TOOL

BOX 6.7

A school mental health training package for the Eastern Mediterranean

WHO's Regional Office for the Eastern Mediterranean (EMRO) has developed a training package for educators to better understand the importance of mental health in a school setting and implement strategies to promote, protect and restore mental health among their students.

Still in the early stages of implementation, the EMRO package includes training manuals and materials

to help scale up the number of “mental health promoting schools” that are able to:

- support their children’s social and emotional development;
- promote mental health and well-being at all levels;
- provide age-appropriate behavioural management strategies; and
- identify and address early signs and symptoms of mental health conditions.

Source: EMRO, 2021 (384).





A key component of a health-promoting school is a safe and supportive school social and emotional environment. This can be nurtured by training educators (see Box 6.7 A school mental health training package for the Eastern Mediterranean). In all cases, school-based prevention and promotion programmes should be linked with other mental health and social services, which may be provided on- or off-site (see section 7.4.1 Mental health care in non-health settings: Early detection and intervention in schools).

Social and emotional learning programmes

School-based programmes for social and emotional learning are linked to mental health benefits in countries at all income levels (385). They can be delivered for all school ages and

are well proven to improve students' emotional well-being, social functioning and academic performance. They are also associated with a reduced risk of depression, anxiety and stress; and prevention of suicide, harmful substance use, antisocial behaviour and health-risking sexual practices (see section 6.3.1 Preventing suicide: foster social and emotional life skills in adolescents) (386).

WHO and UNICEF's HAT initiative advocates a broad approach to school-based social and emotional learning that uses a mix of interventions to build mental health awareness, strengthen emotional, cognitive, and social skills, and engage in physical activity (see Table 6.3) (372, 387).

TABLE 6.3

Psychosocial interventions for social and emotional learning

LEARNING GOAL	INTERVENTION
Emotional	Emotion regulation Techniques to improve one's ability to manage and respond to emotions effectively
	Stress management Techniques to control levels of stress, especially chronic stress, that interferes with everyday functioning
	Mindfulness Activities to enhance abilities to pay attention purposefully, in the present and without judgment
Cognitive	Problem solving Techniques to identify and act on a solution to a challenge or difficult problem
	Drug and alcohol knowledge Education about the use of drugs and alcohol, and their effects
Social	Interpersonal skills Improving skills to develop or improve close, strong and positive relationships with others
	Assertiveness Improving skills to communicate one's viewpoint, needs or wishes clearly and respectfully
Physical	Physical activity Opportunities to engage in sports or physical activity, either individually or in teams

Source: adapted from WHO and UNICEF, 2021 (372).

NARRATIVE

Bullying was the perfect soil for my depression to grow

Benny's experience

My first experience of racist bullying was when I was in second grade. My neighbourhood peers saw me and yelled at me to go back to China. I was only eight years of age and already felt unwelcome and unsafe in my closest environment.

I had active asthma and my parents were very protective of my health. I was mocked as a mama's boy; the weak asthma kid. I used to cry to cope with the bullying, rejection and frustration. By the time I was an adolescent, I had become very sensitive. I tried to be more assertive and bold in stating what I thought and felt. But I was being bullied more than ever. I had started having physical health issues and came from a different religious background to many of my peers. The passive aggressive gestures and microaggressions toward my religious identity became a soft method for their bullying.

These experiences made me very aware of the fact that people can be very ignorant and hateful towards diversity and conditions they know nothing about. They made me wonder why people cannot accept others for identities they have no power to choose, why they inflict suffering toward others, and what happiness and harmony should look like. I had nobody to ask these questions to, leading to a greater sense of alienation.

I constantly felt like I was less than those who hated me; and that I had to prove I could do better than all of them. This long-term and multi-layered impact of bullying also made me feel lonely and worthless. It became the perfect soil for my depression to grow. It took years for me to realize that bullying had disrupted my way of relating to myself and others.

Benny, Indonesia

Universal school-based social and emotional learning programmes can be embedded into the usual school curriculum and delivered by teachers. For example, a Canadian Mental Health Curriculum has been adapted for use in classrooms in Malawi, Nicaragua and the United Republic of Tanzania, where it has shown self-reported improvements in mental health literacy and help-seeking as well as reduced negative attitudes (388, 389, 390).

Such programmes are not only effective but can bring good economic returns (222). One investment case for the Philippines calculated that the return on investment (including productivity gains and the social value of health) of universal school-based social and emotional learning programmes was 14.8 to 1 over 20 years (132).

Anti-bullying interventions

Within any school-based promotion and prevention programme, anti-bullying interventions are especially important.

Bullying can take many forms: physical, verbal and psychological. Nearly one in three adolescents are estimated to be victims of bullying in the past 30 days (391). People who are bullied as a child are more likely to experience emotional distress and mental health conditions and to have problems adjusting to school (392). Bullying can also result in isolation, low self-esteem and self-harm (read Benny's experience).

Anyone involved in bullying – those who bully or are bullied – are more likely to get depression and anxiety.

Childhood bullies themselves are more likely to have academic problems in the short term and are more likely to engage in harmful substance use, antisocial behaviour and interpersonal violence later in life (392). Anyone involved in bullying – those who bully and/or are bullied – are more likely to experience a mental health condition (393, 394).

School-based anti-bullying programmes focus on addressing factors in the school that foster bullying behaviour. They can be implemented in different ways, from parental and peer support interventions to staff and student awareness-raising and social and emotional skill building. Overall, school-based anti-bullying programmes have been found to be effective in reducing bullying by approximately 20% (395). Analysis suggests that the most successful interventions use a multi-level, whole-school approach that includes implementing an anti-bullying policy and classroom rules (including accountability mechanisms), providing information for parents, involving peers and enabling cooperative group work.

In addition to reducing bullying rates, anti-bullying programmes can reduce subsequent aggression and emotional problems in adolescents (396). They may even have an impact on psychosis rates, given the link between bullying and psychotic experiences (397).

Environments outside school

Beyond school, children and adolescents spend a lot of time in communities and, these days, in online environments. Moreover, there are millions of children and adolescents out of school. It is important to ensure that environments outside school are safe and healthy and that they enhance mental health outcomes and facilitate access to resources and support.

Adolescents who live in safe, well-resourced neighbourhoods or participate in extracurricular social, physical, creative or playful activities such as youth clubs, sports teams or arts groups have improved mental well-being compared with those who do not. Conversely, adolescents who live in communities with high levels of adversity or conflict are more likely to have poorer mental health. So any intervention that successfully addresses violence and other adversity in the community can be considered promotive. So too can interventions such as safe spaces that support opportunities for children and adolescents to play (398).

There is much concern around children's use of the Internet and social media (4). Around the world, children and adolescents have different experiences in accessing and using the Internet, with different risks and benefits. Some young people have little or no access to digital technologies and the internet; some have recurrent but irregular access; some have regular access but are limited in their use of them by personal or caregiver concerns; and some have regular access with no support or barriers to use (399).

For those who can access the Internet, online environments can be an important source of entertainment, social support and learning. This has been especially true during the COVID-19 pandemic, with the Internet providing a platform for attending classes and socializing with friends, as well as information on how to cope with

COVID-19 related stressors (see Box 6.8 *My hero is you: a children's book for COVID-19*). Of course, many children had no Internet access during the pandemic, or only limited access that made online learning and socializing very difficult.

TOOL

BOX 6.8

My hero is you: a children's book for COVID-19

My hero is you: how kids can fight COVID-19 is a book for school-aged children explaining how they can protect themselves, their families and their friends from COVID-19 and how to manage difficult emotions when confronted with rapidly changing reality.

The book was made available in 2020, in more than 140 languages and numerous adaptations, including animated video, theatre, activity books and audio formats. It came with a guide for parents on how to read the book with their children, explaining

how adults can create safe spaces for children to openly share their feelings, including their fears and worries, about COVID-19 and frustrations at their changed daily lives.

A sequel, *My hero is you 2021: how kids can hope with COVID-19* addressed children's changing concerns during the second year of the pandemic and is available in 28 languages, showing the continued interest in countries to provide children with information on coping with COVID-19 related stressors.



Sources: IASC, 2020 (400); IASC, 2021 (401).

NARRATIVE

A toxic work environment left me unable to function

Larry's experience

I loved my work but I grew to hate it as I was working in a toxic environment. A lengthy and unpleasant matter at work was sending my mind reeling into panic attacks, anxiety, and depression. My doctor said I had moderate to severe depression. I maintained a façade of happiness but I would hide in my office in tears, trying unsuccessfully to maintain some level of self-control. I took time off.

On my first return to work, I was utterly overwhelmed and took more time off. On my second return, organizational changes made in my absence meant I started to dread my weekly work meetings. It made me ill just thinking about it. I was unable to function at work for several days.

I felt like a target. My normal duties were being eroded and the authority of my role was diminished without any consultation. I reached out to my

professional association and human resources for help, but no action was taken to support me.

Exasperated, feeling cornered, and unable to function in my role I resigned. Following my resignation my personal feelings blazed chaotically between mental anguish, lack of control, isolation, fear, sorrow, intimidation, disbelief, frustration, disappointment, extreme worry for the well-being of my former team, anger about the impact on my 20-year career and, periodically, relief.

The happiness, optimism, and trust in others that used to define me are still mostly absent. I work on those. This was the single most tumultuous experience in my life, but I have no regret as I chose to put my personal sanity and mental health first. In the end, I learned a great deal about myself and what is important to me. This opportunity for self-reflection is the unseen benefit.

Larry White, Canada



When young people spend time online and on social media they can also be exposed to mental health risks such as cyberbullying, cyberstalking, grooming, developmentally inappropriate content, misinformation and unhealthy role models. Social media use can also interfere with sleep (402). And social media breeds social comparison, with adolescents frequently thinking they compare poorly with others (403). So while social media

helps many adolescents make connections and explore new ideas and information, it also undermines self-esteem and body image.

The impact of Internet use on mental health, cognitive development and social connectedness – both positive and negative – remains a topic of concern and is a priority for investigation.

Meanwhile, three interventions in particular are considered promising in promoting safe and healthy engagement online for adolescents (372):

- Adolescent training programmes to strengthen skills in how to use the Internet responsibly and safely and to reduce online-related risks such as cyberbullying and victimization.
- Parenting programmes to train caregivers on how to promote their adolescent's safe use of the Internet, including setting rules, monitoring use and encouraging responsible engagement.
- Technological tools to promote online safety by enabling negative content to be filtered and blocked, including caregiver controls, self-regulation tools, language screening software, and reporting systems.

6.3.3 Promoting and protecting mental health at work

Workplaces can be places of both opportunity and risk for mental health. On the one hand, workplaces that promote good mental health and reduce work stress not only enhance mental and physical health but are also likely to reduce absenteeism, improve work performance and productivity, boost staff morale and motivation, and minimize tension and conflict between colleagues. So action to protect and promote mental health in the workplace can be cost-effective (404).

Workplaces can be places of both opportunity and risk for mental health.

On the other hand, unemployment, discrimination in accessing or carrying out work, and poor working conditions can all be a source of excessive stress, heightening the risk of developing new mental health conditions or

exacerbating existing ones (20). Such negative working environments and experiences are the very opposite of what is needed for staff to do their work (read [Larry's experience](#)).

Some workers, such as health, humanitarian or emergency workers, are more likely to be exposed to adverse experiences at work. This is partly because of the nature of their work (for example, exposure to potentially traumatic events) but also because of the way their job may be designed (for example, high workload, long hours, shift work or work at unsociable hours). This adversity puts workers at risk of negative impacts to their mental health (405, 406). The COVID-19 pandemic has highlighted the heavy workloads carried by health workers, and the potential consequences for their mental health (see [Chapter 2, In focus: COVID-19 and mental health](#)). Yet such burdens and consequences were known to risk depression and suicidal behaviours even before the pandemic (405, 407).

Most initiatives for work-related mental health focus on the formal employment sector. Yet the informal economy – where there are no formal regulations, work is precarious, and workers lack access to social protections – accounts for more than 60% of all global employment, and more than 69% of employment in LMICs (408). These workers face threats to their mental and physical health through lack of structural support or recognition for their work and often also face poor working conditions and societal discrimination, all of which may also impede use of mental health services.

The *Comprehensive mental health action plan 2013–2030* emphasizes the need for countries to promote safe, supportive and decent working conditions for all, including informal workers. It further recommends that countries address discrimination in the workplace and promote full access to work participation for people with mental health conditions. Despite this commitment, work-related promotion and

prevention programmes for mental health were among the least frequently reported by countries (35%) in the *Mental health atlas 2020* (5).

In 2022, following extensive evidence reviews, WHO will publish the first ever global guidelines on mental health and work. These will highlight the importance of key strategies for preventing mental ill-health including:

- organizational interventions
- manager mental health training
- interventions for workers.

In each case, legislation and regulations are important to ensure these strategies – and others to support workers with mental health conditions – are effectively implemented.

While the upcoming guidelines are based on the latest evidence available, there is still much to learn about what works, and for who, when it comes to supporting mental health at work. Strong collaboration between employers and academia is important to gather evidence on the effectiveness of different approaches (409). Interacting with, and listening to, workers to get their perspectives on what they need is just as important.

Legislation and regulation

At national and international levels, legislation and regulation encourage and enforce action to promote and protect mental health at work. For example, the International Labour Organization (ILO) Convention on Occupational Safety and Health (No. 155) and its Recommendation (No 164) call on countries to protect workers' physical and mental health by developing and implementing national policies in occupational

safety and health. The convention provides an impetus for employers to integrate mental health into their own workplace policies and is thus a key enabler of organizational interventions (see [Organizational interventions](#)).

Other international conventions similarly enable organizational interventions to support people living with mental health conditions. Article 27 of the CRPD for example calls for the protection of rights of persons with disabilities in recruitment, hiring, employment and career advancement through accommodations at work (410).

Workplaces can be reticent to hire people with mental health conditions on the misguided assumption that they require more resources, more supervision, have less initiative, cannot deal with customers, or that there are trust issues (411). Laws that compel non-discriminatory practices for all workers can help to uphold people's rights. But changing stigmatizing attitudes requires complementary action, for example to address misconceptions about mental health conditions and increase employers' understanding about how to make reasonable adjustments to recruit and support prospective workers with mental health conditions.

At the national level, a diverse range of employment laws and policies can be used to establish an enabling environment for protecting workers' mental health (see [Box 6.9 Promoting mental health in workplaces in the Philippines](#)). This includes regulations on violence and harassment as well as laws and policies on minimum wage, equality, health, safety, parental leave and flexible working.





CASE STUDY

BOX 6.9

Promoting mental health in workplaces in the Philippines

In 2020, the Department for Labor and Employment in the Philippines issued new guidelines for all employers in the private sector to implement a mental health workplace policy and programme.

The guidelines are enshrined in law through various acts of government and apply to all workplaces and establishments in the formal sector, including those that deploy Filipino migrant workers overseas.

The new guidelines make it mandatory for all employers to establish and implement a mental health workplace policy and programme that:

- raises awareness about mental health in the workplace
- prevents stigma and discrimination
- promotes a healthy lifestyle and work-life balance
- supports workers with mental health conditions and facilitates access to mental health services.

The guidelines are clear that mental health workplace policies and programmes should be co-developed by management and workers' representatives, and regularly monitored and evaluated. All employers must submit annual reviews of their policies and programmes to the Department of Labor and Employment. And those that do not comply with the new guidelines may be fined.

Source: Department of Labor and Employment, 2020 (412).

Organizational interventions

Organizational strategies to promote and protect mental health in the workplace cover interventions that reshape working conditions to reduce workers' exposure to mental health risks. These psychosocial risks may be related to the nature of the work undertaken, the physical, social or cultural characteristics of the workplace, or opportunities for career development, among other things (see Table 6.4) (413). These are risks known to adversely impact mental health outcomes. For example, high job demands, low job control, job insecurity, low relational and procedural justice, bullying and low social support in the workplace are associated with a greater likelihood of developing mental health problems (20).

Violence and harassment at work, in particular, violate human rights and can cause long-lasting harm to mental health (414). Violence and harassment are often enabled by structural factors (for example, gender biases) that foster a negative workplace culture.

Removing or mitigating risks to mental health at work can in part be achieved by integrating mental health into an organization's workplace policies on occupational safety and health (see Box 6.10 SOLVE: integrating mental health into workplace policies). This action helps to ensure that employers meet the requirements of national and international labour standards (see Legislation and regulation).



TABLE 6.4

Examples of risks to mental health at work

POTENTIAL RISK	EXAMPLES
Job content / task design	<ul style="list-style-type: none"> • Lack of variety in the work • Under-use of skills or under-skilled for work • Insecure or informal working
Workload and work pace	<ul style="list-style-type: none"> • Heavy workload
Work schedule	<ul style="list-style-type: none"> • Long work hours • Shift working • Inflexible hours
Job control	<ul style="list-style-type: none"> • Lack of control over workload • Limited participation in decision-making about one's own work
Environment and equipment	<ul style="list-style-type: none"> • Poor physical working conditions
Organizational culture and function	<ul style="list-style-type: none"> • Poor communication • Unclear organizational objectives • Limited opportunities for personal development • Workplace culture that enables violence, harassment, discrimination or bullying
Interpersonal relationships at work	<ul style="list-style-type: none"> • Limited support from supervisors or colleagues • Violence, harassment and bullying
Discrimination	<ul style="list-style-type: none"> • Any discrimination based on identifying factors such as race, ethnicity, sexual orientation, gender identity, religion or age • Discrimination against indigenous peoples, migrants and people with disabilities, including psychosocial disabilities
Role in organization	<ul style="list-style-type: none"> • Unclear job role within the organization or team
Career development	<ul style="list-style-type: none"> • Under promotion or over promotion • Job insecurity • Poor pay
Home-work interface	<ul style="list-style-type: none"> • Conflicting demands between work and non-work life

Source: ILO, 2016 (415).



TOOL

BOX 6.10

SOLVE: integrating mental health into workplace policies on occupational safety and health

The SOLVE training package, developed by ILO, provides practical guidance for managers, supervisors and others on how to integrate mental health into their organizations' workplace policies and practices on occupational safety and health.

Designed to support the ILO Occupational Safety and Health Convention (No. 155), the SOLVE training package covers three main targets for policy design and action:

- psychosocial health, including stress, psychological and physical violence, and economic stressors;

- potential addictions, including tobacco, alcohol and drug consumption; and
- lifestyle habits, including diet, exercise and healthy sleep.

SOLVE aims to provide participants with the knowledge and skills they need to integrate each of these topics into their own occupational safety and health policies. To that end it uses a social dialogue approach, involving employers, workers, governments, public services and nongovernmental organization.

Sources: ILO, 2012 (416); Probst et al, 2008 (417).

Specific organizational interventions for mental health include (418, 419):

- providing flexible working arrangements;
- involving workers in decision-making, for example on their job design, through participatory approaches; and
- modifying workloads or work schedules to promote and enable a healthy work-life balance.

Organizational interventions designed to support people living with mental health conditions may also include facilitating the provision of reasonable accommodations, so that workers are supported to access or continue work. In many cases, supported employment programmes may be needed to create opportunities for

competitive work for those at disproportionate risk of exclusion, including people living with severe mental health conditions.

In all cases, organizations can help foster participation in work activities by providing adapted working conditions to match the capacities and needs of workers with mental health conditions. This may include allowing flexible hours of work, extra time to complete tasks and time off when needed to seek mental health care (420). It may include access to private spaces such as somewhere to store medication or somewhere to rest when necessary. And it may include ensuring supportive relationships with managers and redesigning jobs, for example to avoid interacting with clients if the worker finds this unduly stressful.



Efforts to adapt working conditions may also be beneficial for people returning from absence associated with mental health conditions. If the worker agrees, other stakeholders (such as mental health care providers) may also have a role in supporting their return to work.

Anti-stigma action is critical to ensure workers experiencing difficulties with their mental health feel supported and able to ask for extra support if they need it, without fear of repercussions or judgement. Indeed, reducing stigma at work is vital to the success of efforts to support mental health at work.

Manager mental health training

Mental health training for managers and supervisors is about strengthening knowledge, skills, attitudes and behaviours so that managers may better support their workers' mental health needs (421).

Training may focus on supporting managers' specific mental health needs, for example looking at how to regulate emotions in response to work stressors. Or it may focus on helping managers identify and reduce work-related risk factors for their supervisees, for example by finding ways to manage workloads during busy periods.

Training can also include developing knowledge about mental health and learning how to identify and support supervisees that may be experiencing emotional distress. In these cases, the intention is not for managers to become mental health care providers. Rather it is about enabling appropriate awareness and response,

for example using active listening skills and, where appropriate, referring people to sources of support within or beyond the workplace.

Interventions for workers

Interventions for workers often focus on increasing coping capacity to manage stressors. This includes stress management training using mindfulness-based or cognitive-behavioural approaches as well as strategies to promote leisure-based physical activity (see section 5.4.4 Competencies for self-care). Increasing the amount of social support available for employees can also help individuals cope with a stressful situation by mobilizing group problem-solving and positive team functioning.

Stress management interventions should be delivered along with organizational interventions that address psychosocial risks and manager training.

The evidence supporting stress management approaches for workers is clear (422). The ease with which stress management options can be delivered to a workforce render them popular and appealing. But to ensure a holistic approach to workers' mental health, these interventions should be delivered as part of a comprehensive package of interventions that also includes organizational interventions that address psychosocial risks and manager training. This is because a single focus on interventions for individuals can generate a sense of personal blame for people experiencing understandable stress responses to difficult work circumstances.

7



Restructuring and scaling up care for impact

COMMUNITY-BASED CARE
INTEGRATED SERVICES
COMMUNITY MENTAL HEALTH SERVICES
SERVICES BEYOND THE HEALTH SECTOR

Chapter summary

In this chapter we explore the major restructuring and scaling up required to transform mental health care services so that they meet the needs of all. We emphasize the need for a community-based mental health system. And we show the importance of providing person-centred, human rights-based and recovery-oriented care.



Key messages from this chapter are:

- Community-based mental health care is more accessible and acceptable than institutional care, helps prevent human rights violations, and delivers better recovery outcomes for people with mental health conditions.
- The vast care gap for common mental health conditions such as depression and anxiety means countries must diversify and scale up care, for example through non-specialist psychological counselling or digital self-help.
- Community-based mental health care comprises a network of interconnected services that include: mental health services integrated in general health care; community mental health services; and services that deliver mental health care in non-health settings and support access to key social services.
- Social and informal supports delivered by community providers (such as peers, community volunteers and women's groups) complement formal services and are vital to ensure enabling environments for people with mental health conditions.
- Integrating mental health into health services typically involves task-sharing with non-specialist health care providers; or adding dedicated mental health staff and resources to primary and secondary health care.
- General hospitals and community mental health centres or teams often provide the cornerstone of community-based mental health care and help blend clinical services and support with psychosocial rehabilitation.
- Where feasible, supported living services are key to deinstitutionalization; they include a mix of facilities with varying levels of support for different levels of dependency.
- Complementing health interventions with key social services, including child protection and access to education, employment and social benefits, is essential to enable people with mental health conditions to achieve their recovery goals and live a more satisfying and meaningful life.



At the heart of mental health reform for most countries, lies a major reorganization of mental health services. The task is to simultaneously shift the locus of care for severe mental health conditions away from any institutions and towards communities, while scaling up the availability of care for common conditions such as depression and anxiety. Both strategies are critical to advance human rights and improve the coverage and quality of mental health care.

Every district, province, prefecture, region, major city or other sizeable administrative division (here called “district”) should have a network of accessible community-based mental health services to provide an inter-connected platform for supporting people with a broad range of mental health conditions. This network must also be able

to help meet the broader social and economic needs of people living with mental health conditions, which means that the network must be developed and delivered in close collaboration with multiple sectors and stakeholders (423).

This chapter explores what comprehensive community-based mental health care means in theory and what it might look like in practice. We outline some of the principles behind the idea, consider each of its main component parts, and showcase examples of practice from around the globe. Not all examples necessarily represent the best solution for all contexts. Rather, each country will need to consider what is feasible and adequate depending on their own realities, capacities and needs.

7.1 Understanding community-based mental health care

Discussions on services reform are often confused by a lack of common language. WHO uses the term “community-based mental health care” for any mental health care that is provided outside of a psychiatric hospital. This includes services available through primary health care, specific health programmes (for example HIV clinics), district or regional general hospitals as well as relevant social services. It also includes a range of community mental health services, including community mental health centres and teams, psychosocial rehabilitation programmes and small-scale residential facilities, among others.

7.1.1 Putting people first

WHO has long strongly advocated community-based mental health care as an alternative to institutional care (1, 23). Through

the *Comprehensive mental health action plan 2013–2030*, countries are committed to doubling the number of community-based mental health facilities by 2030.

Compared with institutional care, community-based mental health care is broadly acknowledged to:

- **Increase accessibility.** Community-based care means people can access services closer to home, which eliminates potentially prohibitive costs of seeking care in distant locations and makes services more accessible. It also allows for treatment in a familiar environment, in which people can maintain support networks, relationships, friendships and employment, educational and other activities while receiving care, which facilitates recovery (424).

- **Reduce stigma.** Community-based care can help shift attitudes around mental health conditions to lessen social exclusion for those affected and make them more likely to seek help (425).
- **Better protect human rights.** Community-based care reduces the likelihood of seclusion, restraint, overmedication neglect and abuse, which are especially common in institutional settings. Community-based care is also important to reduce discrimination and meet people's rights to liberty, and participation and inclusion in their community (23).
- **Improve outcomes.** Community-based care is more effective than institution-based care in addressing people's preferences, supporting community reintegration and improving quality of life (426).

When it comes to implementing community-based care in practice, WHO emphasizes the need for a person-centred, recovery-based approach that ensures all people have access to a range of services and supports, from promotion and prevention to treatment and rehabilitation. So care should be coordinated across different levels and sites within and beyond the health sector, according to people's needs throughout the life-course (427).

A life-course approach is especially important to target critical stages, transitions and settings where different interventions may be particularly relevant (see section 2.1.3 Mental health is experienced over the life-course). Mental health services often focus on adults rather than children, adolescents and older people even though these are critical life stages for mental health.

Person-centred care

In all cases, good and supportive community-based health care is organized around the health needs and expectations of people, not diseases. Such person-centred care

engages individuals, families and communities as active participants in, rather than passive recipients of, care. It consciously adopts people's own perspectives and priorities and responds to these in humane and holistic ways (427). Thus it seeks to understand and respect people's cultural understandings of mental health, and to ensure that mental health care providers engage in meaningful conversations about people's needs and concerns (428).

Importantly, person-centred care encourages a more holistic approach to identifying and managing an individual's overall health needs rather than focusing on a particular pathology or disease. This is especially valuable for people with multiple needs or conditions.

*Good and supportive
community-based health
care is organized around the
health needs and expectations
of people, not diseases.*

In practice, person-centred care means many things, including:

- fully respecting people's human rights and personal values;
- accounting for and respecting people's treatment preferences and expressed needs;
- coordinating and integrating care across services and sites;
- involving individuals in planning and delivering their care;
- making sure people are physically comfortable and safe; and
- providing intervention and support as and where needed.

For children and adolescents, person-centred care is typically family-oriented, engaging caregivers in decisions and care as required while respecting older adolescents' evolving autonomy. Across all ages, implementing person-centred care relies on people having

**NARRATIVE**

Access to good quality care put me on my road to recovery

Claudia's experience

In my experience, good quality mental health care is about reciprocal understanding: uncovering the underlying problems and finding solutions by focusing on the individual's unique needs.

My journey in a snapshot is: two voluntary admissions, a clear multi-disciplinary approach to treatment, inpatient and outpatient treatment and continuous therapy. Both hospitalizations were frightening. The first time I was afraid of having knowingly decided to undergo treatment that I did not know much about. The second time I was more versed in mental health but I was still unsure of what to expect. White walls, long queues, constant monitoring, strict visiting hours: it was all new and intimidating.

During my second hospitalization, I had daily sessions with trained practitioners as well as group work that taught me about my diagnosis, what it means to live with a mental health condition and what I could do

to help myself get better. There were other optional classes on meditation, breathing exercises, and arts and craft therapy. It was this mental health care that secured me on my road to recovery.

After my discharge I wanted to help people in the same way my health care practitioners and their person-centred treatment had helped me. I pursued a career in psychology and today I am a certified wellness counsellor and deputy chief executive officer at an international mental health lived experience organization.

Living with a mental health condition does not make you less of a person, nor does it need to take away your ability to function optimally. With the right health care systems in place, I believe that many more people like me can be helped worldwide. With the right skills and tools we can all thrive in life and reach our full potential.

Claudia Sartor, South Africa

the information and support they need to make decisions and participate in their own care (427).

Person-centred care can have lasting benefits for individuals, communities, health workers and even whole health systems (429). It can enhance the trust, experience and outcomes people have from care (read [Claudia's experience](#)). Person-centred

care can also improve access to care and strengthen the health literacy and decision-making skills that promote independence. It can increase confidence and job satisfaction for health professionals. And it can improve the quality and efficiency of health systems.

Recovery-oriented care

Recovery is widely accepted as an important aspect of person-centred care in community-based mental health services, including in those designed for people living with severe mental health conditions such as schizophrenia (430).

The term recovery used to be largely defined in clinical terms to mean a remission of symptoms alongside improved cognitive, social and occupational functioning. But people with lived experience have long challenged the assumption that having a mental health condition means you cannot live a productive and satisfying life, arguing that recovery can occur even as symptoms persist. In this context, the idea of personal recovery emerged to mean a way of living a satisfying, hopeful and contributing life despite the limitations that experiencing mental health problems can impose (431).

From a human rights perspective, recovery focuses on the right to participate in all facets of life on an equal basis with all other people (432).

Recovery-oriented care is not about treatment of symptoms but about empowering people to have control of their own lives.

In practice, recovery-oriented care includes elements of both personal and social recovery. It can mean different things to different people. Importantly recovery-oriented care is not about treatment of symptoms but about empowering people to have control of their own lives (430). It involves supporting people to find hope, develop self-esteem and resilience, build healthy relationships, regain independence and to live a life that has meaning for them, whether that be through school, vocational training, work, friendships, community engagement, spirituality, or something else (23).

Effective recovery-oriented care is often characterized by:

- **Recovery planning.** Individuals are guided to articulate what their expectations and goals are and to describe how they want to live their life, for example by writing a recovery plan, taking into account all aspects of their lives, such as relationships, work, and education (321). For adolescents, recovery planning includes recognizing and respecting their evolving capacities in making recovery plans for themselves (432).
- **Supported self-management.** Individuals are supported to build the skills and confidence they need to recognize and manage the physical, social and emotional impacts of a mental health condition. Supported self-management includes, for example, psychoeducation about the condition and its treatment, recognizing early warning signs of relapse and developing a relapse prevention plan; and strengthening coping skills for dealing with persistent symptoms (433). Evidence suggests that supported self-management can improve outcomes for people with severe mental health conditions (434). It is also relatively straightforward compared with other therapeutic interventions and can be delivered across settings and in various ways.
- **Multisectoral coordination.** Services are coordinated between health, social and other care sectors including child protection. The aim is to simultaneously address the multiple needs of people with mental health conditions.

Human rights-based care

The CRPD requires that governments provide people with disabilities access to quality mental health services that respect their rights and dignity. This means that mental health services should not only be affordable, available, person-centred, recovery-oriented and evidence-based, among other attributes, but also that they should promote

autonomy, legal capacity (equal recognition before the law), non-coercion, confidentiality, participation, and community inclusion.

Respecting people's autonomy can be challenging but good practice case examples show that it is possible (see [section 4.2.3. Autonomy in health decision-making](#)) ([23](#)). For example, services are increasingly introducing advance plans or directives that enable people to indicate what they want to happen in case of a crisis ([203](#)). Advance plans can cover many topics, including when and how to activate them, who to contact for supported decision-making, and what treatment is acceptable or not acceptable, among other things ([205](#)).

Similarly, services should and can make much progress on care that fully involves the person in their care plan. People subjected to care without

their agreement report feeling dehumanized and long-term effects on their mental well-being (read [Sandra's experience](#) and [Alexandra's experience in Chapter 4](#)). Coercive practices undermine people's confidence and trust in mental health service staff, leading people to avoid mental health care ([23](#)). All services can and should promote non-coercive practices (see [Box 7.1 Promoting non-coercive practices](#)).

Throughout this chapter, we use case studies from around the world to illustrate what community-based care looks like in practice and how it can be achieved through mental health care reform. Not all the examples presented here fully live up to all aspects of person-centred, recovery-oriented, human rights-based care in their entirety, but all of them represent advances in care.

TOOL

BOX 7.1

Promoting non-coercive practices

In addition to changing laws and policies, WHO identifies several actions as key to advancing non-coercive practices.

- 1.** Educate service staff about power differentials, hierarchies and how these can lead to intimidation, fear and loss of trust.
- 2.** Help staff to understand what are considered coercive practices and the consequences of using them.
- 3.** Provide systematic training for all staff on non-coercive responses to crisis situations, including de-escalation strategies and good communication.
- 4.** Support individualized planning, including crisis plans and advance directives.

- 5.** Modify physical and social environments to create a welcoming atmosphere, including by using comfort rooms and response teams to avoid or address and overcome conflict or otherwise challenging situations.
- 6.** Establish effective grievance mechanisms for receiving, responding to and learning from complaints, including having a technical debriefing after any use of coercion.
- 7.** Reflect on, and where appropriate change, the role of all stakeholders in coercion, including the justice system, the police, general health care workers and the community at large.

Sources: WHO, 2021 ([23](#)); WHO, 2019 ([435](#)).

7.1.2 A mix of services and supports

People's needs for mental health care vary enormously. Some people may be able to manage their mental health conditions themselves, especially with support from community providers such as family members, peer support groups, faith-based organizations, or community workers (318). Many others will need formal interventions to support their recovery, which are typically offered through a range of daytime services. Some people will experience acute symptoms that require short-term overnight care with follow-up care in the community. Only rarely do people experience conditions that require highly specialized or longer-term round-the-clock care, which should be in the community, for example within general hospitals or in community residential facilities. Children, adolescents, adults or older adults may need different or adapted services.

Many people experiencing mental health conditions also require help accessing key social services such as housing, employment, education and welfare. And anyone with mental health conditions may need different types of services and supports at different points in their lives (436).

All countries will need to organize access to specialized care at the district level or equivalent.

Effective community-based mental health care includes a careful mix of services and supports that can cater to all these needs (437). It also ensures continuity of care between different services and supports, especially for those people who have complex needs or require ongoing care, as is common in schizophrenia. For each person, the aim is to avoid breaks or gaps in the support provided.

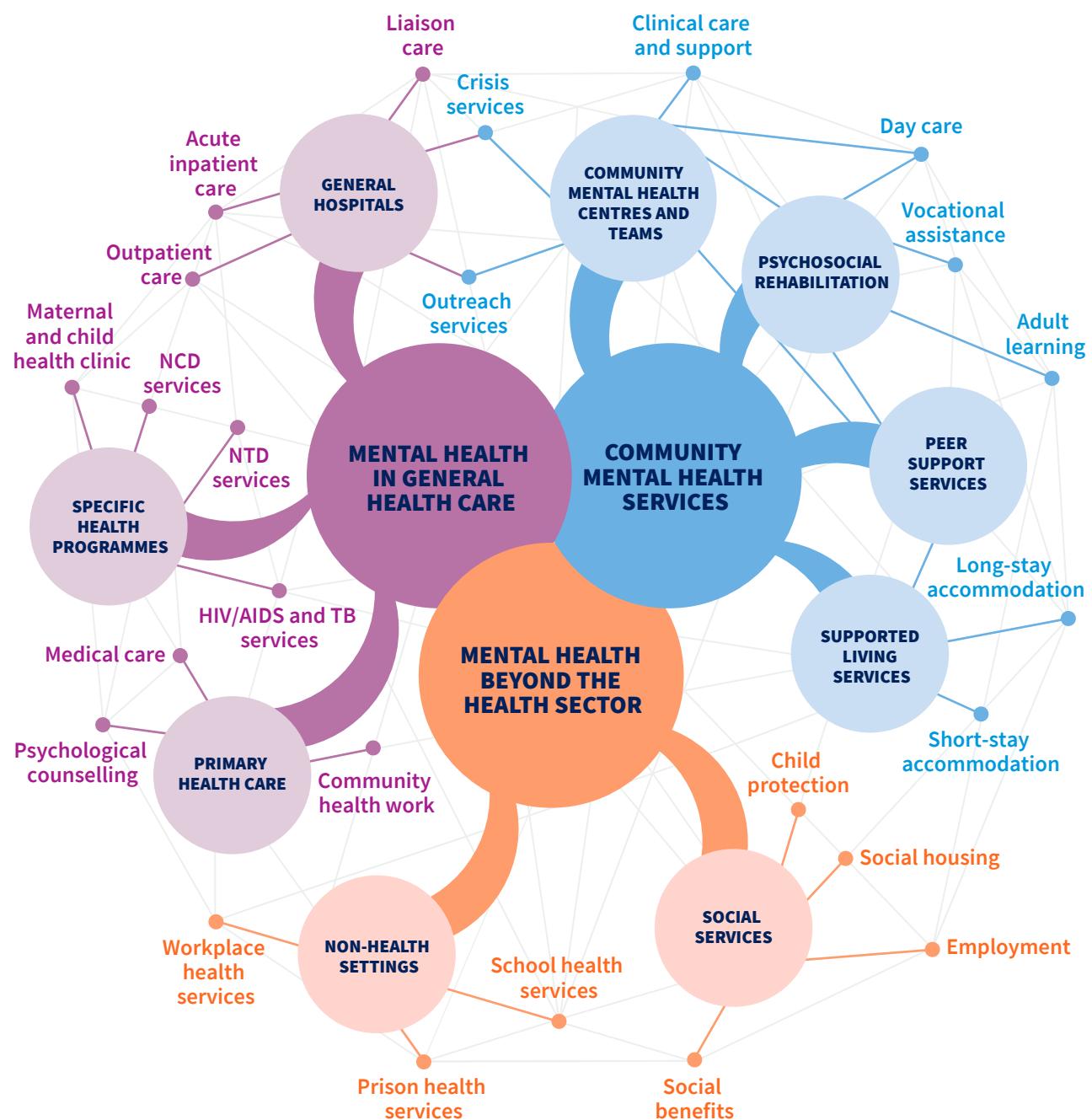
In practice, a community-based mental health system can broadly be described as a network of interconnected services that typically includes a mix of (see Fig. 7.1):

- **Mental health services that are integrated in general health care**, at primary care facilities and general hospitals, including within existing specific health programmes (for example for HIV).
- **Community mental health services** that focus on meeting the needs of people living with mental health conditions and of their families, and that potentially include community mental health centres or teams, as well as peer support services, psychosocial rehabilitation programmes and, where feasible, supported living through small-scale residential facilities. These services are still very rare in low-income countries.
- **Services beyond the health sector** that deliver mental health care in non-health settings such as schools, workplaces and prisons; and that support access to key social services such as housing, education, employment, social benefits and livelihood support.

Fig. 7.1 shows a vision of a comprehensive network of interconnected formal services. This cannot be achieved without sufficient resources, and low-income countries are unlikely to be in a position to have such comprehensive network of services in the near future. In general, most countries need to decide which services to develop or strengthen first. So how service networks for mental health are developed and organized in practice will vary. Almost all countries rightly give primary health care a key role in supporting people with mental health conditions. Yet all countries – including low-income ones – will also need to organize access to some form of specialized mental health care at the district level or equivalent.

FIG. 7.1

Model network of community-based mental health services



Some countries offer specialized care by developing community mental health centres or teams, or by adding community mental health nurses to primary health care. Many others offer these services within district-level general hospitals. And higher-resourced countries tend to

combine multiple types of specialized services. As described in Chapter 5 Foundations for change, when lower-resourced countries do not have sufficient specialists to provide these services at the district level, they should consider strategies to address this gap. This may be, for example,

by introducing and training up new cadres of professionals who can, for the time being, substitute for psychiatrists, clinical psychologists or psychiatric nurses (see [Box 5.11 Innovations in human resources to develop specialist expertise](#)).

Overall, there is no single model for organizing community-based mental health services that will apply to all country contexts. Yet every country, no matter its resource constraints, can take steps to restructure and scale up mental health care. Differences in health system structures, human resources and the legacies of pre-existing mental health services will influence the exact configuration of service networks; and local differences in geography, means of accessing services, literacy and social and informal support systems need to be considered.

Beyond formal services

Beyond the formal services described in [Fig. 7.1](#), community support systems in particular are an important consideration in developing community-based mental health care networks. These systems include the psychosocial supports delivered by a diverse range of community providers, including family members, friends, peers, community and faith-based leaders, community volunteers, teachers, hairdressers, women's groups, youth clubs and traditional and complementary practitioners.

Social and informal supports complement formal services and are vital to ensuring supportive environments for people with mental health conditions (read [Eleni's experience](#)). According to a 2020 global survey, talking to natural carers (i.e. friends and family) is the most common approach people take to alleviate depression or anxiety ([150](#)).

As shown elsewhere in this report, people with lived experience can have a big role in supporting others experiencing mental health conditions,

advocating for their rights and perspectives, promoting their social inclusion, and delivering services (see [Chapter 4, In focus: Engaging and empowering people with lived experience and section 7.3.2 Peer support services](#)) ([438](#)).

In most countries, faith-based leaders and traditional and complementary practitioners are widely consulted. Their beliefs and practices vary widely across settings, as does their effectiveness ([439](#)). Traditional healers sometimes apply highly harmful practices ([440](#)). But they are often the first point of contact for people with mental health conditions, who see their input as meaningful and likely to be helpful ([441](#)). And there are likely many occasions where fruitful collaboration between health services and local healers is possible. Indeed, a large randomized controlled trial in Ghana and Nigeria showed the effectiveness and cost-effectiveness of a shared care model for psychosis delivered by local healers and primary health care providers ([442](#)).

In parallel to developing a network of formal services, all countries should establish an enabling environment for community providers. To that end, governments should make resources (for example, funds and spaces) available to community-based initiatives that can activate and strengthen helpful community supports for people with mental health conditions.

Planning at the national and local level

Comprehensive and cohesive service networks need careful planning and management at multiple levels ([443](#)). National mental health authorities, directorates or departments – which oversee and coordinate country-wide policies and legislation – have a crucial role ([444](#)). These authorities advise the central government and can help prioritize mental health matters at the national level. They also develop quality and service provision norms and compile national data on all mental health services.

They conduct monitoring and evaluation and can facilitate exchanges of good practices across regions. They keep up to date with international developments in mental health and engage in international forums, bringing lessons learned back to the country. A mental health authority can be held accountable for achieving (or not achieving) mental health improvements and development in the country.

Local mental health authorities plan services for a particular geographical area such as a district, taking into consideration local differences in

context and availability of human and other resources. Local planning makes it easier to involve local stakeholders, including people with lived experience. And it allows service users to hold local planners to account (445).

Whether national or local, mental health service planning and implementation must identify and budget for an appropriate range of mental health services, based on assessed needs, priorities and available resources in the population, including trained personnel (see Fig. 7.2).

NARRATIVE

My family are my community care workers

Eleni's experience

I live with bipolar disorder in Ethiopia, where until recently no treatment options beyond medication were available. A decade ago, mental health care was given by a few psychiatrists who had to ration their services across a long queue of people. Other therapies were non-existent; they were not even acknowledged by the country's health system.

For me, my family members are my community care workers. I have the privilege of having parents with a medical background, and a sister and husband who are social workers. Their belief in me has been

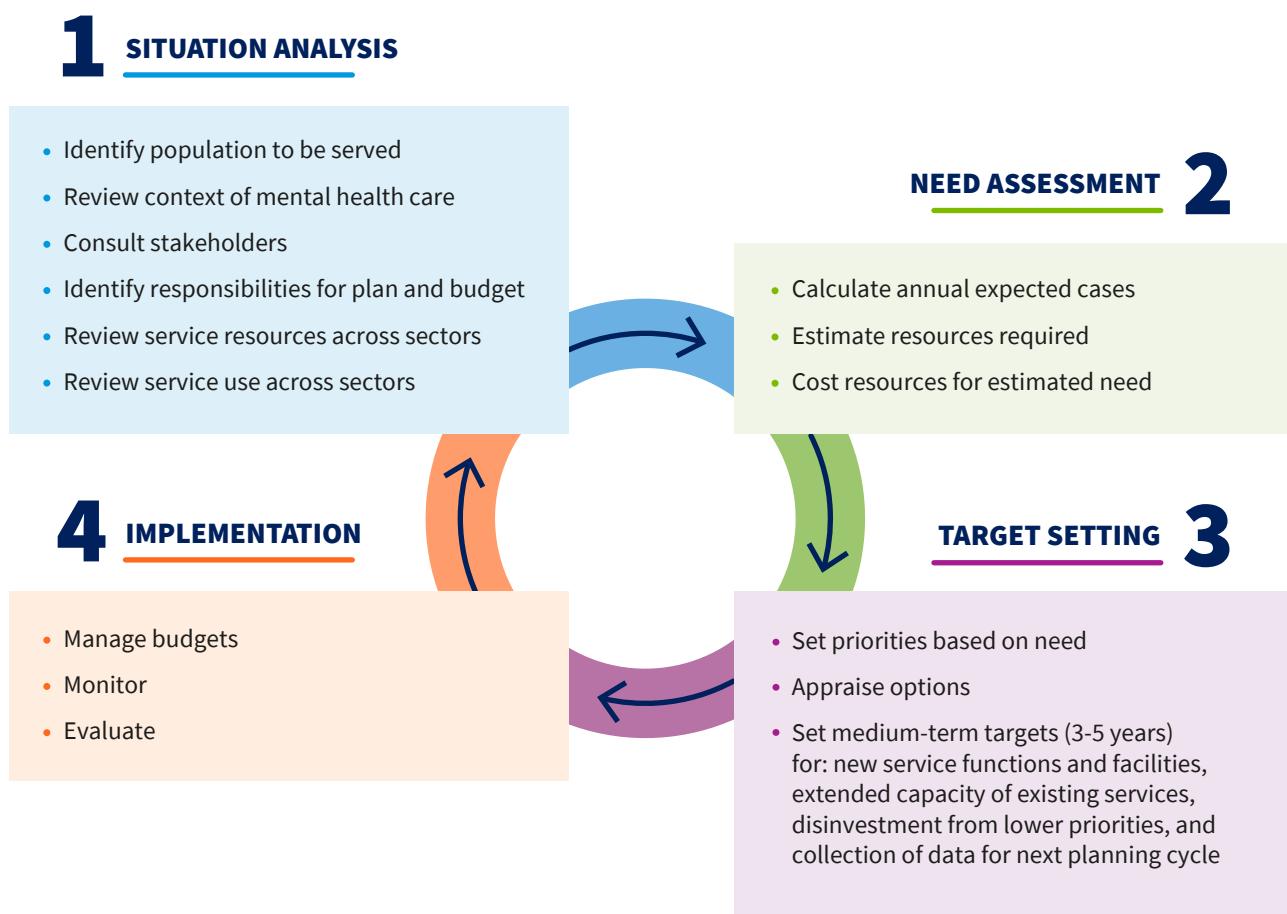
a major support in my recovery journey. Investing in my mental health care has never been considered a wasted effort or resource in my family. Their empathy, emotional and financial support helped me overcome my own limitations and self-stigma.

During the times when there were no counselling services for mental health in town, my family filled the gap graciously; they continue to do so today. I would never have got this far on my recovery journey if my family had not supported me along the road.

Eleni Misganaw, Ethiopia

FIG. 7.2

Steps in planning and budgeting mental health services



Source: adapted from WHO, 2003 (443).

Integrated and dedicated mental health services

Service networks for mental health will always include some services that combine physical and mental health care at the point of delivery (integrated services), and some services that are unique to mental health (dedicated services).

Integrated services include mental health interventions that are provided as part of general health care, mainly at primary care and general hospital facilities. Integration ensures that wherever physical health services are provided, mental health care is also available.

Dedicated services encompass any service specifically designed to support mental health. They include, for example, psychiatric inpatient and outpatient units in general hospitals, community mental health centres or teams, mental health outreach services, day care centres, mental health crisis services and many other services at the secondary care level of the health system.

Dedicated services are often described as referral or specialized care in UHC packages (446). But, in reality, they can be broader than that because some dedicated services (such as crisis mental health services) should be



accessible without referral. And others (such as lay psychological counselling) may be provided by community workers who have been trained and supervised but who cannot be considered specialists as they lack advanced training.

In all cases, when planning mental health care and developing UHC packages, the overall question should never be whether services should be integrated or dedicated but rather how to provide both. Investing to integrate mental health into primary care is unlikely to be sustainable unless there are dedicated mental health services that can support, mentor and supervise primary care staff and accept referrals for complex cases. Conversely, investments in dedicated mental health services alone are unlikely to enable or improve care for the vast majority of people who need it because of the high prevalence of mental health conditions.

Multisectoral responsibilities

The responsibility for delivering community-based mental health care, whether through integrated or dedicated services, straddles multiple sectors.

The ministry or department of health is responsible for providing mental health services in general health care and for most community mental health services. But other responsibilities are not so clearly defined.

For example, in countries that offer supported living services and economic support to people living with severe mental health conditions, these services and supports may, or may not be, included in the health ministry's remit. Similarly, providing mental health services within schools may fall to either the health or education ministry. And many other community-based mental health and psychosocial services – such as those specifically for victims of gender-based violence, homeless people and children in care – are usually run by the ministry of social welfare.

Moreover, in several countries, other ministries are responsible for large, long-term institutions that are de facto asylums for people with mental health conditions, substance use disorders and cognitive, intellectual and psychosocial disabilities.

Deciding which sector takes responsibility for which service is important. But what matters even more is ensuring that a full spectrum of accessible, affordable and quality community-based services exists, that there is strong multisectoral collaboration and coordination mechanisms in place to achieve that, and that long-term institutional care is strategically phased out across sectors.

Including relevant stakeholders is also important. In many countries, local nongovernmental organization are major providers of community-based mental health and social services. These services can be commissioned by the government or established independently. Independent services led by nongovernmental organizations often find it easier to adapt to changing needs and to innovate than government services. But, like government services, they still require regulatory oversight.

7.1.3 Deinstitutionalizing mental health care

In most countries, developing effective service networks for mental health relies on successfully deinstitutionalizing mental health care away from custodial care in psychiatric hospitals or asylums towards care in the community – for all ages. Deinstitutionalization is equally relevant to traditional institutions such as prayer camps (440). And it also applies to any other custodial care institution run by charity or government that operates as an asylum for people with severe mental health conditions.

Deinstitutionalization is a technically and organizationally challenging and complex process that is often gradual and rarely linear.

It is more than just a process that needs to be well-managed. It requires transforming the lives and mindsets of all involved. Responsible deinstitutionalization puts into operation a shared vision to humanize mental health care, based on understanding the importance of community, liberty and autonomy to all people.

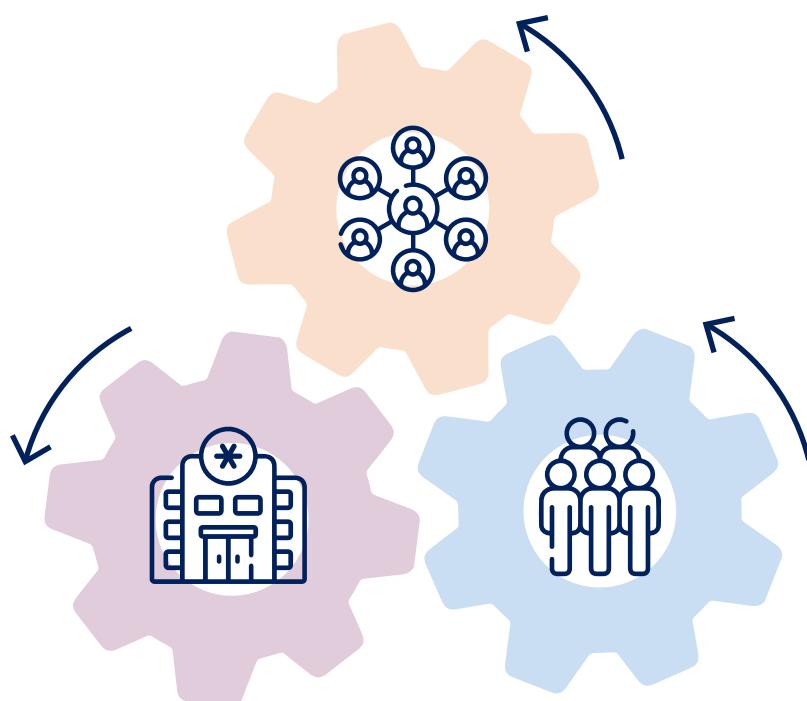
Deinstitutionalization is not the same as discharging people from institutions.

Progressively reducing caseloads to close or repurpose long-stay psychiatric institutions is

important. Deinstitutionalization is not the same as discharging people from institutions as it must be accompanied by sufficient financial, structural and strategic investment in community-based services. This is essential to meet the health and social needs of former institutional residents, and their families or carers, and also to prevent new- or re-admissions (see Fig. 7.3). As community services are developed, it is important to close institutional beds to prevent another generation of long-stay residents being admitted. Indeed, long-stay psychiatric institutions should be closed once there are adequate community alternatives.

FIG. 7.3

Deinstitutionalization involves simultaneously increasing discharges, reducing admissions, and scaling up care in the community



REDUCE ADMISSIONS

Systematically reduce new psychiatric hospital admissions; and enhance the quality of care and rights of people in all inpatient or residential care.

SCALE UP SERVICES

Build up a network of coordinated and linked community-based mental health services and social care to support anyone living with a mental health condition.

INCREASE DISCHARGES

Progressively discharge residents of psychiatric hospitals as community-based solutions to meet their health and social needs become available.

Lessons learned from experience

Deinstitutionalizing mental health care and building community services is a simultaneous process that gradually redirects resources from the institution towards the community. Experience shows that moving people out of custodial psychiatric care can go very well – or very badly (447, 448). Both outcomes offer lessons, and together reveal 10 ingredients for future success.

1. Support at the highest and broadest levels.

Support is key, not only from political leaders and government officials, but also from community leaders and members, and academia.

2. Careful planning and implementation.

Moving long-stay residents from institutional to community-based care requires thorough planning and preparation, as well as phased implementation, including shortening stays and preventing new admissions. Transforming institutions should start with changing life within institutions, for example by changing activities, routines and internal dynamics between staff and residents, and by addressing coercion and abuse.

3. Engagement and empowerment of residents.

Residents must be able to actively participate in the process of change. This means being fully involved in discussions about discharge options and re-introducing skills of daily living. It also means being supported to realize one's rights as citizens, for example to manage one's own resources, make informed decisions on where to live, and choose what clothes to wear, and getting paid for any work in the institution.

4. Community-based services.

To avoid neglect and homelessness, appropriate community-based services and supports, in line with any resident's individual needs, must be available on discharge. Usually, some residents (or groups of residents from defined geographical areas) will be able to leave the institution before others, depending

on their needs and how well-developed the community-based services are in the area where the individual will live.

- 5. Temporary additional financial resources.** To deinstitutionalize, both psychiatric hospitals and community mental health services must have parallel funding during the transition period so that institutions can continue to operate while community-based services are being developed.
- 6. A committed health workforce.** Health workers and their professional organizations need to be consulted widely, and involved in planning and implementing the process, so that they are committed rather than resistant to change. Typically, when long-stay institutions are scaled down, hospital staff need to be trained to provide care in the community.
- 7. Stigma reduction.** Anti-stigma interventions involving leaders, health workers, and the public should form part of any deinstitutionalization programme so as to reduce the chance of mistreatment once people live in the community.
- 8. Consent from residents and involvement from families.** Obtaining consent from residents that are to be discharged and, where possible, involving families and loved ones throughout the process is critical.
- 9. Attention to both mental health and physical health.** Following up not only on discharged residents' mental health but also on their physical health is crucial to prevent people dying prematurely in the community.
- 10. Monitoring and evaluation.** Norms and standards for community care, treatment and rehabilitation must be established. Regular inspections and evaluations must be carried out to ensure that quality care and support is provided to each and every individual who is discharged from the institution.



Timing is key for successful deinstitutionalization (see section 5.2.1 Strengthening political will and engagement: windows of opportunity). Once in place, community-based models of care are not necessarily less or more expensive than institutions, especially after accounting for people's needs and quality of care. In fact, they may be more cost-effective when they deliver better recovery outcomes (449).

In any case, the reason for moving people out of institutions should not just be that it could be cost-effective but that the individuals concerned can live better and more meaningful lives. Experience shows that done well, deinstitutionalization can improve the quality of life for people living with mental

health conditions and protect them from a wide range of human rights violations.

For the most part, bed reduction in parallel with substantial investment in community services has successfully transitioned people into comprehensive, community-based care and reintegrated them into communities, preventing long-term institutionalization, homelessness and imprisonment (read *Regina's experience in Chapter 2* (447, 450)). Reform can be implemented on a small scale, within individual towns or districts, or on a large scale, across whole countries (see Box 7.2 Deinstitutionalizing mental health care in Brazil). In various instances, community placement surveys with long-stay residents have helped plan for their resettlement and continuing care (451).

CASE STUDY

BOX 7.2

Deinstitutionalizing mental health care in Brazil

In the early 1990s, 75% of Brazil's federal funding for mental health went to custodial hospitals operating under poor conditions, with serious human rights violations. In the three decades since, there has been a gradual shift of resources towards care in the community, with people progressively discharged from institutional care. Today, more than 79% of federal funding is invested in a community-based system of care that aims to provide a human rights and recovery-oriented approach.

The new system integrates primary care, general hospitals and crisis care within psychosocial care networks that are coordinated by community mental health centres (CAPS). These operate 24 hours a day, seven days a week. The system includes residential

facilities as well as a rehabilitation allowance for people returning home after a long-stay in hospital. It also provides technical and financial support for local initiatives aimed at social rehabilitation, income generation and advocacy.

From 1998 to 2020, the number of CAPS grew from 148 to 2 657, distributed across the country. They now provide the cornerstone of mental health care in Brazil, used by more than half the population diagnosed with a mental health condition. Studies show that CAPS are effective in supporting individuals' autonomy and recovery, reporting high levels of satisfaction by people with lived experience and their families.

Sources: Lociks de Araújo, 2016 (452); Ministério da Saúde, 2020 (453).



In a few cases, where hospital beds have been reduced without investment in community-based alternatives, the quality and quantity of care has suffered badly, leading to highly adverse outcomes for the people concerned. For example, in 2017 at least 144 people died, including from starvation and neglect, after they were discharged from hospitals to underfunded and underskilled community care as part of a rushed and poorly planned programme to deinstitutionalize mental health care in Gauteng, South Africa (448).

Lessons from Gauteng emphasize the need for comprehensive anti-stigma and anti-discrimination interventions. They recall the need for broad consultation across stakeholders and full consent from service users and families. They underline the importance of a planned and phased approach, with carefully established norms and standards for community care, which should be regularly monitored by health authorities.

Where deinstitutionalization has been done responsibly, experience shows that it can also be highly sustainable, enduring over decades. In 1978, Italy started implementing Law Number 180, a law that stopped all new admissions to public psychiatric hospitals. After 40 years without psychiatric hospitals, the Italian mental health system is comparable with other G7 countries, which are all high-income economies (454). Yet Italy has far fewer mental health staff per 100 000 population. In 2019, Italy had no beds in psychiatric hospitals, while in the other G7 countries the number of psychiatric hospital beds ranged from 11 per 100 000 population in Canada to 170 per 100 000 in Japan (5). In Italy there are also fewer beds for acute care in general hospitals but more beds in community residential facilities than in the other G7 countries. And in Italy the number of compulsory admissions declined from more than 20 000 in 1978 to less than 9 000 in 2015 (see Box 7.3 Trieste, Italy: 40 years of community-based mental health care).



CASE STUDY

BOX 7.3

Trieste, Italy: 40 years of community-based mental health care

In Trieste, Italy, community-based mental health care has proven effective for more than 40 years. The Trieste transformation began in the 1970s, with the relocation of people living in the city's asylum to the community. Funds previously used to run the asylum were gradually diverted to develop a comprehensive network of community-based services. Community mental health centres are open 24 hours a day and provide walk-in clinics, home treatment, day care, psychosocial support, medication and overnight crisis care, among other services. There are also rehabilitation and residential services that provide different levels of supported housing and have links with local networks of social cooperatives that offer job opportunities and run cultural and educational activities.

As much as possible, people are supported in their own homes and neighbourhoods, so that they can continue to live their lives in their communities.

Importantly, in Trieste people are active participants in their care. They help develop personalized care plans, which look beyond clinical interventions to consider a wide range of social care needs, from housing support and personal hygiene to finances and work.

The Trieste model of deinstitutionalization has improved user satisfaction, social functioning and health outcomes for people living with mental health conditions. Suicide rates in the city have fallen. So have involuntary admissions. And stigma around mental health has been reduced as people living with mental health conditions have reintegrated into the community. The new model of care is also cheaper, delivered at 37% of the cost of the old asylum in Trieste.

Sources: Barbui et al, 2018 (454); Mezzina, 2018 (455); Mezzina, 2014 (456); Dipartimento di Salute Mentale, 2019 (457).



Deinstitutionalization is ongoing in a number of countries. In Argentina, mental health reform is happening in several provinces. In the province of Buenos Aires, between January 2020 and June 2021 the number of people in institutions fell from 1 810 to 1 391. This was achieved by stopping long-term admissions, giving 381 people a transfer subsidy to support discharge, and providing housing support for 306 discharged residents. Discharged residents are supported by existing community-based mental health services (458).

7.1.4 Scaling up care for people with common conditions

The high prevalence and vast care gap for common mental health conditions such as depression and anxiety mean that countries need to diversify and scale up options for care for these conditions if they are to move towards, or reach, universal health coverage. New funding and effort will be needed to add evidence-based

psychological care to existing health and mental health services as well as to social care settings, the criminal justice system, schools and universities, and online environments.

Sections 7.2–7.4 detail some of the strategies required to make this happen in different services. For example, although any community mental health service will likely cater for common as well as severe mental health conditions, this will not be enough. Delivery of psychological care needs to be expanded in primary health care settings and through community providers. Other key strategies for scaling up evidence-based care for common mental health conditions include enabling self-help and making better use of digital technologies (see Chapter 5, In focus: Harnessing digital technologies for mental health).

Non-specialist counselling

Psychological counselling programmes that recruit, train and deploy non-specialist counsellors to deliver group or individual evidence-based psychological interventions have proven to be highly effective for people with depression and anxiety (314). This form of counselling should not be confused with giving information or advice (as when someone counsels a new mother on how to care for her baby). Psychological counselling programmes can be implemented at scale (see Box 7.4 Lay mental health care workers treat depression in Uganda and Zambia).

Non-specialist counsellors for depression and anxiety can include a wide range of people. They range from community workers, volunteers and peers with as little as ten years of education to people with a university degree but without specialist mental health training (for example nurses or first-degree psychology graduates).



CASE STUDY

BOX 7.4

Lay mental health care workers treat depression in Uganda and Zambia

In Uganda and Zambia, the social enterprise StrongMinds trains lay workers and volunteers in a culturally adapted and locally validated format of interpersonal therapy, and deploys them to treat depression in women and adolescents.

The lay therapists help group participants identify their depression triggers (prolonged bereavement, disputes, loneliness or social isolation and changes in one's life) and design strategies to overcome these. Groups, typically of 12 participants, meet in their local communities for eight or more sessions. Since depression can recur, the skills acquired through therapy have both an immediate and long-term preventive impact.

The organization identifies clients through a mobilization process that includes psychoeducation and outreach in partnership with community leaders, schools, partner nongovernmental

organizations, and government counterparts. The organization also runs public education campaigns via radio and social media.

Over the past eight years, the programme has treated more than 100 000 people. As assessed by the PHQ-9 depression screening tool, more than 80% of individuals treated recover, and the results are sustained six months after treatment. People who have completed therapy report a 16% increase in work attendance, a 28% increase in being socially connected, a 13% increase in families eating regular meals, and a 30% increase in school attendance among their children.

StrongMinds is now scaling up by partnering with governments and nongovernmental organizations, to integrate its mental health intervention into existing livelihood, food security, health, and education programmes.



Sources: StrongMinds, 2021 (459); Bolton et al, 2003 (460).

In all cases, training and ongoing supportive supervision are important to build non-specialist providers' confidence and to monitor competencies (see section 5.4.3 Equipping community providers with mental health care competencies).

Non-specialist psychological counselling can also add substantial value to specialized psychiatric care. For example, in a tertiary mental health care facility in Islamabad, Pakistan, a brief psychological intervention called Problem Management Plus (PM+) was added to routine, mainly pharmacological, care. PM+ and similar interventions are usually implemented outside specialist settings. In Islamabad, the intervention was delivered within the specialist care setting but by non-specialist counsellors, who had completed an undergraduate degree in psychology without any clinical training. Adding the psychological intervention was found to substantially improve outcomes for people with depression and anxiety (461). If more specialized care facilities included such evidence-based non-specialist counselling in their routine care, then they would be well placed to guide and support the roll out of such counselling to primary care and community settings.

Indeed, non-specialist counselling programmes can, and increasingly are, implemented within primary care facilities and other community-based settings, including through stand-alone services run by nongovernmental organizations.

Studies show that these programmes can boost the capacity of frontline mental health services and greatly improve care. For example, one programme in the North West Province of South Africa saw primary care nurses identify people with depression among patients with chronic disease in a collaborative care programme. They referred those with mild to moderate depressive

symptoms to lay counsellors for structured counselling based on cognitive-behaviour therapy. The study found clinically significant reductions in symptoms at 12 months follow up. People reported feeling more empowered and better equipped to deal with social issues (462).

Non-specialist counselling can boost the capacity of frontline mental health services and greatly improve care.

In rural Maharashtra, India, the Atmiyata approach uses trained community volunteers to identify, support and counsel community members with common mental health conditions. These volunteers offer problem solving and behavioural activation techniques. They also facilitate access to mental health care and social (financial) benefits, improve community awareness of mental health issues and promote well-being. Atmiyata offers a service that complements the formal health sector. Its approach has promise in improving the acceptability of care as well as reducing disability and improving quality of life and social participation for people with depression and anxiety (463, 464).

Non-specialist psychological counselling programmes can also be used to reach specific groups of people that may be particularly vulnerable to depression or anxiety, including new parents, refugees or people living with HIV/AIDS (see Box 7.5 Friendship benches for mental health). A recent promising innovation is to use a single intervention approach for common problems that cross a range of mental health conditions (transdiagnostic therapy) (465, 466). This approach has been successfully tested with survivors of violence in countries as diverse as Colombia, Ethiopia, Iraq, Thailand, Ukraine and Zambia.



CASE STUDY

BOX 7.5

Friendship benches for mental health

In Zimbabwe, the Friendship Bench project has been integrating mental health into other health programmes for more than 20 years. The project uses problem-solving therapies delivered by community volunteers, known as “grandmothers”, to address “kufungisisa” (which means thinking too much and is a local concept in the Shona language that denotes a range of non-psychotic mental health conditions).

Friendship grandmothers are trained to counsel people for structured 45-minute sessions on wooden benches within the grounds of primary care clinics, where people access services for various medical conditions, including HIV/AIDS, TB, NCDs and NTDs. People are referred to the benches by medical care providers and, after the first session, are invited back by the grandmothers for up to five more sessions. They may also receive home visits, join group therapy or be referred to a specialist, depending on their needs.

The Friendship Bench approach has been shown to significantly reduce symptoms of depression and anxiety compared with the usual standard of care. It is also thought to lead to improvements in

co-occurring health conditions, including adherence to antiretroviral therapy for HIV.

Since 2006, more than 600 grandmothers have been trained through the Friendship Bench. They have delivered free therapy to tens of thousands of people in more than 70 communities in Zimbabwe; and can now also be found in a range of other countries.

The model has also been adapted to be more relevant for adolescents, few of whom engaged in the original project, either because they were not using the primary health care clinics where the benches were or because they were embarrassed about being seen seeking help from a grandmother. The Youth Friendship Bench is designed for 16–19 year-olds and uses psychology and sociology student “buddies” to provide problem-solving therapy instead of grandmothers. Counsellor training is the same but with added focus on topics such as drug use, sex and relationships. Buddies reported managing to create alliances with their clients and say they see their work as meaningful and urgent; but more studies are needed to investigate client experiences.

Sources: Chibanda et al, 2016 (467); Wallén et al, 2021 (468).

Self-help

As mentioned in Chapter 5 Foundations for change, self-help can be guided (when a worker helps the person to use materials) or unguided (when the person receives no support or encouragement). Both specialists and non-specialists can have a role in guided self-help interventions for depression and anxiety. For example, they can facilitate discussions, demonstrate techniques and support people to work through self-help materials; and they can do this face-to-face or remotely.

Self-help interventions help equip people with the tools and tactics they need to discuss and manage any mental health problems as they arise (read [Nour's experience in Chapter 5](#)). They can be delivered rapidly to large numbers of people, making them particularly useful for scale-up (see [Box 7.6 Improving Access to Psychological Therapies \(IAPT\)](#)), including in countries affected by crisis (see [Box 7.7 Step-by-Step: guided self-help for depression in Lebanon](#)).

CASE STUDY

BOX 7.6

Improving Access to Psychological Therapies (IAPT)

Improving Access to Psychological Therapies (IAPT) is a national programme of evidence-based psychological treatments for anxiety and depression in the United Kingdom. Launched in 2008 as a service for adults, the programme has since expanded to include a children and young people's sub-component, including in schools. Receiving around 1.25 million referrals each year, it is by far the largest publicly funded and systematic implementation of evidence-based psychological treatment in the world. The programme has served as a model for developing similar services in Australia, Canada, Japan and Norway.

IAPT adopts a stepped care approach that offers progressively intensive treatments, according to need. People are initially offered low-intensity,

guided self-help based on principles of CBT. The self-help is psychoeducational in nature and is delivered over the phone, via computerized CBT, in large groups or individually. It is delivered by supervised non-specialized helpers called Psychological Well-being Practitioners who provide standardized, evidence-based interventions. Practitioners are guided by associated assessment and treatment competency measures.

People who do not improve after guided self-help are stepped up to receive high-intensity psychological therapies from qualified therapists.

A review of 60 studies found large improvements in depression and anxiety among people attending IAPT services.

Source: Wakefield et al, 2021 (469).

Even unguided self-help books and materials can be useful in scaling up psychological support for common mental health conditions. Research shows that using self-help books can help reduce depressive symptoms in adults, including in the long term (470). Nonetheless, unguided interventions tend to be less effective than guided ones

(471). Computer therapy that delivers CBT for depression and anxiety through the Internet has also been shown to be effective, acceptable and practical for those with good digital access. Guided computer therapy based on CBT provides equal benefits to conventional face-to-face CBT (472).

CASE STUDY

BOX 7.7

Step-by-Step: guided self-help for depression in Lebanon

Step-by-Step is a new WHO digital self-help intervention. It provides psychoeducation through a narrated story and uses interactive exercises to teach people to use therapeutic techniques to reduce their depression. It focuses on behavioural activation combined with stress management (slow breathing), increasing social support and relapse prevention.

When Lebanon faced a series of crises in 2020, the Ministry of Public Health and partners tested a culturally adapted version of Step-by-Step called “Khoutweh-Khoutweh” with Lebanese citizens and displaced Syrians. A guided self-help format was

used. Supervised non-specialist counsellors provided no more than 15 minutes of remote guidance (by phone or through online messaging) each week to people with symptoms of depression. People who completed the programme said it was relevant, acceptable and beneficial (read [Nour’s experience in Chapter 5](#)).

Two large randomized controlled trials suggest that the intervention was effective in reducing symptoms of depression and improving functioning and well-being countrywide. The intervention is now offered by government as a routine service.

Source: Cuijpers et al, in press (472).

7.2 Mental health integrated in health services

Integrating mental health into general health services is a crucial ingredient of mental health reform (473). Integrated care helps to increase access and reduce stigma. It means physical and mental health problems can often be treated simultaneously. It also makes mental health services much more accessible, because general health services are usually closer to where people live. Therefore, integration advances UHC.

Integrating mental health into general health care has been an agreed policy objective since the 1970s (474). It can be implemented in different ways, at different levels and through different services (475, 476).

In the sections that follow we explore how strategies for integrating mental health care can and have been used in multiple settings, including primary care, specific health programmes, and general hospitals.

7.2.1 Mental health in primary care

At primary levels of care, appropriate actions for mental health are listed in WHO's UHC Compendium (see section 5.1.3 Evidence to inform policy and practice) and operationalized through WHO's mhGAP programme (306).

In practice, these interventions can be made available within primary care by expanding the mental health workforce in one of two main ways:

- building the capacity of general health care staff in primary care settings to identify, assess and manage mental health conditions, including in children, adolescents, adults and older adults (see Combining responsibilities for physical and mental health in primary care); or

- developing and embedding mental health care providers into primary care settings (see Adding staff to primary care).

In both cases, collaboration between mental and general health care providers can vary in intensity – from operating independently and simply referring people from one service to another through to working as part of the same team to deliver care at one site, using one treatment or care plan (477).

Integrated care is feasible, affordable and cost-effective.

For most common conditions, integrated care by primary care staff trained in mental health has been shown to deliver better health outcomes compared with usual primary health care (read Amira's experience) (296). It is also feasible, affordable and cost-effective, including in LMICs (478).

But integration is not without difficulty. Some of the most frequently reported barriers include (479, 258):

- stigmatizing attitudes of health workers and the public towards mental health;
- inadequate training and supervision of health workers;
- high workloads among primary care staff;
- low mental health awareness in the community;
- health workers' low interest and motivation for change;
- lack or inconsistent availability of essential psychotropic medicines ;
- disjointed management and leadership for mental and physical health care; and
- limited and inequitable funding.

NARRATIVE

Join us as we spark a renaissance in mental health

Amira's experience

My experience with postpartum depression was severe and painful. Like any mother, I waited impatiently for my first child. But instead of being happy to hold him to my chest, I found myself drowning in sadness, isolation and aversion. At that time the term "mental health" was not used much in Jordan.

I suffered for a long time. My depression became chronic because of my ignorance and the ignorance of those around me. I was exhausted by the psychological pain and made multiple suicide attempts.

I thought the solution to my suffering might lie in psychotherapy. But I was worried about being stigmatized. I decided to visit a private mental health clinic and I wore the niqab, so that no one who knew me would see me. Here I found another type of suffering: high prices and harassment. I couldn't afford the care I needed and experienced relapses and setbacks. Eventually I decided to go a government mental health clinic but even here there were violations of human rights. We were all suffering but no one dared to speak. Recovery was slow.

Then God's mercy descended, my country committed to improving mental health, and mental health care was integrated into a local clinic. I was one of the first people to get it. A multi-speciality team

gave me psychological treatment and community rehabilitation to support me to become an active member of the community.

The clinic specialists believed in our abilities and we were invited by WHO to a workshop on human rights. I was surprised and honoured to get to know a group of people with psychological disabilities like me who were terrorized and stigmatized by society. We decided to establish an association, Our Step, to support the rights of people with mental health issues to be included in the community. Our cause is beginning to see the light of day. We actively participated in the production of Jordan's first national mental health strategy in 11 years.

I have spent more than 15 years advocating and raising awareness of the issues affecting people with mental health conditions. I am very happy to have represented them for the first time on the Board of Trustees of the Supreme Council for the Rights of Persons with Disabilities, after working to amend the Law on the Rights of Persons with Disabilities in keeping with the CRPD, which was ratified by Jordan in 2008.

We have achieved a lot, but much remains to be done to realize the full rights of people with mental health conditions. Don't hesitate. Join us as we spark a renaissance in mental health.

Amira Ali Al-Jamal, Jordan

Heavy workloads can be particularly difficult obstacles to overcome. Primary care workers are often overburdened even before integrating mental health care – which can be relatively time-intensive – into their schedules.

Combining responsibilities for physical and mental health in primary care

The first and most common way of integrating mental health into primary care involves training primary care medical staff in mental health care, so that they can combine their usual physical health care with caring for mental health conditions (see Box 7.8 Integrated primary mental health care in the Islamic Republic of Iran).

Primary care staff need to develop competencies for mental health care through pre-service training, in-service training or both (see section 5.4.2 Strengthening general health care providers' competencies). Even once they are trained, these non-specialists need to be supported by specialist services, whether in general hospitals or through community mental health services, for consultation, quality improvement and, if needed, referrals. In countries where specialists are few in number and widely dispersed, digital technologies can be particularly important for supportive supervision and mentoring.





CASE STUDY

BOX 7.8

Integrated primary mental health care in the Islamic Republic of Iran

For decades, the Islamic Republic of Iran has progressively integrated mental health care into its primary health care system. Starting in 1989, community health workers (locally known as “behvarzes”) were given mental health responsibilities, including active case-finding and referral. General practitioners were trained and supported to provide mental health care as part of their general health responsibilities, referring people with complex problems to psychiatrists and other mental health specialists at district or provincial health centers.

This model worked well in rural areas but was less successful in urban areas, especially in the suburbs of large cities, where health infrastructure and human resources were severely lacking. In 2014, a new framework for integration was adopted specifically focused on overcoming the challenge in marginal urban areas. The new model established two new

types of mental health service providers to work alongside general practitioners.

- “Moragheb-e salamat” serve as multipurpose community health workers. They are the urban counterpart to the established behvarzes and have similar mental health responsibilities.
- Psychologists with a master’s degree in clinical psychology provide mental health services at urban health centers. They are responsible for educating the public for primary prevention, providing psychoeducation to people with mental health conditions and their families, delivering brief psychological interventions and telephone follow-up for those in need, and referring people to social services where relevant.

Evaluations of the new model show it has expanded availability and access to mental health care in marginal urban areas.

Sources: Ahmed Hajebi, Director of Mental Health and Substance Use, Ministry of Health and Medical Education, Islamic Republic of Iran, personal communication, April 2022; Smith, 2020 (480).

Integrated care by non-specialists forms the basis for WHO’s mhGAP roll out, which is being implemented to strengthen skills and scale up mental health care for priority conditions among young people, adults and older adults in non-specialist settings all over the world (see section 5.4.2 Strengthening general health care providers’ competencies) (305). Studies show the initiative improves knowledge, attitudes and confidence among primary care providers after training; and leads to improved symptoms and engagement with care for people living with mental

health conditions (308). It has also been shown to help reduce the treatment gap and increase effective coverage for priority mental health conditions (see Box 7.9 mhGAP in Nepal: closing the treatment gap).

While mhGAP is most often used to scale up mental health care for the general population, it can also be used for specific groups, such as refugees (see Box 7.10 mhGAP in Türkiye: scaling up services for refugees) or youth. For example, in the Islamic Republic of Iran, the mhGAP-IG is being used to

strengthen the skills and confidence of family doctors in child and adolescent mental health so that they can treat priority conditions themselves, rather than refer them to specialist centres.

A humanitarian version of the mhGAP-IG (mhGAP-HIG) also exists and is used widely by international nongovernmental organizations responding to humanitarian emergencies (481). For example, it has been used to scale up mental health care in the fragile and conflict-affected context of Libya (482). Here, the Ministry of Health, WHO, International Rescue Committee, International Medical Corps and other partners

worked together to adapt mhGAP-HIG materials for the local context, engaging stakeholders early on to raise awareness and support for the programme. Non-specialist health workers from 20 primary care facilities received the mhGAP-HIG training; and local psychologists and psychiatrists were also trained in mhGAP supervision and administration to make the programme more sustainable. Once training was completed, mobile units were dispatched and began rotating to fill gaps across various municipalities where services were limited or non-existent.

CASE STUDY

BOX 7.9

mhGAP in Nepal: closing the treatment gap

In Nepal, mhGAP was implemented as part of a comprehensive mental health care plan in Chitwan district. Non-specialists in primary care facilities were trained and supervised to detect, diagnose and begin treatment for priority mental health conditions using the mhGAP-IG. Other strategies in the Chitwan package included awareness raising, active case-finding in the community; evidence-based lay counselling in the community; and strengthening referral, medicine supplies and monitoring mechanisms within services, among other things.

The plan effectively boosted mental health care capacities and increased treatment coverage. After implementing the district plan, the percentage of people in the community receiving treatment increased from 3% to 53% for psychosis, 0% to 12% for depression, 1% to 12% for epilepsy, and 0% to 8% for alcohol use disorder.

The interventions in the Chitwan plan had results. A year after starting treatment, people with depression, alcohol use disorder and psychosis showed improvements in symptoms and daily functioning. Improvements among depressed people were especially driven by the added value of psychological treatment from the community counsellors. For all conditions, combining demand- and supply-side interventions encouraged people to take up treatment and care.

Importantly, people living with mental health conditions, and their care-givers, perceived the primary care-based mental health services provided in Chitwan as accessible, acceptable and effective.

Sources: Jordans et al, 2019 (265); Luitel et al, 2020 (483).



CASE STUDY

BOX 7.10

mhGAP in Türkiye: scaling up care for refugees

In 2021, Türkiye was home to an estimated 3.7 million Syrian refugees living under temporary protection, which entitles them to free essential health care. Refugees are known to be at higher risk of mental health conditions. And yet they are often less likely to access care.

Back in 2016, Türkiye began using mhGAP to train Syrian and Turkish primary care providers to deliver essential mental health care through refugee health centres and community mental health services.

By 2021, nearly 2 600 doctors had been trained across the 29 (out of 81) provinces where large numbers of refugees live. That means around 8% of Turkish general practitioners working in primary care settings

(2 100 people) and more than 50% of Syrian doctors (561 people) have now been trained using mhGAP.

Assessments indicate that more than 95% of the trainees found the training useful and beneficial. The training led to a statistically significant knowledge increase in Turkish and Syrian doctors; and participating doctors were also found to be more attentive to people's mental health needs, resulting in more people with mental health conditions being identified and treated. Most doctors were observed to comply with standards of care defined in training. And 96% of people who received services from the newly-trained doctors said they were satisfied with the quality of mental health care provided.

Source: Kahiloğulları et al, 2020 (484).

The programme has increased workforce capacity and confidence, and has strengthened referral pathways between community providers and health system facilities. It has also helped increase awareness of mental health's importance and has increased access to services for refugees and migrants. More than 1 000 people living with mental health conditions gained access to the services they needed through this initiative in 2020 alone.

Adding staff to primary care

The second way to integrate mental health in primary care is to embed mental health care providers in primary care settings. Depending

on the context and resources available, these additional staff may be child or adult psychiatrists or psychologists, nurses trained in child or adult mental health, social workers, care managers, community workers or other community providers trained in mental health care.

These staff may work full-time in a single clinic (for example, when a care manager or a non-specialist counsellor is added) or they may divide their time across multiple clinics (for example, when a psychiatrist or psychiatric nurse runs fortnightly mental health clinics at different primary care facilities).



CASE STUDY

BOX 7.11

Sri Lanka: adding community workers for mental health to primary health care

In Sri Lanka, the need for and interest in mental health after the 2004 Indian Ocean tsunami led to the creation of a new category of community worker, called the community support officer. Closely connected to the primary health care system, and technically accountable to mental health staff in district hospitals, these community support officers supported thousands of people with mental health conditions living in the community. They were also

responsible for a large proportion of referrals to the hospital-based psychiatric units, accounting for up to three-quarters of all referrals in some districts.

Although the programme was not sustained, an evaluation in 2010 showed that 128 community support officers in three districts were case-managing more than 1 500 people with mental health conditions in the community.

Source: Kakuma et al, 2011 (298).

In addition to adding staff to primary care clinics, countries have added community workers to the health care system to better address mental health. Indeed, primary care facilities can extend their reach for mental health through networks of supervised lay workers in the community (see Box 7.11 Sri Lanka: adding community workers for mental health to primary health care).

Collaborative care

Collaborative care is one specific and well-studied example of the second approach to integration (485). It is a multi-component model of integration with a large body of evidence – including from LMICs – strongly supporting its use in managing depression and other common mental health conditions (17).

In collaborative care models, a health team shares tasks, with a care manager playing a central role and coordinating the care.

For example, in collaborative care for depression, people with depression typically:

- are identified with a validated depression measure (a task often done by the care manager);
- are linked with relevant resources in the community to address any social needs or determinants (also often done by the care manager);
- receive evidence-based psychological interventions (a task in LMICs often done by the care manager or, where available, by a non-specialist counsellor);
- are prescribed medication if indicated (a task done by a general medical care provider); and
- have their depression monitored over the course of their care. This is done by administering the same measure at the beginning of every visit, and recording the results in a simple registry that is regularly reviewed to inform changes to care. Changes potentially include stepping up the intensity of care and specialist referral.



As part of the team-based care, a mental health care specialist regularly advises and supervises the care manager and general medical care provider. In all cases, care plans are tailored to the person's needs and preferences.

Collaborative care has been applied in diverse programmes all over the world. This includes some programmes targeted at integrating depression care within care for specific physical health conditions such as diabetes (486).

Most implementation of collaborative care has been done in high-income countries; but experience with collaborative care in LMICs is growing, including for psychosis (442, 487).

In high- and low-resource settings alike, collaborative care ensures that key social, psychological and medical aspects of care are addressed in a holistic way. And it has been shown to be even more effective and cost-effective than routine integration of mental health in general health care (488). But collaborative care requires additional resources (most notably the care manager's time), which has been a barrier to scale-up.

7.2.2 Mental health in specific health programmes

Integrating mental health in health programmes for specific physical diseases or populations has proven both feasible and cost-effective, improving both mental and physical health (486, 489, 490). Providing care in the same place, by the same practitioner or treatment team and at the same time, greatly helps reduce the logistical challenges of receiving care through two or more systems and enables more holistic, person-centred care. Importantly, it can also help services reach vulnerable people with higher risk of mental health conditions.

Mental health in disease-specific services

People with comorbidities who are supported through integrated care models are more likely to have better health outcomes and to experience better quality of life, self-care and adherence to medical and mental health interventions (476).

Global targets for HIV/AIDS in particular underscore the need to better integrate mental health and social care with HIV services, including those led by communities (491). The opportunities for integration are plentiful – from services targeted at HIV prevention and testing to those for starting and managing treatment to services for viral suppression and care for people living with HIV (166). Development agency guidance for TB care similarly recommends integrating mental health services within TB programmes, from training to treatment (167).

There is plenty of evidence to show that integration, for example through task-sharing with lay health workers, can improve the mental health of people living with HIV; even in extremely remote and disadvantaged communities (492). It can also improve the physical health of HIV-affected communities by reducing the risk and stigma of infection and boosting adherence to antiretroviral treatment.

Integrating mental health into HIV programmes has the potential to avoid nearly a million new infections by 2030.

Incorporating mental health care into TB programmes can be similarly beneficial. In Pakistan, for example, psychological counselling for people attending TB clinics with signs of depression and anxiety has been found to both reduce symptoms and improve TB treatment completion (493).

Research suggests that integrating mental health into HIV programmes has the potential to reduce the rate of infection for HIV by 10–17%, avoiding possibly nearly a million new infections by 2030 (494). For TB the research predicts an even greater decrease (13–20%) in infection rates, with the potential to avoid up to 14 million infections by 2030.

Beyond HIV and TB, there are many opportunities to integrate mental health into disease-specific care, including programmes for NCDs or NTDs (174, 168).

In South Africa, an integrated chronic disease management model has been developed to increase systems efficiencies and cost-effectiveness, and deal with comorbidities (495). The model is supported by Adult Primary Care, a clinical decision support tool that primary care providers can use to deliver comprehensive, quality clinical care to adults in every consultation. The model is innovative in that it enables care providers to treat all chronic conditions – both physical and mental – together. So, for example, rather than running separate clinics for diabetes, hypertension, HIV and mental health, the primary care facility uses routine consultations to provide chronic care for all these conditions at once. For people with comorbidities this approach makes care logically easier; it also enables a more holistic and person-centred approach to their care.

Mental health in population-specific services

Just as mental health can be integrated into physical disease programmes, so too can it be integrated into health services for specific groups, including women, parents and caregivers, children, adolescents and older adults.

Programmes for women's health can offer a discrete way of providing not only reproductive health care but also mental health care to women affected by sexual violence, a highly potent risk factor for mental health conditions. Such programmes are quite often made available to populations affected by armed conflict and forced displacement.

Similarly, perinatal programmes offer a good platform for educating parents and other caregivers about mental health, screening them for mental health conditions, delivering basic therapies and proving peer support (496).

Integrating mental health in perinatal programmes is especially important because maternal mental ill-health is common and impacts both mothers and infants (see section 6.3.2 Protecting and promoting child and adolescent mental health) (497).

Maternal (and paternal) mental health conditions are treatable, including by trained non-specialists through maternal and infant health services (498). For example, in Uganda, trained and supervised midwives screen pregnant women for perinatal depression in maternal care settings; and treat those screening positive with group-based problem-solving therapy given during scheduled antenatal visits. Studies show significant improvement in treated women's clinical and functional outcomes after six months (499).



7.2.3 Mental health in general hospitals

However much mental health services are provided through primary health care, it is essential to have dedicated mental health services at secondary care level. Without these, investments in primary health care are unlikely to be sustainable (258).

Providing mental health in secondary care is a cornerstone for mental health reform.

Providing mental health in secondary care is a cornerstone for mental health reform.

Secondary level services – which may employ both specialists and non-specialists – can be provided through general hospitals (as discussed in this section) or through a range of formal community mental health services (as discussed in section 7.3 Community mental health services).

General hospitals have a multifaceted role in the mental health system, which may include:

- **Outpatient care** to assess and manage people of all ages (including children and older adults) with complex, refractory and severe presentations that cannot be easily dealt with in primary health care.
- **Short-term inpatient care** for people experiencing acute episodes or mental health crises that may benefit from hospitalization. This may be through acute inpatient units or, when resources are very scarce, through psychiatry beds in general wards.
- **Support for non-specialists** in primary care through training, supportive supervision and mentoring.

- **Support for long-term care** of people with chronic mental health conditions living in the community in circumstances where community-based mental health services are unable to help sufficiently.
- **Liaison psychiatric care** for people hospitalized for physical health problems.
- **Mobile teams** to provide outreach or crisis services in the community.

General hospital-based mental health services are usually well accepted by the community. Those in urban centres in large districts may be hard to access for remote communities but they are much more accessible than, and preferable to, psychiatric institutions.

General hospital-based mental health services are more accessible than psychiatric institutions.

Experience shows that it is possible to provide quality mental health care in general hospital settings and that this can complement other community-based mental health services (see Box 7.12 Dominican Republic: putting regional hospitals centre stage). In Brazil, for example, hospital-based services complement local community mental health centres by reserving a limited number of beds specifically for referrals, usually during a crisis situation or because of a comorbidity that requires both psychiatric and medical care. Only staff from the community mental health centre can ask for a bed, which prevents inappropriate use and unnecessary hospitalizations (500).

In Brazil and beyond, countries have shown that hospital-based services can be delivered in a non-coercive way that respects a person's autonomy and treatment preferences and supports them towards recovery (500).

CASE STUDY

BOX 7.12

Dominican Republic: putting regional hospitals centre stage

The Dominican Republic has been reforming its mental health care since 2014. Its mental health plan, which is backed by policy and legislation and overseen by the Ministry of Public Health, has long focused on closing the country's only psychiatric hospital while simultaneously building up a network of community-based services. These include clinical services and support embedded in general health facilities, alongside day centres and supported living services to support psychosocial rehabilitation.

Mental health units within general hospitals play a critical part in enabling the country's plans for mental health reform. These crisis intervention units were conceived to respond to the psychiatric hospital closure, initially for the capital metropolitan area and later expanding to the rest of the country. Today, these units cater for all people with mental health conditions that cannot be easily looked after in primary health care.

The hospital-based units provide:

- crisis services, including beds for short-term stays where needed;
- outpatient psychiatric and psychological care for people who have been discharged from hospital but not yet referred to outpatient services; and
- liaison psychiatry and health psychology with other hospital services.

The hospital-based mental health units are closely linked to both primary and tertiary care facilities, providing the lynchpin for a robust referral system that spans all three levels of care.

Since 2008, the number of mental health units in district hospitals has grown from 9 to 15, with the number of short-stay beds available similarly growing from 76 to 113. Overall, these units make up more than half (53%) of all public sector mental health beds available in the country, compared with 33% in 2008.

Sources: PAHO, personal communication, January 2022; Ministerio de Salud, 2019 (501); WHO, 2021 (454).



7.3 Community mental health services

Community mental health services such as general hospital services are part of the secondary care system and, compared with psychiatric institutions, generate better mental health outcomes (426).

Community mental health services comprise a mix of services that provide clinical care and support, psychosocial rehabilitation and residential services, as described in the sections that follow.

They have a large role in providing outreach services to deliver care and support in people's homes or in public spaces; and to disseminate information about mental health and engage in mental health prevention and promotion.

7.3.1 Community mental health centres and teams

Clinical care and support for people with mental health conditions, including crisis and outreach services, are often provided through community mental health centres or teams, but can also be delivered through drop-in centres. In all cases, community mental health centres and teams may offer links with peer support services (see section 7.3.2 Peer support services).

Community mental health centres

In many countries, community mental health centres are the cornerstone of community-based care. These centres are typically staffed by multidisciplinary teams and need to be well connected with primary care facilities, local hospitals and with organizations beyond the health sector (see Box 7.13 Peru: comprehensive community-based mental health care).



CASE STUDY

BOX 7.13

Peru: comprehensive community-based mental health care

In 2013, Peru's Ministry of Health estimated mental health conditions were very prevalent but few people could access the care they needed. So began a series of reforms to enable mental health care for all. Following progressive legislation to add mental health care coverage to the national health insurance scheme and secure the rights of people with mental health conditions, health authorities have adopted a multi-pronged approach to establish comprehensive community-based care across the country (see Figure).

At the core of Peru's approach lies a network of community mental health centres that has grown ninefold from 2015 to 2021, stretching across every region. These centres are staffed by a multidisciplinary team and serve a population of around 100 000, providing mental health treatment and rehabilitation for adults, adolescents and children. Each one organizes community activities including mental health promotion and prevention initiatives. They also support primary health care providers with training and technical assistance.

The community mental health centres are complemented by 30 specialized units in general hospitals and 55 protected homes (hogares protegidos) that provide accommodation and 24/7 care for people with relatively high support needs or weak family support systems, and for women who are victims of domestic violence. The specialized units in general hospitals offer short-term hospitalization only.

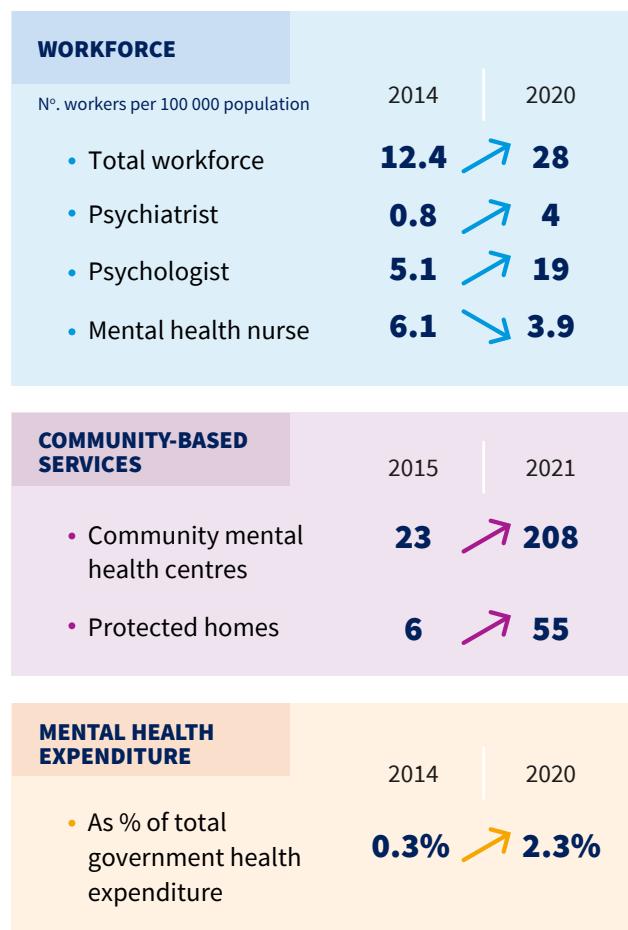
Together, the community mental health centres, protected homes and specialized units in general hospitals ensure that people who would otherwise end up in psychiatric hospitals can be cared for in

their own communities. As such, these facilities play an important part in providing accessible and acceptable mental health care.

The Ministry of Health plans to continue expanding the network to ensure that comprehensive community-based mental health care is available to all.

FIGURE

Expanding mental health care in Peru, 2014–2020.



Source: Ministerio de Salud, 2021 (502). Figure source: Mental health atlas, WHO, unpublished raw data, 2014 and 2020.

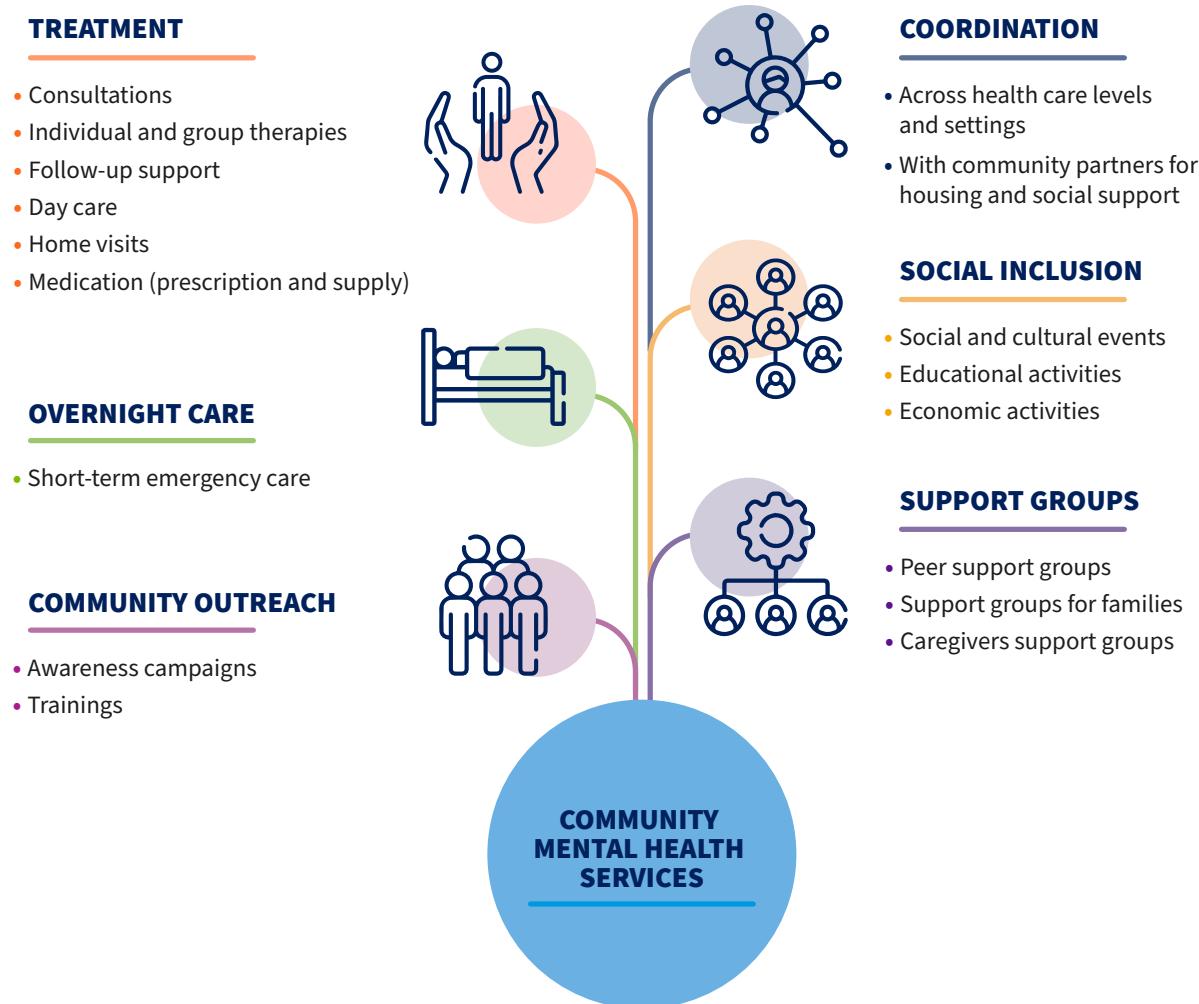
Community mental health centres may cater for a range of mental health conditions in adults, children and adolescents alike. They look different in different countries but often have a multi-faceted role in supporting people (see Fig. 7.4). In community mental health centres people usually receive services for acute episodes or relapses in functioning, and may be admitted for short periods. Individuals may also be admitted as part of respite care. Or they may attend the centre during the day for regular check-ups and to receive daytime

medical or psychological care, or to take part in therapeutic groups and recovery programmes.

Often, community mental health centres also have spaces and activities to support participation in community life (503). In Brazil, for example, each centre includes common areas for socializing, interacting and eating alongside individual counselling rooms and a group activities room. Some centres will also hold activities and events in the community using public spaces such as parks, community leisure centres and museums.

FIG. 7.4.

Examples of services that can be provided by community mental health centres



Community mental health teams

Some countries use community mental health teams to provide community clinical care and support. These teams may work across different facilities, such as general hospitals, primary care clinics or community health centres.

There may be different teams for different age groups. They may provide clinical services in non-health settings such as prisons. And they may provide home-based care if it is needed.

Members of the community mental health team work together to support multiple needs of people living with mental health conditions. They fill the gap between care provided by generalists, as part of primary health care, and hospital care. They can support people to avoid hospitalization during periods of crisis.

Mental health teams can also be providers of specialized early interventions for people in a clinical high-risk state for psychosis, often blending home-based care with inputs from family and friends (see [Box 7.14 Services for people with first-episode psychosis](#)). Specialized early intervention in psychosis is becoming common practice in high-income countries. Experts suggest that these preventive interventions may be adapted for LMIC settings by incorporating the principles and therapeutic ingredients of early intervention into mental health services in LMICs ([504](#), [505](#)).

Depending on resource availability, teams may be large and fully multisectoral, comprising a psychiatrist, psychologist, psychiatric nurse, social worker and occupational therapist, or they may be much smaller and made up of one or two mental health professionals that focus on specific services.

As a specialized and dedicated service, community mental health teams can fulfil various important functions within a community-based network of services. Some of the roles they have may include:

- training, supervising and supporting non-specialist primary health care providers;
- delivering clinical interventions for people who are experiencing conditions that are too complex to be cared for in primary care, but that do not necessarily require hospitalization; and
- carrying out preventive and promotive activities in their area.

In some countries, where primary health care is run by nurses who are not allowed to prescribe psychotropic medicines, an important function of community mental health teams may be to provide initial assessment and prescription services that can prevent hospital visits (see [Box 7.15 Community mental health teams in Georgia](#)).





CASE STUDY

BOX 7.14

Services for people with first-episode psychosis

Over the past three decades, evidence-based early psychosis prevention and intervention programmes for adolescents and young adults experiencing a first episode of psychosis have emerged. Starting in Australia, a range of early psychosis services have been launched in high-income countries worldwide. Such services are typically available 24 hours a day, seven days a week, with referrals from any source and a single telephone contact point.

The first phase of care involves a face-to-face assessment of the young person. The meeting is usually in the young person's home and includes inputs from family, friends and other supports to try to understand what is happening and what kind of support the young person needs.

A multidisciplinary team then provides intensive, home-based case management. Caring at the person's home means friends and family can help the young person as needed, with mental health professionals providing regular support.

Source: Orygen Youth Health, 2021 (506).

Psychosocial interventions vary according to the person's needs. For example, as recovery progresses, counselling can help the young person learn practical ways to prevent further episodes, such as by managing stress and recognizing early warning signs. Treatment also involves working with the person to identify what is important to them in their recovery. This can mean returning to school, getting a job, finding accommodation, getting financial help, or making new friends. One-to-one counselling, group activities and activity-based therapies are used to help achieve these goals.

Although the focus is on community services, spending some time in hospital during an episode of psychosis before continuing with home-based treatment is sometimes part of the care. Overnight care is provided in a youth-friendly setting and in most instances is only short term.

Community mental health teams are usually mobile so that they can reach out to diverse facilities within an area. This generally takes some of the financial burden away from the user and so encourages people to engage in ongoing care.

This is particularly important in more rural areas where, for example, access to the local clinic may be relatively easy while access to the nearest hospital may be too difficult or costly to consider.

Services provided by community mental health teams are not necessarily available all day every day, which may be inconvenient to some people; although they can be provided on an appointment basis for regular, set days.

Having community mental health teams can substantially reduce the number of people needing hospital care, and putting resources into this level is often cost-effective and helps hospitals from being overwhelmed.



CASE STUDY

BOX 7.15

Community mental health teams in Georgia

In Georgia, community mental health teams provide specialized secondary level services designed to care for adults with severe mental health conditions close to where they live.

Each team accepts referrals from outpatient mental health centres, after a person has been diagnosed with a mental health condition, and if that person meets certain criteria (i.e. several past hospitalizations). The teams then provide a range of treatment and rehabilitation services.

Across the country there are 32 community mental health teams in operation, serving 28 locations. The teams work out of mobile clinics and provide mental health care to adults (aged 18 years or more) based on informed consent. People attend the mobile clinics to consult a psychiatrist, review and receive prescriptions for psychotropic medicines where appropriate, receive basic psychoeducation and access psychosocial support in solving social issues.

Georgia's community mental health teams are multidisciplinary in nature and comprise at least three specialists. One member of the team is a team leader who carries out overall supervision of the working process. A psychiatrist is a necessary member of the team while other team members may include social workers, psychologists, nurses or junior doctors.

From 2015 to 2022 the number of community mental health teams in Georgia increased from 3 in Tbilisi to 32 across different districts. As a whole, the network of community mental health teams includes 33 psychiatrists and 66 allied mental health practitioners working to provide community-based mental health care to Georgia's population of more than 3.7 million people.

This growth was made possible by the Health Ministry prioritizing community-based mental health care, including a twelve-fold increase in budget allocation for community mental health teams.

Sources: E Chkonia, G Geleishvili and N Makhashvili, Georgia, personal communications, 2021–2022.



Often one member of the team will take on the role of care coordinator or case manager, working with individuals to codevelop care plans.

The teams can boost people's uptake of, and satisfaction with, mental health services. They increase continuity and flexibility of care. And people cared for by the teams are significantly less likely to be admitted to hospital or to use social services than people accessing standard mental health care (507).

Community mental health teams usually operate within a defined geographical area and are equipped to provide a broad range of interventions.

In some high-income countries, specialized teams have been developed as an additional service to achieve specific goals or reach specific groups. For example, many European countries use assertive community treatment (ACT) teams to provide specialized mobile outreach treatment for hard-to-reach children



and adolescents living with severe mental health conditions (508). Research suggests that these active approaches can reduce hospital admissions as well as improving symptoms and general functioning of both adults and youth with severe mental health conditions (509).

Crisis services

Mental health crisis services are designed to support people experiencing acute mental health needs, either because of a suddenly deteriorating mental health condition or because of a new need for urgent help. They are largely provided through community mental health centres and teams and may include daytime emergency care or overnight stays at a facility (including for respite). They may also be offered through specialized units in general hospitals. For example, in the Dominican Republic, crisis services that include short-term stays where necessary are provided at both regional hospitals (see Box 7.12 Dominican Republic: putting regional hospitals centre stage) and referral hospitals.

In some countries, crisis houses and safe havens in community settings provide an additional option for people who do not want to go to hospital. Crisis houses usually offer intensive treatment and

overnight accommodation in a small number of beds. Safe havens do not necessarily have beds but are open overnight as supportive places for people to go during a crisis. Some crisis houses and safe havens are open to anyone experiencing acute mental health needs; others are designed for specific groups, such as homeless women or adolescents at imminent risk of suicide.

In some countries, people can also access expert advice and support during a mental health crisis without having to leave home. Sometimes this is because home treatment teams are available to provide rapid assessment, support and intensive care in a person's home. This type of treatment minimizes disruption to a person's life and considers ways in which family and social networks can help the recovery process, particularly for children and adolescents.

In most countries, crisis services provided by specialists are complemented by 24-hour helplines that are usually staffed by trained and supervised volunteers who can refer people needing additional help to professionals (see Box 7.16 Malaysia: helplines for mental health).

CASE STUDY

BOX 7.16

Malaysia: helplines for mental health

In Malaysia, the government and nongovernmental organizations run multiple helplines to provide psychological support during a mental health crisis.

Befrienders hotline. Befrienders provides free emotional support from trained volunteers 24 hours a day, 7 days a week, to anyone feeling lonely, in distress or despair, or having suicidal thoughts.

Lifeline counselling. Lifeline Association Malaysia offers free counselling by trained volunteers face-to-face, over the phone or by email. All counsellors receive supervision and support; and volunteers with more than three years' experience play a large part in training new recruits.

Survivor hotlines. The Women's Aid Organization (WAO) and All Women's Action Society both provide free and confidential crisis services, including phone or online counselling, to survivors of violence. During the COVID-19 pandemic, WAO provided more than 7 100 consultations via phone, SMS and email.

MHPSS hotline. In partnership with Mercy Malaysia, the Ministry of Health established the MHPSS hotline to support people coping with the impacts of COVID-19. It is staffed by a mix of ministry counsellors and trained lay volunteers. From January to June 2021, the hotline received more than 122 300 calls asking for support. Around 90% of these were related to social problems such as unemployment, loss of income, and family-related issues.

Sources: AIA Malaysia, 2021 (510); Kaos, 2021 (511).

Supporting the transition from adolescent to adult mental health care

Standard mental health care is usually provided via two discrete systems, child and adolescent mental health services (CAMHS) and adult mental health services. In most LMICs, child and adolescent mental health services are much less available than adult ones (512).

In most countries, the upper eligibility limit for child and adolescent services is around 16–18 years, after which a young person with ongoing needs may be obliged to transition to adult services. A significant weakness in overall service provision is that this transition is far from fluid. Where referral pathways between

the two systems are imperfect, people can drop out or fall between the two sets of services. Some young people, although unwell, may not meet the eligibility thresholds for care by adult services. Moreover, youth often experience a dramatic difference in care when transitioning from child and adolescent to adult services.

The transition from child and adolescent to adult mental health services is often far from fluid.

In response, there has been a growing movement to develop integrated community-based hubs providing uninterrupted services for adolescents and young adults (usually 12–25 years).



CASE STUDY

BOX 7.17

Headspace: no wrong door for young people in Australia and Denmark

Headspace started in 2006 in Australia, to address the gap in mental health services for young people aged 12–25 years. There are now more than 100 Headspace centres in Australia and 28 in Denmark.

Local young people help design each centre and the services it provides. And each centre is deliberately located near public transport hubs for easy access. Mental health professionals at the centres provide evidence-based psychological care; and young

people can also access physical and sexual health services, and work and study support.

A key feature of Headspace is the “no wrong door” policy. This means that young people can refer themselves or be referred from any service. All centres routinely report data to a national database that is used to monitor and evaluate service activity and outcomes and inform continuous improvement.

Sources: Headspace, 2021 (513); Rickwood et al, 2019 (514).

In addition to mental health services, these hubs often deliver other health and social services in a single community-based setting (see Box 7.17 Headspace: no wrong door for young people in Australia and Denmark). They are sometimes referred to as “one-stop services”.

efficacy for these services across a wide range of mental health conditions and intervention types.

Peer support services are not regulated and come in many different shapes and sizes and may be offered at different levels of health care. They may be self-help groups of peers that meet face-to-face to exchange psychosocial support (read [Dixoni's experience](#)) or plan local advocacy activities (see Box 7.18 Kenya: USP-K peer support groups) (509). They may be online therapy groups that are led by a trained peer. Or they may be a mentoring or befriending service that connects people on a one-to-one basis (312). In all cases, the aim is to support people on their chosen path to recovery in a way that protects confidentiality and is free from judgment and assumptions.

Peer supporters are similarly varied. They may be staff hired by mental health services, advocates appointed through a peer-led network, or volunteers with lived experience. In all cases

7.3.2 Peer support services

Peer support services in mental health care are about people using their own experiences to help each other – by sharing knowledge, providing emotional support, creating opportunities for social interaction, offering practical help or engaging in advocacy and awareness raising. A systematic review of 30 randomized trials found that these services may be effective for clinical and personal recovery from mental illness (Dorien Smit, Pro Persona Mental Health Care, unpublished data, March 2022). Effects are modest, though consistent, suggesting potential

NARRATIVE

Gratitude and generosity is my cure

Dixoni's experience

I have three siblings. My mother and father were of a different tribe, kind but very reserved. There was no closeness. Going to school was difficult for me. It was noisy and boisterous, and I was bullied. To avoid attention I could not handle, I became invisible. At the coming of age, I began to be what I call “screwed up”. I found it difficult to move out in the world and I did not know what was happening to me. I felt I had lost my soul.

For years, I was very unwell. One week down, then high for a while, anxious for a few days, then not sleeping. My emotions were all over the shop. I was in soul pain. A few of my friends from college died by suicide. I tried it once myself. I was hanging in there.

Then my luck changed. I started a new medication and started seeing my college psychologist for guidance and counselling. Soon I was feeling a lot better. Now I'm quite well although I still get nervous with people. It takes a long time for your self-esteem to grow.

Today I live happily on my own. I attend GROW, a self-help peer group where I get friendship and support. I take an interest in spirituality. Being at the bottom actually helped me see that there are things more important than the rat race.

I have found that gratitude and generosity is a cure for me feeling miserable and small. I am beginning to like myself.

Dixoni Emmanuel, United Republic of Tanzania

they are experts by experience and can draw on their first-hand knowledge to connect with and relate to people experiencing mental health conditions. Peer supporters can serve as compassionate listeners, educators, coaches, advocates, partners and mentors.

In many cases peers may share characteristics not directly related to mental health, such as age or ethnicity, that can help people feel more comfortable and confident about seeking help. For example, in the Michigan Peer-to-Peer Depression Awareness Programme in the United States, which

aimed to support early detection and treatment of depression in school settings, students acted as peer advocates (515). They designed and implemented depression awareness campaigns to help create a supportive school environment and to connect their peers with appropriate resources, information, and venues for mental health care. One year after the programme, students reported feeling more comfortable and confident speaking to their peers about mental health issues; and said they were more likely to ask for help if they had symptoms of depression.

CASE STUDY

BOX 7.18

Kenya: USP-K peer support groups

The Users and Survivors of Psychiatry in Kenya (USP-K) is a peer-led national membership organization that works to promote the rights of people with psychosocial disabilities. As part of its activities, USP-K runs community-based peer support groups where people with lived experience can come together to share their stories, give each other psychosocial support and discuss specific issues, for example, crisis response strategies or local livelihoods.

Since launching its first peer support group in Nairobi in 2012, USP-K has developed a network of 13 groups across six counties in Kenya. Each group is run by a group-appointed peer and meets regularly, with

20–35 people attending each meeting. Each group also has two-way links to local health facilities through a community health or social worker that forms part of the group and through a strong referral system in which mental health professionals can refer individuals to the peer support groups.

USP-K estimates that in total its peer support groups have given more than 200 people access to mental health services within their community. The organization further reports that the peer support groups have reduced stigma and discrimination, empowered members to self-advocate and enhanced overall well-being and independent living.

Sources: WHO, 2021 (438); USP Kenya, 2021 (516).



7.3.3 Psychosocial rehabilitation

Just as clinical care is a key component of community mental health services, so too is psychosocial rehabilitation, which involves a set of activities focused on improving functioning and reducing disability for people with mental health conditions (517). Community-based psychosocial rehabilitation supports people to achieve their optimal functioning and inclusion in the community. It involves both improving people's competencies and making environmental changes so that people with mental health conditions can live a productive and satisfying life in the community.

Person-centred, recovery-oriented, human rights based support is essential (see [section 7.1.1 Putting people first](#)). And ensuring the availability of psychosocial rehabilitation activities in the community is not just important for successful deinstitutionalization, but also to address people's needs for social inclusion and independent living, in line with their will and preferences.

Community mental health centres and teams have a large role in supporting psychosocial rehabilitation through a mix of routine, outreach and livelihood activities. These may include things such as peer group discussions, independent living and social skills training, housing support, education and vocational assistance, activities that strengthen social support networks, and leisure

activities. Providing support to access health and social services such as housing or welfare benefits is also part of psychosocial rehabilitation.

Community-based psychosocial rehabilitation is often delivered in partnership with nongovernmental partners. It may be provided through day-care centres or "clubhouses" run by civil society organizations (see [Box 7.19 Fountain House: clubhouses for recovery](#)). Clubhouses may include specific programmes to tailor support for different age groups. For example, programmes for young adults (18–25 years of age) may focus on encouraging autonomy and independence and offer support in applying for jobs, accessing further education and finding their own place to live. Programmes for older adults on the other hand may focus on reducing social isolation and supporting friendships and social connections, including by overcoming transportation barriers and building confidence in using technology for staying connected.

Psychosocial rehabilitation may also be provided through other models of task-sharing with non-specialists and community providers drawn from local communities. Experience shows that involving local communities in delivering community-based rehabilitation can complement specialist services and improve access, equity and acceptability of interventions (see [Box 7.20 Living with psychosis: three tiers for community-based rehabilitation](#)) (518).





CASE STUDY

BOX 7.19

Fountain House: clubhouses for recovery

For more than 65 years, Fountain House has been supporting people with severe mental health conditions through its pioneering clubhouse model of psychosocial rehabilitation. Clubhouses are organized as a support system for people living with mental health conditions, rather than as a formal service or treatment programme.

What began as a social club in New York City in 1948 has evolved into a global network of more than 300 clubhouses in more than 30 countries, including Argentina, China, India, and Russia. Each clubhouse is founded on the belief that everyone can recover from the effects of mental health conditions enough to lead a personally satisfying life in the community. To that end, each clubhouse provides a blend of basic health and social services that not only aims to meet basic needs but also emphasizes individuals' goals and aspirations.

Clubhouses are recovery-oriented participatory communities, where members and staff work together to maintain day-to-day operations.

Together, they run activities aimed at supporting members to return to school or work, access community-based housing, promote wellness, reduce hospitalizations and improve social relationships. In all cases, members choose when and how to participate.

Close partnerships with the health system enable clubhouses to influence and drive the quality of health care offered to people with severe mental health conditions and to ensure person-centred care that traverses health and social needs.

Fountain House clubhouses are effective at promoting employment, reducing hospitalizations and improving quality of life. They can also help improve educational attainment and create a greater sense of community, translating into higher ratings of self-empowerment and self-confidence for members. For young adults, clubhouses can help bridge the gap between child and adult mental health care, continuing support into later life if needs be.

Sources: McKay et al, 2018 (519); Pardi et al, 2018 (520).

CASE STUDY

BOX 7.20

Living with psychosis: three tiers for community-based rehabilitation

In remote and rural India, a tiered approach to community-based rehabilitation has offered a feasible and effective model of care for people living with chronic schizophrenia, bipolar affective disorder and other psychoses.

The approach, which was applied in partnership with local nongovernmental organizations Ashagram Trust, comprised three tiers of service delivery.

- Outpatient clinics, where a psychiatrist conducted clinical reviews, prescribed psychotropic medications and, working with a psychologist, provided psychoeducation and family counselling.
- Community health workers, who were trained to provide psychoeducation and basic psychosocial interventions for improving personal care, linking people to general health and job opportunities and

improving social inclusion by enhancing social and political participation.

- Families and village health groups (samitis), who help strengthen social networks and promote social and economic participation, including by providing access to micro-credit.

The approach has been applied in four blocks (sub-districts) of India and in each case was found to be effective in overcoming barriers to care, leading to better treatment adherence, reduced disability and improved social inclusion. In Pati, where the tiered model of care was evaluated four years after starting, more than 80% of participants were found to have taken part in community activities such as weddings and community festivals. Most had also exercised their rights as citizens by attending village council meetings and voting in village elections.

Sources: Chatterjee et al, 2003 (521); Chatterjee et al, 2009 (522).



7.3.4 Supported living services

Where feasible, supported living services (or supported housing) are another important component of community mental health services. They serve a small minority of people living with mental health conditions, specifically those who have complex, long-term needs.

For these people, supported living services help avoid hospital care (454). They are also a crucial support for many long-term residents once they are being discharged during deinstitutionalization (read [Alejandra's experience](#)).

In Brazil, the deinstitutionalization strategy includes two complementary services to address housing needs of former long-term residents:

- the Therapeutic Residential Service, which comprises houses for up to eight people located in urban spaces; and
- the De Volta para Casa programme, which provides financial support for assistance, follow up and resocialization outside the hospital.

Today in Brazil, more than 4 000 people who were hospitalized for long periods are living with their families or in residential therapeutic services and receiving benefits from the De Volta para Casa programme, while being monitored by community-based mental health services (523).

Importantly, just as levels of dependency among people living with mental health conditions differ, so too do the levels of support provided through supported living services.

Sometimes all people need is the physical infrastructure to live independently – either on their own or with others in similar situations. But sometimes people require additional layers of support to help with health needs (including mental health), drug and alcohol use, managing benefits and debt, developing daily living skills or accessing education, training and employment.

Some countries use personal health budgets to help ensure that the additional support provided meets individual priorities. Personal health budgets do not represent new money; rather they are a different way of spending health funding to meet the needs of an individual. They can be used for a selection of things such as therapies, personal care or equipment. An evaluation of personal health budgets in the United Kingdom found that they significantly improve people's quality of life and well-being and are cost-effective (524).

The range of residential services needed and feasible in any given area will depend on what other resources and services are available locally, and on diverse sociocultural factors, such as how much family care is usually given. This means that supported housing schemes should consider a mix of facilities that may include, among other things:

- social housing, with priority access reserved for people living with mental health conditions;
- hostels that offer short-stay accommodation with supervision;
- rehabilitation centres that offer short-term stays, with group or individual therapy;
- residential care homes offering clinical and social support; and
- group homes where people with varying needs and abilities live together and offer each other peer support. Rent in group homes is usually subsidized and residents are usually also supported by a multidisciplinary team of health and social workers (see [Box 7.21 Home Again: group homes for women in India](#)).

In all cases, to avoid (re-)creating institutional environments (known as transinstitutionalization), any supported housing facilities that are established should be small in scale, sufficiently resourced, and well-monitored (488). They should promote independent living and respect people's rights, including the right to choose where and with whom to live (525, 526).

NARRATIVE

A society that embraces well-being fully works better



Alejandra's experience

I have lived a life of emotional instability and wrong decisions. At age 39 I got a schizoaffective disorder, but I only recently received effective treatment (at 44 years of age). During my hospitalization, my father died and I was abandoned in the hospital. I agreed to go to a protected home (hogar protegido) to get support and so reinsert myself in society in a productive way.

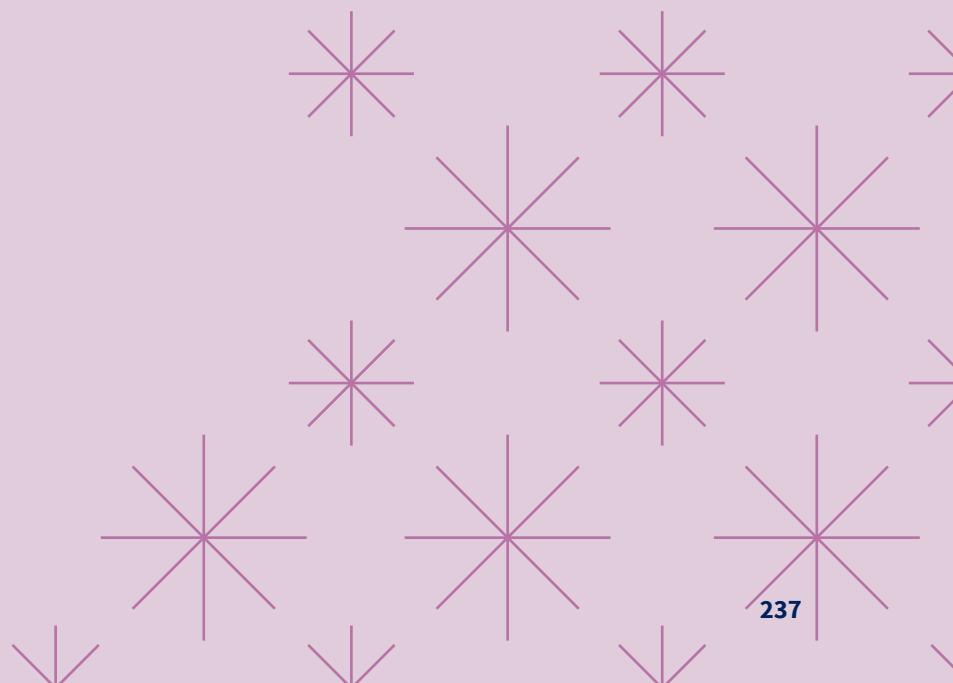
The protected home is part of a social inclusion project for people with mental disorders. In each home, there is a trained member of staff who supports us in our personal development and practical needs, and together we form a family, which gives us encouragement and confidence. For me, the home provided a base of support and emotional security on which to rebuild my life healthily. It is encouraging to get support like this, and it gives me a lot of hope for personal fulfillment, and confidence in life. Now I am working while I still live in a protected home.

I believe that disseminating information on mental health is very important. Information gives us the power to generate change. It helps raise awareness in society to prevent mental health conditions or identify them early, and to create empathy and social inclusion. Information makes us freer – a human aspiration. And it helps guarantee individual rights to information, health, and a decent job and life.

It has been difficult for me to get work, but starting over takes time. Mental disorders are not isolated problems, or a consequence of some specific family dynamics. They are social problems that involve us all as a community. United we are stronger. Investing in mental health is betting on the future because a society that embraces well-being fully works better.

Mental health is our treasure, our identity, what makes us unique.

Alejandra Rivera, Peru





CASE STUDY

BOX 7.21

Home Again: group homes for women in India

Home Again is a housing intervention with supportive services for homeless women in India living with long-term mental health conditions.

Run by nongovernmental organizations The Banyan, Home Again provides shared housing in urban and rural spaces where four to five women live together in home-like environments, with a mix of work, leisure and social activities that are facilitated by a multidisciplinary team of service providers. Each house is also home to a community worker trained to provide basic psychosocial and medical care.

In 2019, 245 women received support through 50 houses in the states of Tamil Nadu, Kerala and Maharashtra.

Home Again has been shown to improve community functioning, reduce social distancing between women living with mental health conditions and other community members, increase participation in the workforce and reinforce experiences of hope and interdependence.

Source: WHO, 2021 (527).

Traditionally, supported housing schemes for homeless people with mental health conditions adopted a treatment first approach in which people had to be treated and sober before being housed; or had to prove their ability to live independently by graduating through different housing services before accessing permanent accommodation.

But since the early 1990s, especially in high-income countries, these traditional models have given way to a rapid re-housing approach known as “housing first”, which gives people experiencing chronic homelessness with co-occurring mental health conditions immediate

access to stable and affordable housing without prerequisites; and couples it with flexible support services tailored to individual needs (528). In all cases, the housing first approach is designed to provide choice and control, giving rights and responsibilities back to people who may have been repeatedly excluded.

There is evidence that a housing first approach improves housing stability and reduces homelessness and hospitalization (529). There is also evidence to suggest that it reduces the use of responsive services for emergency health, emergency shelter and criminal justice (530).

7.4 Mental health services beyond the health sector

As emphasized throughout this report, health care alone is often not enough to meet all the needs of people living with mental health conditions, especially those living in poverty or without housing, education or the means to generate an income. This means that other sectors have a key role in complementing any mental health services provided by health sector. So too do a wide range of community providers (for example, volunteers, women's groups and traditional midwives) that may provide psychosocial supports (see section 7.1.2 A mix of services and supports: Beyond formal services).

Transforming mental health services means taking a multisectoral approach by embedding services for people with mental health conditions into the policies and programmes of all relevant sectors, including livelihoods support, housing, education, vocational training, employment, social welfare, and legal support. A whole-of-government approach is needed.

In practice, formal mental health services beyond the health sector can be divided into two broad types.

- Clinical care services are delivered in non-health settings, including schools, prisons and women's shelters.
- Social services provide support to people living with mental health conditions to ensure inclusion and fulfil basic needs, including social housing, education, employment and social benefits.

7.4.1 Mental health care in non-health settings

Mental health activities in non-health settings are largely focused on mental health promotion

and prevention activities (see Chapter 6 Promotion and prevention for change). But in some cases, mental health services may include services to identify and provide basic treatment for mental health conditions.

Early detection and intervention in schools

Schools offer a strong platform for early identification and treatment of mental health conditions in children and adolescents because they operate where most school-going children are, have access to families, are free at point of use and overcome typical access barriers such as inconvenient location, costly transport and stigma. There is much impetus for the educational system to offer this platform as there is strong evidence that investing in mental health improves educational outcomes (531, 532).

Mental health should be part of school health services.

The potential role of schools in safeguarding student health and wellbeing is well-recognized in WHO's Global School Health Initiative and in WHO and UNICEF's HAT initiative (see section 6.3.2 Protecting and promoting child and adolescent mental health).

WHO's recent guidelines for school health services state mental health should be part of school health services (533). The guidelines recommend that school health services should be capable of early identification for referral and support for a range of mental health conditions as well as for stress. The guidelines also recommend that the services conduct crisis counselling and counselling for substance use; and that school health services support policies on bullying and health promotion.

CASE STUDY

BOX 7.22

REACH: community-based partnerships to improve youth mental health

Since 2007, the Response, Early Intervention and Assessment in Community Mental Health (REACH) initiative in Singapore has provided front-line support to students with mental health conditions by establishing regional multidisciplinary and intersectoral networks of care.

School counsellors are trained to identify emotional, social and behavioural issues and refer students to a mobile case management team of REACH clinicians for assessment and intervention. REACH teams comprise a mix of doctors, psychologists, medical social workers, occupational therapists and psychiatric nurses. Although mobile, the teams are based in a regional hospital to ensure a continuum of care in case further specialist services are needed.

Between 2007 and 2015, school counsellors referred more than 4 000 students to REACH teams.

REACH continuously builds clinical competencies among the hospital-based teams, through regular supervision and trainings on evidence-based interventions. The initiative also works to increase knowledge and clinical capacity within the community, through targeted training and outreach activities around youth mental health issues.

School professionals, social service organizations and others are trained on specific mental health conditions and intervention techniques (including for depression, suicide and gaming); and on how to support youths whose caregivers are experiencing mental health issues.

Source: Lim et al, 2017 (534).

School-based counselling can be used as a preventive intervention for children with emerging signs of mental health conditions; for assessment purposes; as an early intervention; or as parallel support alongside specialist mental health services. All counselling aims to provide young people with an opportunity to discuss their difficulties in a supportive environment and to find their own ways of addressing their issues. Counselling may include family or group work. School-based counsellors may also link children and their families with social and specialist services (see Box 7.22 REACH: community-based partnerships to improve youth mental health).

Mental health care in the justice system

Prisoners are much more likely to have a mental health condition than the general population. Before incarceration, they are more likely to have been exposed to adverse social circumstances that are risk factors for mental health conditions as well as for crime. And once in prison, people may be subjected to social isolation, poor living conditions, physical or sexual assault or psychological abuse, which further elevate the risk of mental health conditions.

Around 70% of the world's prison population – more than seven million people – are based

in LMICs, where most people in the world live. Researchers estimate the rates of non-affective psychosis and depression among these prisoners are 6.2% and 16.0% respectively, which is respectively 16 and 6 times higher than the rates among the general population (535). Adolescents in the juvenile justice system are similarly much more likely to experience mental health conditions than those in the general population, with an estimated 70% having at least one diagnosable mental health condition (536).

Prisoners are much less likely to have their mental health needs recognized and to receive the care and support they need.

Even though severe mental health conditions are much more prevalent in prisons, prisoners are much less likely to have their mental health needs recognized and to receive the care and support they need. In some low-income countries, where mental health services are particularly lacking, prisons can end up being used as a place where people who are deemed to be out of control due to acute mania or psychosis are brought and held without trial, often in horrific living conditions (537). In many countries, people that could easily be diverted into mental health care are tried and imprisoned, even for very minor crimes.

People who were tried for a crime and found not guilty because they have a mental health condition often suffer human rights violations. In some jurisdictions, these people are kept in prisons without adequate care and support, while in others they may be transferred to a forensic psychiatric hospital (or section) where they are often treated like prisoners, with severely restricted freedoms. Discharge is often difficult or erratic and people are often kept for far longer than any sentence they may have received for the criminal act they were accused of (538).

In all countries, trying to navigate the criminal justice system with a mental health

condition can be extremely difficult and distressing (read [Laura's experience](#)).

Addressing mental health needs in the criminal justice system benefits prisoners, prison employees and the wider community. It can be achieved in multiple ways, depending on local needs and contexts.

For example, in some high-income countries, liaison and diversion services, or street triage services have been developed to identify people with possible mental health conditions when they first come into contact with the criminal justice system. These services are then used to support people through early stages of the criminal system, refer them for appropriate health or social care, or divert them away from the criminal justice system towards more appropriate settings.

Other proposed strategies for improving mental health care in the criminal justice system include integrating mental health into general health services available to all prisoners. An example might be implementing the mhGAP programme with supportive supervision by mental health professionals (539). Training employees at all levels of the criminal justice system on mental health issues can also help raise awareness, challenge stigmatizing attitudes, and encourage mental health promotion for both staff and prisoners.

7.4.2 Key social services

Social services need to be part of action to transform mental health.

People with severe and chronic mental health conditions are often excluded from social and economic opportunities such as child protection, housing, employment, education and state benefits. This puts additional burdens on families and communities and impedes rehabilitation and recovery. Complementing health interventions with key social

**NARRATIVE**

Navigating the criminal justice system with a mental health condition



Laura's experience

In the Spring of 2015, there were eight warrants out for my arrest. My crimes were misdemeanours, and several warrants were compounded charges resulting from a failure to appear in court. I was petrified to go to court alone and equally scared to not show up. I could barely keep the time of day. Eventually I was hospitalized. On discharge, I returned to a shelter and began to get help.

I retained an attorney. I went to court. I paid fines. This could easily have broken me were it not for the help and support of friends and family. At my final court hearing, I found out I might spend six months in jail – for stealing a grilled cheese sandwich from a hospital cafeteria while homeless. This was the most frightening experience.

The fear I experienced navigating the system while mentally unwell impeded my recovery and re-entry into the community. Nights spent homeless, fending for food and safety, created a devastating cycle of despair.

My journey is not uncommon among people like myself with behavioural health conditions. Too often we are found in the grips of the criminal legal system for infractions that could be considered minor. This can cause great pain to ourselves, our families and friends; and has long-term impacts on our ability to rent housing or get employment.

Today I struggle to understand what happened and why. Is taking a sandwich the result of hunger or mental illness? Some people call my crimes “homeless crimes.” I’d agree they are borne out of this experience, but I was also unwell: there is a fine line between homelessness and mental illness.

I am now no longer on probation and I’ve successfully completed 80 hours of community service. I feel like a weight has been lifted. Instead of worrying about legal issues I am working to change behavioural health care policy in coalition with others. The fresh start feels good, and I am hopeful.

Laura Van Tosh, United States of America

services can enable people with mental health conditions to achieve their recovery goals and live a more satisfying and meaningful life. On paper, the responsibility for providing these social services lies beyond the health sector. But in practice the division between mental health and social services is blurred. Supported living services, for example, may be run by authorities or nongovernmental organizations in the health or social sector.

Complementing health care with social services enables people with mental health conditions achieve their recovery goals.

Many other public and private community mental health services that are discussed above, in section 7.3 Community mental health services, also support access to key social services. Community mental health centres and teams in particular often work with community partners to provide social support and facilitate access to social benefits. Like clubhouses and other psychosocial rehabilitation organizations, they may also offer supported employment and education schemes.

As argued throughout this report, addressing social problems is part and parcel of transforming mental health. In terms of service uptake, social care sometimes needs to be provided as a first step of mental health care. For example, depressed survivors of ongoing intimate partner violence will often urgently need safe accommodation, financial aid, identity papers and livelihood and legal support, among other things (540).

Addressing the social needs of people with mental health conditions is especially important in emergency settings, where they are especially vulnerable to risks such as abuse and neglect and require priority access to protection, social support and clinical care.

International guidelines on MHPSS emphasize the need to link services for people with mental

health conditions in humanitarian settings with other community-based supports (541, 542). These include programmes for shelter, food, water and sanitation, education as well as specific support for survivors of sexual and gender-based violence.

Child protection

Exposure to adversity during childhood is a major risk factor for mental health conditions (see section 2.2.2 Risks undermine mental health), as well as a wide range of other health and social issues. An effective child protection system is critical to prevent and respond to all forms of violence against children, including exploitation, abuse and neglect.

Effective child protection requires a comprehensive, multistakeholder approach that can tackle the root causes of violence and abuse. WHO and partners advocate a seven-pronged strategy (INSPIRE), which includes not only preventive measures for all children but also response and support services for both victims and juvenile offenders (337).

Basic health services, such as emergency medical care for violence-related injuries and clinical care for victims of sexual violence, must be in place and guidance on clinical care for victims of sexual violence should be applied. Psychological counselling to victims and perpetrators may break the cycle of violence and help them better cope with and recover from any mental health consequences. The range of services and supports to be considered includes: linking identification of child maltreatment to access to mental health care and psychosocial supports; case management; psychological counselling based on cognitive behavioural therapy; specific programmes for juvenile offenders; and foster care as needed (337).

In many countries – especially during humanitarian emergencies – child protection stakeholders are proactive in mental health and psychosocial support. Good coordination and collaboration between people working in health and child protection is essential to ensure coherent care.

Education and training

Adults with severe mental health conditions may struggle to access adult learning and vocational training opportunities either because of the demands of the education or because of discrimination. Similarly, children and adolescents with severe mental health conditions are often excluded from mainstream education, and may be segregated into separate schools or classrooms or, sometimes, not given any schooling at all. Mainstream education's generally inflexible teaching systems and structures mean that even if children with severe mental health conditions are allowed to go to school, they are more likely to fail, have to repeat a year or drop out early (543, 544).

Inclusive education means providing meaningful learning opportunities to all learners, including those with mental health conditions, without discrimination. Specifically, it means: supporting all learners in the same schools and classrooms; eliminating any communication, information and attitude barriers from schools; ensuring that learning resources are accessible to all; and ensuring all educators and administrators foster inclusion. Key strategies for inclusive education include employing specially trained staff or adopting flexible curricula, different teaching methods and alternative educational resources. Peer support or mentoring services can also be valuable in supporting inclusive education as a source of emotional support and practical advice.

For adult learners, supported education programmes are designed to help people with mental health conditions identify their learning goals and enter and navigate an education programme to meet those goals. Supported education programmes come in different shapes and sizes but often include staff dedicated to supporting people with mental health conditions, one-to-one and group skill-building activities, practical help to navigate the academic setting and local community, and opportunities for mental health counselling (545).

In rural areas, providing people with mental health conditions with basic agricultural skills can mean that they become productive members of their community, and their involvement in work and their contributions to the household also reduce stigma.

Employment

As with education, people with severe mental health conditions are often discriminated against in the world of employment. They are more likely to be unemployed or underpaid than the general population (546), yet access to paid work is often important for recovery. It not only gives people a livelihood but can also improve their quality of life by adding daily structure and a sense of purpose and achievement. For employers, there are benefits too, as mental health care is associated with improved occupational outcomes (218).

Supported employment is more effective than vocational training in helping people with mental health conditions access paid work.

There are many ways that people with mental health conditions can be supported to gain access to a livelihood. Encouraging businesses to adopt inclusive recruitment and employment policies and practices is important and, like inclusive education, requires employers to provide support that is tailored to an individual's needs.

There are several models for helping people with mental health conditions gain and sustain competitive employment. One tried and tested model is supported employment, where people with mental health conditions are supported to learn on the job, usually by social services or psychosocial rehabilitation programmes (see section 7.3 Community mental health services). Like housing first approaches, which prioritize access to housing over ensuring people are housing-ready, supported employment prioritizes access to employment and then provides training and support once the person

is in place. Supported employment has been found to be more effective than vocational training in helping people with severe mental health conditions to access paid work (547).

Another model of support is transitional employment, where people with mental health conditions are given professional experience through time-limited work placements. These can provide important stepping-stones to longer-term employment afterwards. They may also be run by social services or as part of broader intersectoral recovery-based interventions within community mental health services (see section 7.3.3 Psychosocial rehabilitation).

Other intersectoral interventions to improve access to employment for people with mental health conditions emphasize the opportunities available through entrepreneurship. Interventions may include establishing social enterprises and livelihood programmes (see Box 7.23 Nurturing entrepreneurs with mental health conditions).

In addition to supporting access to work, it is also important to ensure that working conditions are safe and supportive of mental health for all workers, including those with mental health conditions (see section 6.3.3 Promoting and protecting mental health at work).

CASE STUDY

BOX 7.23

Nurturing entrepreneurs with mental health conditions

Community Recovery Achieved Through Entrepreneurism (CREATE), Kenya

CREATE couples social business with psychosocial rehabilitation and peer support to help people living with severe mental health conditions into paid work. The project, which was implemented over 18 months in peri-urban Kenya, established a full-service print shop called Point Tech Solutions and employed seven people with severe mental health conditions to help run it. Employees reported a number of benefits from the experience, including improved well-being and self-identity, greater productivity and financial independence, better employment and social skills and greater connectedness with their families and the larger community. Family members also reported feeling a reduced sense of burden as carers.

BasicNeeds, Ghana

BasicNeeds is an international nongovernmental organization dedicated to mental health and development, with operations in a range of LMICs. It combines clinical, social and economic approaches to support the multiple needs of people living with mental health conditions. For example, while providing accessible treatment, BasicNeeds helps individuals and their families and carers develop self-help groups to enable mutual support and joint activities. In Ghana, the BasicNeeds self-help groups focus on employment and economic empowerment. They operate revolving funds based on voluntary contributions, which they use to provide access to credit for people with severe mental health conditions. First loans are interest free. Not all loans are paid back; and some are used simply to cover the costs of emergency care; but many are used to support livelihood activities.

Sources: Grand Challenges Canada, 2016 (548); Cohen et al, 2012 (549).

Social benefits

Access to social benefits – including for maternity, work injury, disabilities, unemployment and pensions – can be a lifeline for people with mental health conditions in times of hardship, and can be critical for recovery (550). Yet these people are often excluded from social benefits by complex application processes and eligibility assessments or because they work in the informal economy (551).

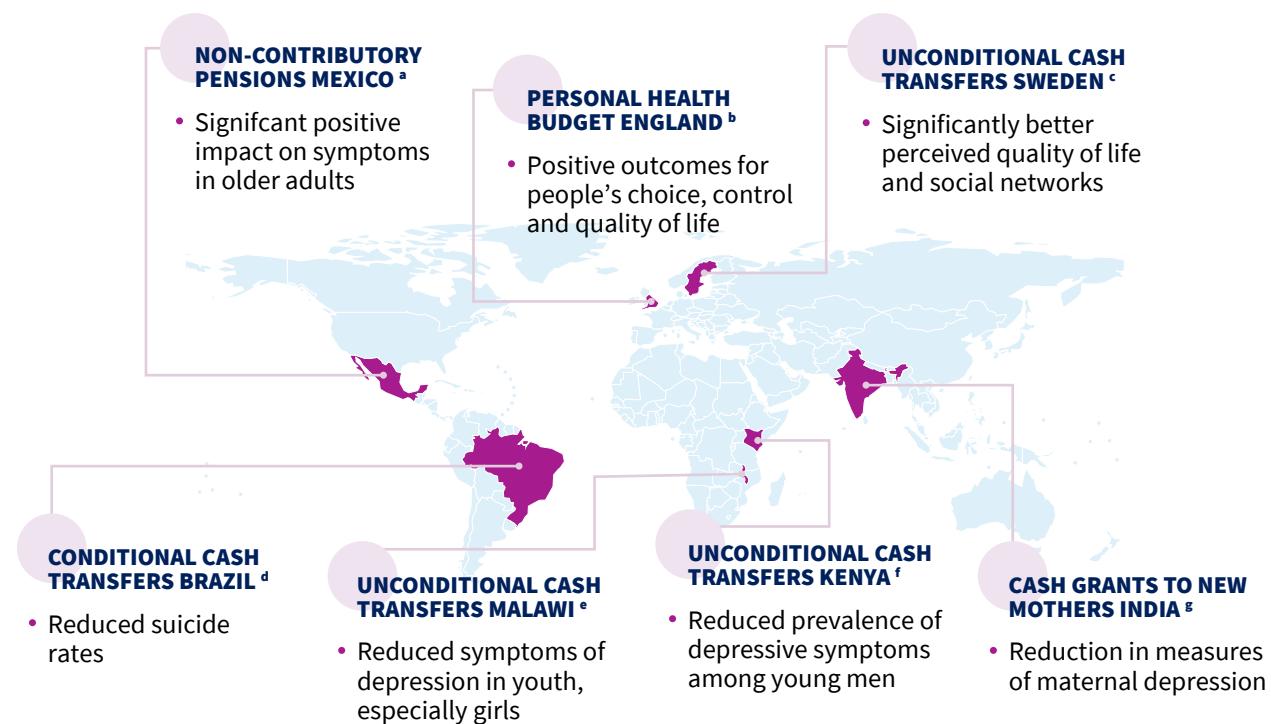
There are many ways to improve access to state benefits for people with mental health conditions. Benefit systems can be adjusted so that they are more accessible, for example by offering a wider range of communication channels and entry points, by providing targeted support during application, and by simplifying reassessment processes (552). Training assessors on mental health conditions and associated social problems may also help improve the assessment processes.

Some experts recommend introducing an unconditional component to social benefits, backed by evidence that such payments can reduce psychiatric symptoms and improve claimants' quality of life (553).

While not explicitly designed to improve mental health, there is growing evidence that cash transfer programmes (conditional and unconditional) can significantly benefit people living with mental health conditions, especially in LMICs (see Fig. 7.5) (554, 555). By increasing household income and economic security, cash transfers may also reduce family conflict associated with financial stress and so reduce domestic violence and mental health risks for all family members (556).

FIG. 7.5

Examples of how social benefits from around the world can promote and protect mental health



Sources: ^a Fernald et al, 2008 (557); ^b Webber et al, 2014 (558); ^c Ljungqvist et al, 2015 (559); ^d Oliveira Alves et al, 2019 (560); ^e Angeles et al, 2019 (561); ^f Kilburn et al, 2016 (562); ^g Powell-Jackson et al, 2016 (563).



8

Conclusion

Mental health is critically important for everyone, everywhere. It is an inherent and vital part of our overall health and well-being and affects our lives in many ways (see [Chapter 2 Principles and drivers in public mental health](#)). Our mental health enables us to function and thrive as individuals, family members and community participants. It helps us cope with stress and adapt to change. It allows us to build healthy relationships and connect with others. And it supports us to learn well and work productively. Mental health and access to mental health care are a basic human right.

For decades, mental health has been one of the most neglected areas of public health globally. Undervalued and misunderstood, it receives a tiny part of the attention and resources it needs and deserves. The result is that for too many people, achieving and maintaining good mental health is a challenge.

All over the world, people suffer because of poor mental health. And health and social systems are ill-equipped to help (see [Chapter 3 World mental health today](#)). Ongoing crises around the world increasingly justify prioritizing mental health. But even before the COVID-19 pandemic, which has affected the mental health of so many, close to a billion people were estimated to have a mental disorder. Just a small fraction of these people in need have access to effective, affordable and quality care. Stigma, discrimination and human rights violations against people with mental health conditions are widespread in communities and care systems everywhere. And in all countries, it is the poorest and most disadvantaged in society who are at greater risk of mental ill-health and who are also the least likely to receive adequate services.

8.1 Comprehensive action

This report argues for a worldwide transformation towards better mental health for all. The need for change has long been recognized. And the benefits of change are clear: reduced suffering and improved public health, stronger protection of human rights and better social and economic outcomes (see [Chapter 4 Benefits of change](#)). Investing to transform mental health means investing in a better life and future for all.

The vision is a world where mental health is valued, promoted and protected. It is a world where mental health conditions are prevented and where anyone and everyone can exercise their full range of human rights and access the high quality, timely and culturally appropriate health and social care they need and deserve. And it is a world where everyone has the

chance to achieve the highest possible level of health and to participate fully in society free from stigma and discrimination.

The *WHO Comprehensive mental health action plan (2013–2030)* commits all countries to try and make that vision a reality. As its name suggests, it also provides a blueprint for action, making recommendations for countries, WHO and partners around four key objectives:

- 1.** stronger effective leadership and governance;
- 2.** comprehensive, integrated and responsive community-based care;
- 3.** strategies for promotion and prevention; and
- 4.** stronger information systems, evidence and research.



Importantly, the plan includes a wide range of implementation options for realizing each objective, recognizing that their relevance to different countries will depend on national circumstances.

In 2019, WHO Member States reaffirmed their commitment to the plan's original four objectives and extended the timeline for achieving them to 2030 (from 2020). In 2021 they endorsed an updated set of targets and implementation options to reflect learnings from research and practice over the past decade.

Some countries have successfully translated the commitments agreed in the action plan and other global or regional instruments into their own national strategies for mental health. But in most cases there remain huge implementation gaps and needs.

For each country, identifying which actions to prioritize is key. No country is expected to fulfil every implementation option in the global action plan. And many countries do not have the

resources to implement every action described in this report. But every country has ample opportunities to make meaningful progress towards better mental health for its population. Whether developing rights-aligned mental health policies and laws, covering mental health in health care benefit packages and insurance schemes, effectively integrating mental health into primary health care practice and emergency preparedness and response, or implementing suicide prevention measures, the many examples in this report show that strategic changes can make a big difference.

No country is expected to fulfil every implementation option in the global action plan. But every country can make meaningful progress towards better mental health for its population.

Choosing what to focus on first will depend on country contexts, local mental health needs, other priorities and the existing state and structure of each mental health system.

8.2 Paths to transformation

The evidence, experience and expertise presented in this report point to three key paths to transformation. These focus on shifting attitudes to mental health, addressing risks to mental health and strengthening systems of care for mental health.

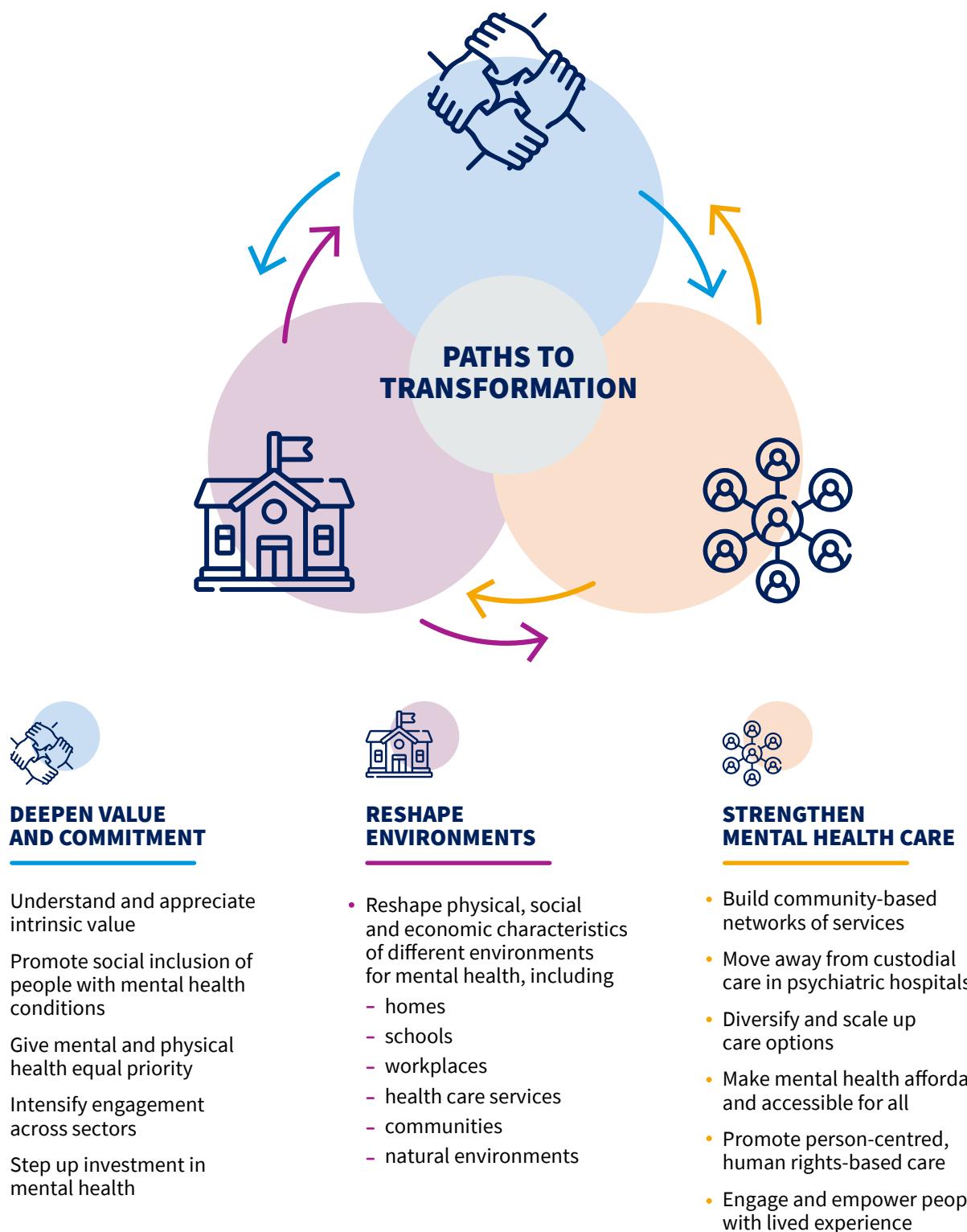
First, we must **deepen the value and commitment** we give to mental health as an integral part of our own health and well-being, as a basic human right and as a critical contributor to public health, social well-being and sustainable development. Second, we must **reshape environments that influence**

mental health in ways that reduce risks and strengthen protective factors so that everyone has an equal opportunity to thrive and reach the highest attainable level of mental health and well-being. Third, we must **strengthen mental health care** so that the full spectrum of mental health need is met through a community-based network of accessible, affordable and quality services and supports (see Fig. 8.1).

Each path to transformation is important in its own right and each one can contribute to specific mental health goals and priorities. But they are also deeply connected and mutually reinforcing.

FIG. 8.1

Three transformative paths towards better mental health



8.2.1 Deepen value and commitment

Transforming mental health is about deepening the value we give to mental health as individuals, communities and governments; and matching that value with commitment, engagement and investment by all stakeholders, across all sectors.

To deepen value and commitment to mental health means, for example, to:

- **Understand and appreciate the intrinsic value** of mental health and put time and effort into taking care of one's own mental health as well as supporting the mental health of others.
- **Include people with mental health conditions** in all aspects of society and decision-making to overcome stigma and discrimination, reduce disparities and promote social justice.
- **Give mental health the same value and priority as physical health**, including through enhanced social and financial protection measures, equitable access to quality services, equal access to education and employment opportunities for people with mental health conditions, and increased research support.
- **Intensify engagement with mental health across sectors**, understanding its value as a basic human right and a critical contributor to public health, social well-being and economic development, and supporting a whole-of-government and all-of-society approach to improving mental health.
- **Step up investments in mental health**, not just by securing appropriate funds and human resources across health and other sectors to meet mental health needs, but also through committed leadership, pursuing evidence-based policies and practice, and establishing robust information and monitoring systems.

8.2.2 Reshape environments for better mental health

Transforming mental health is about reshaping the physical, social and economic characteristics of our environments to better protect mental health and prevent mental health conditions. This includes reshaping both our immediate surroundings and the broader conditions of daily life, as well as structural threats such as social and economic inequalities, conflict, public health emergencies and the climate crisis. For people with mental health conditions, reshaping environments also means ensuring equal opportunities to live, learn, work and play.

At heart, reshaping environments for better mental health is about understanding the social and structural determinants of mental health and intervening in ways that reduce risks, build resilience and dismantle barriers that stop people with mental health conditions participating fully in society. This includes integrating mental health promotion and prevention within health and social services. It also includes macro-level policies and strategic actions (such as strengthening rules and regulations or introducing adequate support mechanisms) to tackle disadvantage, uphold human rights and ensure fair and equal access to infrastructure, services and opportunities for all.

Reshaping environments is a truly multisectoral venture. Most of the strategies and interventions required cannot be delivered by the health sector alone. Yet the health sector has a major role in enabling action by advocating, initiating and, where appropriate, facilitating multisectoral collaboration and coordination for mental health.



Key environments where action can be taken to reduce risks and build resilience are:

- **Homes**, where priority actions include: eliminating intimate partner violence, preventing abuse and neglect of children and older people; enabling nurturing care for early childhood development; as well as protecting against household hardship through, for example, poverty alleviation programmes and livelihood support for people with mental health conditions.
- **Communities**, where strategies may include specific initiatives to improve social interactions, stop discrimination, strengthen safety and tackle negative social norms and practices.
- **Schools**, where priority interventions include social and emotional learning programmes as well as initiatives to counter bullying, discrimination and violence.
- **Workplaces**, where action is needed both to secure safe, supportive and decent working conditions for all; and to support people with mental health conditions to gain competitive employment or return to work after absence.
- **Health care services**, where action to shift attitudes and strengthen rights is important to offer supportive care, and eliminate coercion and abuse of people with mental health conditions.
- **Natural environments**, where strategies are needed to address the climate crisis, increase access to green spaces, and prevent exposure to toxic pollutants.

8.2.3 Strengthen mental health care

Transforming mental health care is about changing where, how, and by whom mental health care is delivered and received. It is about restructuring mental health services to shift the locus of care for severe mental health conditions away from

psychiatric hospitals towards communities, while simultaneously scaling up the availability of care for common conditions. And it is about shifting from fragmented services, which currently only meet a small proportion of people's needs, to coordinated services that cater to everyone.

To change mental health care means, among other things, to:

- **Build community-based networks** of interconnected services that cover the full spectrum of biopsychosocial care and support for all mental health conditions. Comprehensive networks include: mental health services that are integrated in general health care; community mental health services; and services beyond the health sector.
- **Move away from custodial care in psychiatric hospitals** as community-based services become available by simultaneously improving quality of all inpatient and residential care, shortening stays and preventing new admissions to long-stay psychiatric hospitals and increasing discharges of long-term residents, and closing long-stay psychiatric institutions once there are adequate community alternatives. This requires a carefully planned participatory process that prepares residents for life in the community and that follows up on them after discharge.
- **Diversify and scale up care** options for common mental health conditions such as depression and anxiety. This includes adopting a task-sharing approach that expands the evidence-based care offered by general health workers and community providers. It also includes using digital technologies to support guided and unguided self-help and to deliver remote care.
- **Make mental health care accessible and affordable for all** by explicitly including mental health interventions in UHC basic packages of essential services and financial protection schemes. Everyone in society, no matter their age or where they live, should

get the mental health care they need without suffering financial hardship, social exclusion or coercive forms of treatment.

- **Deliver person-centred, human rights-based care** by moving away from models of care that focus exclusively on clinical pathologies and symptomatic outcomes, towards ones that also respect and embrace a person's rights, needs, perspectives and priorities.
- **Involve people with lived experience** by empowering individuals in their own mental health care, engaging people with lived experience in local services planning,

delivery and evaluation in meaningful ways, and ensuring they participate actively in policy-making and research.

Each path to transformation is a path towards better mental health for all. Together, the paths lead us closer to the world envisaged by the *Comprehensive mental health action plan 2013–2030*, where mental health is valued, promoted and protected; where everyone has an equal opportunity to thrive and to exercise their human rights; and where everyone can access the mental health care they need (see Fig. 8.2).





FIG. 8.2

Key shifts to transform mental health for all



8.3 Combining efforts for change

No one should travel the paths to transformation alone. It will take the combined efforts of all of us, across all sectors, to transform mental health and mental health care. Everyone has a part to play.

Individuals can make a big difference by better understanding and valuing mental health – both their own and that of others – and taking action to promote and protect it in daily life. This includes various elements of self-care as well as individual efforts to support, include and respect the rights of people with mental health conditions in society.

Governments have a key role in mobilizing, shaping and supporting action. This includes prioritizing mental health in health and development agendas and developing laws and policies to promote rights and improve access to mental health care. Governments can and should ensure that quality mental health services are developed, resourced and tailored to meet local mental health needs. They should establish mechanisms for multi-sectoral engagement, take action to involve and empower people with mental health conditions in care and support and facilitate research and training. And they should organize services to expand coverage, and develop promotion and prevention programmes that target the social and structural determinants of mental health.

Care providers, from family members and community providers to general health workers and mental health professionals, have a major responsibility to deliver care that is respectful, provides dignity, and supports autonomy. Mental health professionals can and should lead transformation in practice, advocating an

integrated approach to care and facilitating new ways of working to achieve it, for example task-sharing. Other health and social care workers should also be active participants and partners in transforming mental health care. For example, they can improve their own and other people's knowledge and understanding of mental health, or facilitate access to needed services.

Nongovernmental organizations, academia, employers and other civil society stakeholders complement the efforts of governments and care providers at every level. Civil society organizations of all sizes, including local organizations of persons with disabilities, have key roles. They can, for example, join forces with and amplify the voices of people with lived experience and build public awareness and understanding of mental health. All stakeholders should advocate for the rights of people with mental health conditions and support their inclusion in the community. Academia should continue to strengthen mental health science. Along with other stakeholders, academics can demonstrate what affordable, quality mental health care looks like, and advocate for it in health and social services. Depending on local circumstances, nongovernmental organizations may play a crucial part in training providers and in delivering community-based mental health services and supports, including in humanitarian settings.

Our choices and commitments today shape our opportunities tomorrow. By committing to transform mental health, we choose to end suffering, improve well-being and lift the lives of everyone. All of us can help to make change happen.



References

- 1** The world health report 2001. Mental health: new understanding, new hope. Geneva: World Health Organization; 2001 (<https://apps.who.int/iris/handle/10665/42390>, accessed 25 March 2022).
- 2** Expert Committee on Mental Health: report on the second session, Geneva, 11–16 September 1950. Geneva: World Health Organization; 1951 (<https://apps.who.int/iris/handle/10665/37982>, accessed 25 March 2022).
- 3** Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345301>, 25 March 2022).
- 4** The state of the world's children 2021. On my mind: promoting, protecting and caring for children's mental health. Geneva: UNICEF; 2021 (<https://www.unicef.org/reports/state-worlds-children-2021>, accessed 25 March 2022).
- 5** Mental health atlas 2020. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345946>, accessed 25 March 2022).
- 6** Goldin I, Muggah R. COVID-19 is increasing multiple kinds of inequality. Here's what we can do about it. In: WEF [website]. Geneva: World Economic Forum; 2020 (<https://www.weforum.org/agenda/2020/10/covid-19-is-increasing-multiple-kinds-of-inequality-here-s-what-we-can-do-about-it>, accessed 25 March 2022).
- 7** Kola L, Kohrt BA, Hanlon C, Naslund JA, Sikander S, Balaji M, et al. COVID-19 mental health impact and responses in low-income and middle-income countries: reimagining global mental health. *Lancet Psychiatry*. 2021;8(6):535–550. doi:10.1016/S2215-0366(21)00025-0.
- 8** Prior K, Mills K, Ross J, Teesson M. Substance use disorders comorbid with mood and anxiety disorders in the Australian general population. *Drug Alcohol Rev*. 2017;36(3):317–324. doi:10.1111/dar.12419.
- 9** Epilepsy: a public health imperative. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/325293>, accessed 25 March 2022).
- 10** Hailemichael Y, Hailemariam D, Tifessa K, Docrat S, Alem A, Medhin G, et al. Catastrophic out-of-pocket payments for households of people with severe mental disorder: a comparative study in rural Ethiopia. *Int J Ment Health Syst*. 2019; 13(39). doi: 10.1186/s13033-019-0294-7.
- 11** Investing in mental health: evidence for action. Geneva: World Health Organization; 2013 (<https://apps.who.int/iris/handle/10665/87232>, accessed 26 March 2022).
- 12** Global Health Data Exchange: Mental disorders; prevalence; 2019. Seattle: Institute for Health Metrics and Evaluations; 2021 (<http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/0da144dff4afefddfaf45d5564118c6>, accessed 26 March 2022).
- 13** Ryan G, Qureshi O, Salaria N, Eaton J. Mental health and the 2030 Sustainable Development Agenda. London: London School of Hygiene & Tropical Medicine; 2018 (<https://www.mhinnovation.net/sites/default/files/downloads/resource/UNGA%20brief%20final.pdf>, accessed 25 March 2022).
- 14** National Institute of Mental Health strategic plan. Washington DC: National Institutes of Health; 2008 (<https://www.hsdl.org/?view&did=755067>, accessed 15 March 2022).
- 15** Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018;392(10157):1553–1598. doi:10.1016/S0140-6736(18)31612-X.
- 16** Tudor, K. Mental health promotion: paradigms and practice. East Sussex: Routledge; 1996.
- 17** Herrman H, Patel V, Kieling C, Berk M, Buchweitz C, Cuijpers P, et al. Time for united action on depression: a Lancet-World Psychiatric Association Commission. *Lancet*. 2022;399(10328):957–1022. doi:10.1016/S0140-6736(21)02141-3.
- 18** Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/272603>, accessed 26 March 2022).
- 19** Borges G, Nock MK, Haro Abad JM, Hwang I, Sampson NA, Alonso J, et al. Twelve-month prevalence of and risk factors for suicide attempts in the World Health Organization World Mental Health Surveys. *J Clin Psychiatry*. 2010;71(12):1617–1628. doi: 10.4088/JCP.08m04967blu.
- 20** Harvey SB, Modini M, Joyce S, Milligan-Saville JS, Tan L, Mykletun A, et al. Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. *Occup Environ Med*. 2017;74(4):301–310. doi:10.1136/oemed-2016-104015.
- 21** Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. Elder abuse prevalence in community settings: a systematic review and meta-analysis. *Lancet Glob Health*. 2017;5(2):e147–e156. doi:10.1016/S2214-109X(17)30006-2.
- 22** Drew N, Funk M, Tang S, Lamichhane J, Chávez E, Katontoka S, et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *Lancet*. 2011;378(9803):1664–1675. doi:10.1016/S0140-6736(11)61458-X.
- 23** Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341648>, accessed 26 March 2022).
- 24** Thornicroft G, Tansella M. Growing recognition of the importance of service user involvement in mental health service planning and evaluation. *Epidemiol Psychiatr Soc*. 2005;14(1):1–3. doi:10.1017/s1121189x00001858.
- 25** Item A/HRC/44/48. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Human Rights Council; 2020 (<http://undocs.org/A/HRC/44/48>, accessed 26 March 2022).
- 26** Marmot M, Friel S, Bell R, Houweling TAJ, Taylor S. Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet*. 2008;372(9650):1661–1669. doi:10.1016/S0140-6736(08)61690-6.
- 27** Risks to mental health: an overview of vulnerabilities and risk factors. Background paper by WHO Secretariat for the development of a comprehensive mental health action plan. Geneva: World Health Organization; 2012 (<https://www.who.int/publications/m/item/risks-to-mental-health>, accessed 26 May 2022).
- 28** Ingram RE, Luxton DD. Vulnerability-stress models. In: Hankin BL, Abela JRZ (editors). Development of psychopathology: a vulnerability-stress perspective. Thousand Oaks: Sage Publications; 2005. doi:10.4135/9781452231655.n2.
- 29** Optimizing brain health across the life-course: WHO position paper. Geneva: World Health Organization; in press.
- 30** Heilmann A, Mehay A, Watt RG, Kelly Y, Durrant JE, van Turnhout J, et al. Physical punishment and child outcomes: a narrative review of prospective studies. *Lancet*. 2021;398(10297):355–364. doi:10.1016/S0140-6736(21)00582-1.
- 31** Global Burden of Disease 2019: Mental disorders – Level 2 cause. Seattle: Institute for Health Metrics and Evaluations; 2021 (http://www.healthdata.org/results/gbd_summaries/2019/mental-disorders-level-2-cause, accessed 26 March 2022).
- 32** Frankl VE. Man's search for meaning: an introduction to logotherapy. Boston: Beacon Press; 1962.
- 33** Cuijpers P, Smit F, Furukawa TA. Most at-risk individuals will not develop a mental disorder: the limited predictive strength of risk factors. *World Psychiatry*. 2021;20(2):224–225. doi:10.1002/wps.20852.
- 34** Risks to mental health: an overview of vulnerabilities and risk factors. Background paper by WHO Secretariat for the development of a comprehensive mental health action plan. Geneva: World Health Organization; 2012 (<https://www.who.int/publications/m/item/risks-to-mental-health>, accessed 26 May 2022).
- 35** Arango C, Dragioti E, Solmi M, Cortese S, Domschke K, Murray RM, et al. Risk and protective factors for mental disorders beyond genetics: an evidence-based atlas. *World Psychiatry*. 2021;20(3):417–436. doi:10.1002/wps.20894. (<https://www.who.int/publications/m/item/risks-to-mental-health>, accessed 26 May 2022).



- 36** WHO and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf, accessed 26 March 2022).
- 37** Jones L, Bellis MA, Wood S, Hughes K, McCoy E, Eckley L, et al. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *Lancet.* 2012;380(9845):899–907. doi:10.1016/S0140-6736(12)60692-8.
- 38** Hillis S, Mercy J, Amobi A, Kress H. Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics.* 2016;137(3):e20154079. doi:10.1542/peds.2015-4079.
- 39** Nelson CA, Scott RD, Bhutta ZA, Harris NB, Danese A, Samara M. Adversity in childhood is linked to mental and physical health throughout life. *BMJ.* 2020;371:m3048. doi:10.1136/bmj.m3048.
- 40** Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Pub Health.* 2017;2(8):e356–366. doi:10.1016/S2468-2667(17)30118-4.
- 41** Dohrenwend BP. The role of adversity and stress in psychopathology: some evidence and its implications for theory and research. *J Health Soc Behav.* 2000;41(1): doi:10.2307/2676357.
- 42** Just societies: health equity and dignified lives. Report of the Commission of the Pan American Health Organization on Equity and Health Inequalities. Washington DC: Pan American Health Organization; 2019 (<https://iris.paho.org/handle/10665.2/51571>, accessed 26 March 2022).
- 43** Chen S, Oliva P, Zhang P. Air pollution and mental health: evidence from China. Working paper 24686 Cambridge: National Bureau of Economic Research; 2018 (<http://www.nber.org/papers/w24686>. Accessed 26 March 2022).
- 44** Newbury JB, Stewart R, Fisher HL, Beavers S, Dajnak D, Broadbent M, et al. Association between air pollution exposure and mental health service use among individuals with first presentations of psychotic and mood disorders: retrospective cohort study. *Br J Psychiatry.* 2021;1–8. doi:10.1192/bj.p.2021.119.
- 45** Kessler RC, Aguilar-Gaxiola S, Alonso J, Benjet C, Bromet EJ, Cardoso G, et al. Trauma and PTSD in the WHO World Mental Health Surveys. *Eur J Psychotraumatol.* 2017;8(sup5):1353383. doi:10.1080/2008198.2017.1353383.
- 46** Marmot M, Allen J, Goldblatt P, Herd E, Morrison J. Build back fairer: the COVID-19 Marmot review. London: The Health Foundation; 2020 (<https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review>, accessed 26 March 2022).
- 47** Priebe S, Matanov A, Schor R, Straßmayr C. Good practice in mental health care for socially marginalised groups in Europe: a qualitative study of expert views in 14 countries. *BMC Public Health.* 2012;12(1):248. doi: 10.1186/1471-2458-12-248.
- 48** Plöderl M, Tremblay P. Mental health of sexual minorities. A systematic review. *Int Rev Psychiatry.* 2015;27(5):1–19. doi: 10.3109/09540261.2015.1083949.
- 49** Elliott I. Poverty and mental health. London: Mental Health Foundation; 2016 (<https://www.mentalhealth.org.uk/sites/default/files/Poverty%20and%20Mental%20Health.pdf>, accessed 26 March 2022).
- 50** De Silva M, Roland J. Mental health for sustainable development. London: All-Party Parliamentary Groups on Global Health and Mental Health; 2014 (https://www.mhinnovation.net/sites/default/files/downloads/resource/APPG_Mental-Health_Web.pdf, accessed 26 March 2022).
- 51** Dybdahl R, Lien L. Mental health is an integral part of the sustainable development goals. *Prev Med Commun Health.* 2017;1(1):1–3. doi:10.15761/PMCH.1000104.
- 52** Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P, et al. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry.* 2018;5(4):357–369. doi:10.1016/S2215-0366(18)30060-9.
- 53** Marwaha S, Durrani A, Singh S. Employment outcomes in people with bipolar disorder: a systematic review. *Acta Psychiatr Scand.* 2013;128:179–193. doi: 10.1111/acps.12087.
- 54** Marwaha S, Johnson S. Schizophrenia and employment. A review. *Soc Psychiatry Psychiatr Epidemiol.* 2004;39:337–349. doi: 10.1007/s00127-004-0762-4.
- 55** Green and blue spaces and mental health: new evidence and perspectives for action. Copenhagen: World Health Organization Regional Office for Europe; 2021 (<https://www.euro.who.int/en/publications/abstracts/green-and-blue-spaces-and-mental-health-new-evidence-and-perspectives-for-action-2021>, accessed 26 March 2022).
- 56** Seedat S, Margaret Scott K, Angermeyer MC, Berglund P, Bromet EJ, Brugha TS, et al. Cross-national associations between gender and mental disorders in the World Health Organization World Mental Health Surveys. *Arch Gen Psychiatry.* 2009;66(7):785–795. doi:10.1001/archgenpsychiatry.2009.36.
- 57** Chang S-S, Stuckler D, Yip P, Gunnell D. Impact of 2008 global economic crisis on suicide: time trend study in 54 countries. *BMJ.* 2013;347:f5239. doi:10.1136/bmj.f5239.
- 58** Case A, Deaton A. Deaths of despair and the future of capitalism. Princeton: Princeton University Press; 2020.
- 59** Van Bortel T, Basnayake A, Wurie F, Jambai M, Koroma AS, Muana AT, et al. Psychosocial effects of an Ebola outbreak at individual, community and international levels. *Bull World Health Organ.* 2016;94:210–214. doi:10.2471/BLT.15.158543.
- 60** WHO toolkit for the care and support of people affected by complications associated with Zika virus. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/255718>, accessed 24 March 2022).
- 61** Neurology and COVID-19: scientific brief, 29 September 2021. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345574>, accessed 26 March 2022).
- 62** Mahler DG, Yonzan N, Lakner C, Aguilar RAC, Wu H. Updated estimates of the impact of COVID-19 on global poverty: turning the corner on the pandemic in 2021? World Bank Blogs. June 24 2021 (<https://blogs.worldbank.org/opendata/updated-estimates-impact-covid-19-global-poverty-turning-corner-pandemic-2021>, accessed 3 March 2022).
- 63** Policy brief: COVID-19 and the need for action on mental health. New York: United Nations; 2020 (<https://unsdg.un.org/resources/policy-brief-covid-19-and-need-action-mental-health>, accessed 3 March 2022).
- 64** Public mental health and wellbeing and COVID-19. In: Local Government Association [website]. London: Local Government Association; 2022 (<https://www.local.gov.uk/public-mental-health-and-wellbeing-and-covid-19>, accessed 3 March 2022).
- 65** Piquero AR, Jennings WG, Jemison E, Kaukinen C, Knaul FM. Domestic violence during the COVID-19 pandemic – evidence from a systematic review and meta-analysis. *J Crim Justice.* 2021;74:101806. doi:10.1016/j.jcrimjus.2021.101806.
- 66** Managing the COVID-19 infodemic: promoting healthy behaviours and mitigating the harm from misinformation and disinformation. Joint statement by WHO, UN, UNICEF, UNDP, UNESCO, UNAIDS, ITU, UN Global Pulse, and IFRC. 23 September 2020 (<https://www.who.int/news-room/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation>, accessed 3 March 2022).
- 67** Mental health impacts of the COVID-19 pandemic in Scotland on vulnerable groups. Glasgow: Mental Health Foundation; 2020 (<https://www.mentalhealth.org.uk/sites/default/files/MHF-Impact-Covid-19-Pandemic-Scot.pdf>, accessed 3 March 2022).
- 68** COVID-19 Mental Disorders Collaborators. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *Lancet.* 2021;S0140-6736(21)02143-7. doi:10.1016/S0140-6736(21)02143-7.
- 69** Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/352189>, accessed 3 March 2022).
- 70** Action required to address the impacts of the COVID-19 pandemic on mental health and service delivery systems in the WHO European Region. Copenhagen: World Health Organization Regional office for Europe; 2021 (<https://apps.who.int/iris/bitstream/handle/10665/342932/WHO-EURO-2021-2845-42603-59267-eng.pdf>, accessed 3 March 2022).

- 71** Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021: interim report, 7 February 2022. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/351527>, accessed 4 March 2022).
- 72** The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/335838>, accessed 4 March 2022).
- 73** EB148/20. Mental health preparedness and response for the COVID-19 pandemic. Report by the Director-General. In: 148th session of the WHO Executive Board. Geneva: World Health Organization; 2021 (https://apps.who.int/gb/ebwha/pdf_files/EB148/B148_20-en.pdf, accessed 4 March 2022).
- 74** Mental health and psychosocial support. Resources for COVID-19. In: IASC [website]. Geneva: Inter-Agency Standing Committee; 2022 (<https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-resources-covid-19>, accessed 17 March 2022).
- 75** Mental health & COVID-19. In: WHO [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/teams/mental-health-and-substance-use/mental-health-and-covid-19>, accessed 17 March 2022).
- 76** Decision EB148(3). Promoting mental health preparedness and response for public health emergencies. In: 148th session of the WHO Executive Board: resolutions and decisions. Geneva: World Health Organization; 2021 (https://apps.who.int/gb/ebwha/pdf_files/EB148/B148_CONF5-en.pdf), accessed 26 May 2022.
- 77** Global humanitarian overview 2022. In: OCHA Services [website]. New York: UN Office for Coordination of Humanitarian Affairs; 2021 (<https://gho.unocha.org>, accessed 26 March 2022).
- 78** Jones L, Asare JB, El Masri M, Mohanraj A, Sherief H, van Ommeren M. Severe mental disorders in complex emergencies. *Lancet*. 2009;374(9690):654–661. doi:10.1016/S0140-6736(09)61253-8
- 79** Weissbecker I, Ventevogel P, Hanna F, Pathare S. Mental health and psychosocial support in humanitarian settings: considerations for protecting and promoting human rights. In: Rubin NS, Flores RL (editors). *The Cambridge handbook of psychology and human rights*. Cambridge: Cambridge University Press; 2020. doi:10.1017/9781108348607.026.
- 80** Mental health and psychosocial well-being among children in severe food shortage situations. Geneva: World Health Organization; 2006 (<https://apps.who.int/iris/handle/10665/332423>, accessed 26 March 2022)
- 81** Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental health in conflict settings: a systematic review and analysis. *Lancet*. 2019;394(10194):240–248. doi:10.1016/S0140-6736(19)30934-1.
- 82** Goldmann E, Galea S. Mental health consequences of disasters. *Annu Rev Public Health*. 2014;35:169–183. doi:10.1146/annurev-publhealth-032013-182435.
- 83** Refugee data finder. In: UNHCR: The UN Refugee Agency [website]. Geneva: United Nations High Commissioner for Refugees; 2022 (<https://www.unhcr.org/refugee-statistics/>, accessed 26 March 2022).
- 84** Blackmore R, Boyle JA, Fazel M, Ranasinha S, Gray KM, Fitzgerald G, et al. The prevalence of mental illness in refugees and asylum seekers: a systematic review and meta-analysis. *PLoS Med*. 2020;17(9):e1003337. doi:10.1371/journal.pmed.1003337.
- 85** Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry*. 2017;16(2):130–139. doi:10.1002/wps.20438.
- 86** Hamber B, Gallagher E, Ventevogel P. Narrowing the gap between psychosocial practice, peacebuilding and wider social change: an introduction to the special section in this issue. *Intervention* (Amstelveen). 2014;12(1):7–15. doi:10.1097/WTF.0000000000000029.
- 87** Costello A, Abbas M, Allen A, Ball S, Bell S, Bellamy R, et al. Managing the health effects of climate change. *Lancet Commissions*. 2009;373(9676):1693–1733. doi:10.1016/S0140-6736(09)60935-1.
- 88** Watts N, Amann M, Ayeb-Karlsson S, Belesova K, Bouley T, Boykoff M, et al. The Lancet countdown on health and climate change: from 25 years of inaction to a global transformation for public health. *Lancet*. 2017;391(10120):581–630. doi:10.1016/s0140-6736(17)32464-9.
- 89** Augustinavicius JL, Lowe SR, Massazza A, Hayes K, Denckla C, White RG, et al. Briefing paper: global climate change and trauma. Chicago: International Society for Traumatic Stress Studies; 2021 (<https://istss.org/public-resources/istss-briefing-papers/briefing-paper-global-climate-change-and-trauma>, accessed 26 March 2022).
- 90** Hayes K, Blashki G, Wiseman J, Burke S, Reifels L. Climate change and mental health: risks, impacts and priority actions. *Int J Ment Health Syst*. 2018;12:28. doi:10.1186/s13033-018-0210-6.
- 91** Pourmotabbed A, Moradi S, Babaei A, Ghavami A, Mohammadi H, Jalili C, et al. Food insecurity and mental health: a systematic review and meta-analysis. *Public health Nutrition*. 2020;23(10):doi:10.1017/S136898001900435X.
- 92** Mental health and climate change: policy brief. Geneva: World Health Organization; 2022 (<https://apps.who.int/bitstream/handle/10665/354104/9789240045125-eng.pdf>, accessed 11 May 2022).
- 93** Thompson R, Hornigold R, Page L, Waite T. Associations between high ambient temperatures and heat waves with mental health outcomes: a systematic review. *Public health*. 2018;161:171–191. doi:10.1016/j.puhe.2018.06.008
- 94** Martin-Latry K, Goumy MP, Latry P, Gabinski C, Bégaud B, Faure I, et al. Psychotropic drugs use and risk of heat-related hospitalisation. *Eur Psychiatry*. 2007;22:335–338. doi:10.1016/j.eurpsy.2007.03.007.
- 95** Hayes K, Berry P, Ebi KL. Factors influencing the mental health consequences of climate change in Canada. *Int J Environ Res Public Health*. 2019;16(9):1583. doi:10.3390/ijerph16091583.
- 96** GBD Results Tool. In: Global Health Data Exchange [website]. Seattle: Institute for Health Metrics and Evaluation; 2019 (<http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/cb9c37d9454c80df77adaed394d7fc0f>, accessed 3 February 2022).
- 97** COVID-19 and the need for action on mental health. New York: United Nations; 2020 (https://www.un.org/sites/un2.un.org/files/un_policy_brief_covid_and_mental_health_final.pdf, accessed 25 March 2022).
- 98** GBD Results Tool. In: Global Health Data Exchange [website]. Seattle: Institute for Health Metrics and Evaluation; 2019 (<http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/2537ec0fb3bbbf9114a868394976128b>, accessed 25 March 2022).
- 99** GBD Results Tool. In: Global Health Data Exchange [website]. Seattle: Institute for Health Metrics and Evaluation; 2019 (<http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/5066348dc958b095cb6ceb4bfd9c3e07>, accessed 25 March 2022).
- 100** Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/274603>, accessed 25 March 2022).
- 101** World drug report 2021. New York: United Nations Office on Drugs and Crime; 2021 (<https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html>, accessed 25 March 2022).
- 102** Global status report on the public health response to dementia. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/344701>, accessed 28 March 2022).
- 103** WHO methods and data sources for global burden of disease estimates 2000–2019. Geneva: World Health Organization; 2020 (https://cdn.who.int/media/docs/default-source/gho-documents/global-health-estimates/ghe2019_daly-methods.pdf?sfvrsn=31b25009_7, accessed 25 March 2022).
- 104** Barra M, Broqvist M, Gustavsson E, Henriksson M, Juth N, Sandman L, et al. Severity as a priority setting criterion: setting a challenging research agenda. *Health Care Anal*. 2020;28(1):25–44. doi:10.1007/s10728-019-00371-z.
- 105** Woody CA, Ferrari AJ, Siskind DJ, Whiteford HA, Harris MG. A systematic review and meta-regression of the prevalence and incidence of perinatal depression. *J Affect Disord*. 2017;219:86–92. doi:10.1016/j.jad.2017.05.003.
- 106** Oram S, Khalifeh H, Howard LM. Violence against women and mental health. *Lancet Psychiatry*. 2017;4(2):159–170. doi:10.1016/S2215-0366(16)30261-9.
- 107** Khalifeh H, Moran P, Borshmann R, Dean K, Hart C, Hogg J, et al. Domestic and sexual violence against patients with severe mental illness. *Psychol Med*. 2015;45(4):875–886. doi:10.1017/S0033291714001962.

- 108** Kessler R, Berglund P, Demler O, Jin R, Merikangas K. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Arch Gen Psychiatry*. 2005;62(6):593–602. doi:10.1001/archpsyc.62.6.593.
- 109** GBD Results Tool. In: Global Health Data Exchange [website]. Seattle: Institute for Health Metrics and Evaluation; 2019 (<https://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/d1089abd9ea6072c2e5203256b0c7960>, accessed 30 March 2022).
- 110** GBD Results Tool. In: Global Health Data Exchange [website]. Seattle: Institute for Health Metrics and Evaluation; 2019 (<https://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-451c9ab283c67271ec9a20c28b772f57>, accessed 25 March 2022).
- 111** Kohrt BA, Rasmussen A, Kaiser BN, Haroz EE, Maharjan SM, Mutamba BB, et al. Cultural concepts of distress and psychiatric disorders: literature review and research recommendations for global mental health epidemiology. *Int J Epidemiol*. 2014;43(2):365–406. doi:10.1093/ije/dyt227.
- 112** GBD Results Tool. In: Global Health Data Exchange [website]. Seattle (<https://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/4131c27249674bcd9caad1cebf68eeff>, accessed 25 March 2022).
- 113** GBD Results Tool. In: Global Health Data Exchange [website]. Seattle (<https://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/859960795493214831bfa831846a9a7f>, accessed 28 March 2022).
- 114** Management of physical health conditions in adults with severe mental disorders: WHO guidelines. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/275718>, accessed 25 March 2022).
- 115** Chesney E, Goodwin GM, Fazel S. Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry*. 2014;13(2):153–160. doi:10.1002/wps.20128.
- 116** Correll CU, Detraux J, De Lepeleire J, De Hert M. Effects of antipsychotics, antidepressants and mood stabilizers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder. *World Psychiatry*. 2015;14(2):119–136. doi:10.1002/wps.20204.
- 117** Thornicroft G, Rose D, Kassam A. Discrimination in health care against people with mental illness. *Int Rev Psychiatry*. 2009;19(2):113–122. doi:10.1080/09540260701278937.
- 118** Smith DJ, Langan J, McLean G, Guthrie B, Mercer SW. Schizophrenia is associated with excess multiple physical-health comorbidities but low levels of recorded cardiovascular disease in primary care: cross-sectional study. *BMJ Open*. 2013;3(4):e002808. doi:10.1136/bmjopen-2013-002808.
- 119** Smith DJ, Martin D, McLean G, Langan J, Guthrie B, Mercer SW. Multimorbidity in bipolar disorder and undertreatment of cardiovascular disease: a cross sectional study. *BMC Med*. 2013;11:263. doi:10.1186/1747-7015-11-263.
- 120** Liu NH, Daumit GL, Dua T, Aquila R, Charlson F, Cuijpers P, et al. Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry*. 2017;16(1):30–40. doi:10.1002/wps.20384.
- 121** Charlson FJ, Baxter AJ, Dua T, Degenhardt L, Whiteford HA, Vos T. Excess mortality from mental, neurological and substance use disorders in the Global Burden of Disease Study 2010. *Epidemiol Psychiatr Sci*. 2015;24(2):121–140. doi:10.1017/S2045796014000687.
- 122** Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. *Br J Psychiatry*. 2011;199(6):441–442. doi:10.1192/bjp.bp.111.092718.
- 123** Global Health Estimates 2019: Deaths by cause, age, sex, by country and by region, 2000–2019. Geneva: World Health Organization; 2020 (https://www.who.int/docs/default-source/gho-documents/global-health-estimates/ghe2019_deaths-2000-country1d20517f-89e3-4787-b639-26acbd9b8f8.xlsx?sfvrsn=51458b03_7, accessed 25 March 2022).
- 124** Preventing suicide: a global imperative. Geneva: World Health Organization; 2014 (<https://apps.who.int/iris/handle/10665/131056>, accessed 28 March 2022).
- 125** Suicide worldwide in 2019: Global health estimates. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341728>, accessed 25 March 2022).
- 126** Global Health Estimates 2019: Deaths by cause, age, sex, by country and by region, 2000–2019. Geneva: World Health Organization; 2020 (<https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death>, accessed 25 March 2022).
- 127** Vigo D, Thornicroft G, Atun R. Estimating the true global burden of mental illness. *Lancet Psychiatry*. 2016;3(2):171–178. doi:10.1016/S2215-0366(15)00505-2.
- 128** Global Health Estimates 2019: disease burden by cause, age, sex, by country and by region, 2000–2019. Geneva, World Health Organization; 2020 (https://www.who.int/docs/default-source/gho-documents/global-health-estimates/ghe2019_daly_global_2000_2019106cc197-7fec-4494-9b12-64d11150302b.xlsx?sfvrsn=ab2e645c_9, accessed 25 March 2022).
- 129** Global Health Estimates 2019: disease burden by cause, age, sex, by country and by region, 2000–2019. Geneva, World Health Organization; 2020 (https://www.who.int/docs/default-source/gho-documents/global-health-estimates/ghe2019_yld_global_2000_2019c417f68b-841d-4a7a-9e5c-f087f9f86e48.xlsx?sfvrsn=dac29788_7, accessed 25 March 2022).
- 130** GBD 2019 Risk Factors Collaborators. Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet*. 2020;396:1223–1249. doi:10.1016/S0140-6736(20)30752-2.
- 131** Bloom DE, Cafiero ET, Jané-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, et al. The global economic burden of noncommunicable diseases. Geneva: World Economic Forum; 2011 (http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf, accessed 25 March 2022).
- 132** Prevention and management of mental health conditions in the Philippines: the case for investment. Manila: World Health Organization Regional Office for the Western Pacific; 2021 (<https://www.ph.undp.org/content/philippines/en/home/library/prevention-and-management-of-mental-health-conditions-in-the-phi.html>, accessed 25 March 2022).
- 133** Christensen MK, Lim CCW, Saha S, Plana-Ripoll O, Cannon D, Presley F, et al. The cost of mental disorders: a systematic review. *Epidemiol Psychiatr Sci*. 2020;29:e161. doi:10.1017/S204579602000075X.
- 134** Ryan G, Lemmi V, Hanna F, Loryman H, Eaton J. Mental health for sustainable development: a topic guide for development professionals. London and Brighton: Mental Health Innovation Network and Institute for Development Studies; 2020 (<https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/14908>, accessed 25 March 2022).
- 135** Saxena S, Kline S. Countdown global mental health 2030: data to drive action and accountability. *Lancet Psychiatry*. 2021;8(11):941–942. doi:10.1016/S2215-0366(21)00391-6.
- 136** Countdown global mental health 2030: data to drive action and accountability. London: United for Mental Health; 2021 (<https://unitedgmh.org/countdown-global-mental-health>, accessed 25 March 2022).
- 137** Woelbert E, White R, Lundell-Smith K, Grant J, Kemmer D. Inequities of mental health research funding. Montreal: International Alliance of Mental Health Research Funders; 2020. doi:10.6084/m9.figshare.13055897.v2.
- 138** Abimbola S, Asthana S, Montenegro C, Guinto RR, Jumbam DT, Louskieter L, et al. Addressing power asymmetries in global health: imperatives in the wake of the COVID-19 pandemic. *PLoS Med*. 2021;18(4):e1003604. doi:10.1371/journal.pmed.1003604.
- 139** Eaton J, Carroll A, Scherer N, Daniel L, Njenga M, Sunkel C, et al. Accountability for the rights of people with psychosocial disabilities: an assessment of country reports for the Convention on the Rights of Persons with Disabilities. *Health Hum Rights*. 2021;23(1):175–189.
- 140** Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet*. 2007;370(9590):878–889. doi:10.1016/S0140-6736(07)61239-2.
- 141** Alegria M, Chatterji P, Wells K, Cao Z, Chen CN, Takeuchi D, et al. Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services*. 2008;59:1264–1272. doi:10.1176/appi.ps.59.11.1264.
- 142** Liese BH, Gribble RSF, Wickremesinhe MN. International funding for mental health: a review of the last decade. *Int Health*. 2019;11(5):361–369. doi:10.1093/inthealth/ihz040.

- 143** Global Health Estimates 2016: DALYs by age, sex and cause. In: Global Health Estimates 2019: disease burden by cause, age, sex, by country and by region, 2000–2019. Geneva: World Health Organization; 2020 (<https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/global-health-estimates-leading-causes-of-dalys>, accessed 25 March 2022).
- 144** Todesco B, Ostuzzi G, Barbui C. Mapping the selection, availability, price and affordability of essential medicines for mental health conditions at a global level. *Epidemiol Psychiatr Sci*. Apr 19;31:e22. doi:10.1017/S2045796022000087. PMID: 35438063; PMCID: PMC9069582.
- 145** Measuring digital development: facts and figures 2020. Geneva: International Telecommunications Union; 2020 (<https://www.itu.int/en/ITU-D/Statistics/Pages/facts/default.aspx>, accessed 25 March 2022).
- 146** Greer B, Robotham D, Simblett S, Curtis H, Griffiths H, Wykes T. Digital exclusion among mental health service users: qualitative investigation. *J Med Internet Res*. 2019;21(1):e11696. doi:10.2196/11696.
- 147** Moitra M, Santomauro D, Collins PY, Vos T, Whiteford H, Saxena S, et al. The global gap in treatment coverage for major depressive disorder in 84 countries from 2000–2019: a systematic review and Bayesian meta-regression analysis. *PLoS Med*. 2022;19(2):e1003901. doi:10.1371/journal.pmed.1003901.
- 148** Gorringe J, Hughes D, Kidy F, Kesner C, Sale J, Sabouni A. Return on the individual: time to invest in mental health. London: United for Global Mental Health; 2020 (https://unitedgmh.org/sites/default/files/2022-04/The%20Return%20on%20the%20Individual_Full%20Report_2.pdf, accessed 26 May 2022).
- 149** Patel V, Chisholm D, Kirkwood BR, Mabey D. Prioritizing health problems in women in developing countries: comparing the financial burden of reproductive tract infections, anaemia and depressive disorders in a community survey in India. *Trop Med Int Health*. 2006;12(1):130–139. doi:10.1111/j.1365-3156.2006.01756.x.
- 150** Wellcome Global Monitor 2020: Mental health. London: Wellcome Trust; 2021 (<https://wellcome.org/reports/wellcome-global-monitor-mental-health/2020>, accessed 25 March 2022).
- 151** Rhodes A. Child mental health problems: can parents spot the signs? Melbourne: The Royal Children's Hospital; 2017 (https://www.rchpoll.org.au/wp-content/uploads/2017/10/RCH-National-Child-Health-Poll-Report_Poll-8_Final.pdf, accessed 25 March 2022).
- 152** Shi W, Shen Z, Wang S, Hall BJ. Barriers to professional health help-seeking among Chinese adults: a systematic review. *Front. Psychiatry*. 2020;11:442. doi:10.3389/fpsyg.2020.00442.
- 153** Ventevogel P, Jordans M, Reis R, de Jong J. Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Confl Health*. 2013;7(1):1–16. doi:10.1186/1752-1505-7-3.
- 154** Funk M, Drew N, Freeman M, Faydi E. Mental health and development: targeting people with mental health conditions as a vulnerable group. Geneva: World Health Organization; 2010 (<https://www.who.int/publications/i/item/9789241563949>, accessed 25 March 2022).
- 155** Thornicroft G. Shunned: discrimination against People with Mental Illness. Oxford: Oxford University Press; 2006.
- 156** Corrigan P, Watson AC. Understanding the impact of stigma on people with mental illness. *World Psychiatry*. 2002;1(1):16–20.
- 157** Gureje O, Lasebikan VO, Ephraim-Oluwanuga O, Olley BO, Kola L. Community study of knowledge of and attitude to mental illness in Nigeria. *Br J Psychiatry* 2005;186:436–441. doi:10.1192/bjop.186.5.436.
- 158** Polyakov M, Sale J, Kline S, Saxena S. No health without mental health: the urgent need for health integration in universal health coverage. London: United for Global Mental Health; 2020 (<https://unitedgmh.org/sites/default/files/2020-12/Universal%20Health%20Coverage%20-%20No%20Health%20Without%20Mental%20Health.pdf>, accessed 25 March 2022).
- 159** mhGAP Evidence Resource Centre. In: WHO [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre>, accessed 25 March 2022).
- 160** Caddick H, Horne B, Mackenzie J, Tilley H. Investing in mental health in low-income countries. ODI Insights report. Overseas Development Institute: London; 2016 (<https://odi.org/en/publications/investing-in-mental-health-in-low-income-countries>, accessed 25 March 2022).
- 161** mhGAP operations manual. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/275386>, accessed 28 March 2022).
- 162** Stein DJ, Benjet C, Gureje O, Lund C, Scott KM, Poznyak V, et al. Integrating mental health with other non-communicable diseases. *BMJ*. 2019;364:l295. doi:10.1136/bmj.l295.
- 163** Scott KM, Von Korff M, Angermeyer MC, Benjet C, Bruffaerts R, de Girolamo G, et al. Association of childhood adversities and early-onset mental disorders with adult-onset chronic physical conditions. *Arch Gen Psychiatry*. 2011;68(8):838–844. doi:10.1001/archgenpsychiatry.2011.77.
- 164** Berkowitz AL, Raibagkar P, Pritt BS, Mateen FJ. Neurological manifestations of the neglected tropical diseases. *J Neurol Sci*. 2015;349(1–2):20–32.
- 165** Thakur KT, Boubour A, Saylor D, Das M, Bearden DR, Birbeck GL. Global HIV neurology: A comprehensive review. *Aids*. 2019; 33(2):163–184. doi:10.1097/QAD.0000000000001796.
- 166** Integration of mental health and HIV interventions: key considerations. Geneva: UNAIDS and World Health Organization; 2022 (https://www.unaids.org/sites/default/files/media_asset/integration-mental-health-hiv-interventions_en.pdf, accessed 11 May 2022).
- 167** Fujiwara PI. The links between tuberculosis and mental health: evidence and best practice incorporating guidance to USAID. Washington DC: USAID; 2022 (<https://www.usaid.gov/global-health-health-areas/tuberculosis/resources/publications/link-tuberculosis-mental-health>, accessed 25 March 2022).
- 168** Mental health of people with neglected tropical diseases: Towards a person-centered approach. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/335885>, accessed 25 March 2022).
- 169** Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *Lancet*. 2007;370(9590):851–858. doi:10.1016/S0140-6736(07)61415-9.
- 170** Ciesla JA, Roberts JE. Meta-analysis of the relationship between HIV infection and risk for depressive disorders. *Am J Psychiatry*. 2001;158(5):725–730. doi:10.1176/appi.ajp.158.5.725.
- 171** Pelton M, Ciarletta M, Wisnousky H, Lazzara N, Manglani M, Ba DM, et al. Rates and risk factors for suicidal ideation, suicide attempts and suicide deaths in persons with HIV: a systematic review and meta-analysis. *Gen Psychiatry* 2021;34:e100247. doi:10.1136/gpsych-2020-100247.
- 172** Ambaw F, Mayston R, Hanlon C, Medhin G, Alem A. Untreated depression and tuberculosis treatment outcomes, quality of life and disability, Ethiopia. *Bull World Health Organ*. 2018;96:243–255. doi:10.2471/BLT.17.192658.
- 173** Sartorius N. Comorbidity of mental and physical diseases: a main challenge for medicine of the 21st century. *Shanghai Arch Psychiatry*. 2013;25(2):68–69. doi:10.3969/j.issn.1002-0829.2013.02.002.
- 174** Integrating the prevention, treatment and care of mental health conditions and other noncommunicable diseases within health systems. WHO European high-level conference on noncommunicable diseases. Copenhagen: World Health Organization Regional Office for Europe; 2019 (https://www.euro.who.int/__data/assets/pdf_file/0004/397786/Mental-Health-Conditions-ENG.pdf, accessed 25 March 2022).
- 175** Integrating the response to mental disorders and other chronic diseases in health care systems. Geneva: World Health Organization; 2014 (<https://apps.who.int/iris/handle/10665/112830>, accessed 25 March 2022).
- 176** Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*. 2012;10:CD006525. doi:10.1002/14651858.CD006525.pub2.

- 177** Li LW, Xue J, Conwell Y, Yang Q, Chen S. Implementing collaborative care for older people with comorbid hypertension and depression in rural China. *Int Psychogeriatr.* 2020;32(12):1457–1465. doi:10.1017/S1041610219001509.
- 178** Knapp M, Funk M, Curran C, Prince M, Grigg M, McDaid D. Economic barriers to better mental health practice and policy. *Health Policy Plan.* 2006;21(3):157–170. doi:10.1093/heapol/cz003.
- 179** UHC Compendium. In: WHO/Universal Health Coverage [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/universal-health-coverage/compendium/database>, accessed 25 March 2022).
- 180** Aguilera I, Infante A, Ormeño H, Urriola C. Improving health system efficiency: Chile: Implementation of the Universal Access with Explicit Guarantees (AUGE) reform. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/187657>, accessed 25 March 2022).
- 181** Bitran R. Explicit health guarantees for Chileans: the AUGE benefits package. Washington DC: The World Bank; 2013. (<https://documents.worldbank.org/en/publication/documents-reports/documentdetail/308611468014981092/explicit-health-guarantees-for-chileans-the-auge-benefits-package>, accessed 25 March 2022).
- 182** Araya R, Zitko P, Markkula N. The impact of universal health care programmes on improving ‘realized access’ to care for depression in Chile. *Adm Policy Ment Health.* 2018;45:790–799. doi:10.1007/s10488-018-0864-z.
- 183** Lasalvia A, Zoppe S, Van Bortel T, Bonetto C, Cristofalo D, Wahlbeck K, et al. Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: A cross-sectional survey. *Lancet.* 2013;381(9860):55–62. doi:10.1016/S0140-6736(12)61379-8.
- 184** QualityRights materials for training, guidance and transformation. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools>, accessed 25 March 2022).
- 185** Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D, et al. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *Lancet.* 2016;387(10023):1123–1132. doi:10.1016/S0140-6736(15)00298-6.
- 186** Corrigan PW, River LP, Lundin RK, Penn DL, Uphoff-Wasowski K, Campion J, et al. Three strategies for changing attributions about severe mental illness. *Schizophr Bull.* 2001;27(2):187–195. doi:10.1093/oxfordjournals.schbul.a006865.
- 187** Clay J, Eaton J, Gronholm PC, Semrau M, Votruba N. Core components of mental health stigma reduction interventions in low- and middle-income countries: a systematic review. *Epidemiol Psychiatr Sci.* 2020;29:e164. doi:10.1017/S2045796020000797.
- 188** Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. Ending discrimination against people with mental and substance use disorders: the evidence for stigma change. Washington DC: National Academies Press; 2016. doi:10.17226/23442.
- 189** Strengthening mental health [website]. London: The Indigo Network; 2021 (<https://indigo-group.org/>, accessed 24 October 2021).
- 190** Thornicroft G, Bakolis I, Evans-Lacko S, Gronholm PC, Henderson C, Kohrt BA, et al. Key lessons learned from the INDIGO global network on mental health related stigma and discrimination. *World Psychiatry.* 2019;18(2):229–230. doi:10.1002/wps.20628.
- 191** Yon Y, Ramiro-Gonzalez M, Mikton CR, Huber M, Sethi D. The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. *Eur J Public Health.* 2019;29(1):58–67. doi:10.1093/ejpub/cky093.
- 192** Desmond C, Watt K, Saha A, Huang J, Lu C. Prevalence and number of children living in institutional care: Global, regional and country estimates. *Lancet Child Adolesc Health.* 2020;4(5):370–377. doi:10.1016/S2352-4642(20)30022-5.
- 193** WHO and the Calouste Gulbenkian Foundation. Promoting rights and community living for children with psychosocial disabilities. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/184033>, accessed 25 March 2022).
- 194** Living in chains: shackling of people with psychosocial disabilities worldwide. New York: Human Rights Watch; 2020 (<https://www.hrw.org/report/2020/10/06/living-chains/shackling-people-psychosocial-disabilities-worldwide>, accessed 23 November 2021).
- 195** Peterson I, Marais D, Abdulmalik J, Ahuja S, Alem A, Chisholm D, et al. Strengthening mental health system governance in six low- and middle-income countries in Africa and South Asia: Challenges, needs and potential strategies. *Health Policy Plan.* 2017;32(5):699–709. doi:10.1093/heapol/czx014.
- 196** WHO QualityRights e-training on mental health, recovery and community inclusion [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training>, accessed 25 March 2022).
- 197** WHO QualityRights [website]. Geneva: World Health Organization; 2019 (<https://qualityrights.org>, accessed 25 March 2022).
- 198** Funk M, Drew Bold N, Ansong J, Chisholm D, Murko M, Nato J, et al. Strategies to achieve a rights-based approach through WHO QualityRights. In: Stein MA, Mahomed F, Patel V, Sunkel C (editors). Mental health, legal capacity and human rights. Cambridge: Cambridge University Press; 2021. doi:10.1017/9781108979016.
- 199** Freeman MC, Kolappa K, Caldas de Almeida JM, Kleinman A, Makhashvili N, Phakathi S, et al. Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. *Lancet Psychiatry.* 2015;2(9):844–850. doi:10.1016/S2215-0366(15)00218-7.
- 200** Puras D, Gooding P. Mental health and human rights in the 21st century. *World Psychiatry.* 2019;18(1):42–43. doi:10.1002/wps.20599.
- 201** Minkowitz T. CRPD advocacy by the World Network of Users and Survivors of Psychiatry: The emergence of an user/survivor perspective in human rights. *SSRN.* 2012. doi:10.2139/ssrn.2326668.
- 202** Sunkel C. The UN convention: a service user perspective. *World Psychiatry.* 2019;18(1):51–52. doi:10.1002/wps.20606.
- 203** Barbui C, Purgato M, Abdulmalik J, Caldas-de-Almeida JM, Eaton J, Gureje O, et al. Efficacy of interventions to reduce coercive treatment in mental health services: Umbrella review of randomised evidence. *Br J Psychiatry.* 2020;1–11. doi:10.1192/bjp.2020.144.
- 204** Strategies to end seclusion and restraint: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329605>, accessed 25 March 2022).
- 205** Supported decision-making and advance planning: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329609>, accessed 25 March 2022).
- 206** Vásquez Encalada A, Bialik K, Stober K. Supported decision making in South America: Analysis of three countries’ experiences. *Int J Environ Res Public Health.* 2021;18:5204. doi:10.3390/ijerph18105204.
- 207** User empowerment in mental health: a statement by the WHO Regional Office for Europe. Empowerment is not a destination, but a journey. Copenhagen: World Health Organization Regional Office for Europe; 2010 (<https://apps.who.int/iris/handle/10665/107275>, accessed 25 March 2022).
- 208** Voice, agency, empowerment – handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/342704>, accessed 25 March 2022).
- 209** Semrau M, Lempp H, Keynejad R, Evans-Lacko S, Mugisha J, Raja S, et al. Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: systematic review. *BMC Health Serv Res.* 2016;16:79. doi:10.1186/s12913-016-1323-8.
- 210** Kohrt BA, Jordans MJD, Turner EL, Rai S, Gurung D, Dhakal M, et al. Collaboration with people with lived experience of mental illness to reduce stigma and improve primary care services: a pilot cluster randomized clinical trial. *JAMA Netw Open.* 2021;4(11):e2131475. doi:10.1001/jamanetworkopen.2021.31475.
- 211** Civil society organizations to promote human rights in mental health and related areas: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329589>, accessed 25 March 2022).



- 212** Joint position statement. Equality and equity in COVID-19 response. Global Mental Health Peer Network & Human Rights in Mental Health FGIP; 2020 (https://www.gmhpn.org/uploads/1/2/0/2/120276896/gmhpn_fgip_joint_position_statement_-_covid19.pdf, accessed 25 March 2022).
- 213** Healthy, prosperous lives for all: the European health equity status report. Copenhagen: World Health Organization Regional Office for Europe; 2019 (<https://apps.who.int/iris/handle/10665/326879>, accessed 25 March 2022).
- 214** Pathare S, Burgess RA, Collins PY. World Mental Health Day: Prioritise social justice, not only access to care. *Lancet*. 2021; 398(10314):1859–1860. doi:10.1016/S0140-6736(21)02232-7.
- 215** Marmot M, Allen J. Health priorities and the social determinants of health. *East Mediterr Health J*. 2015;21(9):671–672 (https://applications.emro.who.int/emhj/v21/09/EMHJ_2015_21_9_671_672.pdf?ua=1&ua=1, accessed 25 March 2022).
- 216** Lund C, Docrat S, Abdulmalik J, Alem A, Fekadu A, Gureje O, et al. Household economic costs associated with mental, neurological and substance use disorders: a cross-sectional survey in six low- and middle-income countries. *BJPsych Open*. 2019;5(3):E34. doi:10.1192/bjo.2019.20.
- 217** Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry*. 2016;3(5):415–424. doi:10.1016/S2215-0366(16)30024-4.
- 218** Lund C, Orkin K, Witte M, Davies T, Haushofer J, Bass J, et al. The economic effects of mental health interventions in low- and middle-income countries: a systematic review and meta-analysis. Working paper. 2018 (<https://www.semanticscholar.org/paper/Economic-impacts-of-mental-health-interventions-in-Lund-Orkin/023b6dd83154b0793efae987aba6e7d493f7854>, accessed 26 May 2022).
- 219** Kangasniemi A, Maxwell L, Sereno M. The ROI in workplace mental health programs: good for people, good for business: a blueprint for workplace mental health programs. New York: Deloitte; 2019 (<https://www2.deloitte.com/us/en/insights/topics/talent/workplace-mental-health-programs-worker-productivity.html>, accessed 25 March 2022).
- 220** Santini ZI, Becher H, Jørgensen MB, Davidsen M, Nielsen L, Hinrichsen C, et al. Economics of mental well-being: a prospective study estimating associated health care costs and sickness benefit transfers in Denmark. *Eur J Health Econ*. 2021;22:1053–1065. doi:10.1007/s10198-021-01305-0.
- 221** Mental health investment case: a guidance note. Geneva: World Health Organization and United Nations Development Programme; 2021 (<https://apps.who.int/iris/handle/10665/340246>, accessed 25 March 2022).
- 222** WHO menu of cost-effective interventions for mental health. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/343074>, accessed 25 March 2022).
- 223** Chisholm D, Saxena S. Cost effectiveness of strategies to combat neuropsychiatric conditions in sub-Saharan Africa and South East Asia: mathematical modelling study. *BMJ*. 2012;344:e609. doi:10.1136/bmj.e609.
- 224** Chisholm D, Burman-Roy S, Fekadu A, Kathree T, Kizza D, Luitel NP, et al. Estimating the cost of implementing district mental healthcare plans in five low- and middle-income countries: the PRIME study. *Br J Psychiatry*. 2016;208(Suppl 56):s71–s78. doi:10.1192/bjp.bp.114.153866.
- 225** Care for mental health conditions in Jamaica: The case for investment. Evaluating the return on investment of scaling up treatment for depression, anxiety, and psychosis. Washington DC: Panamerican Health Organization; 2019.
- 226** Prevention and management of mental health conditions in the Philippines. The case for investment. Manila: World Health Organization Regional Office for the Western Pacific; 2021.
- 227** Besada D, Docrat S, Lund C. Mental health investment case for South Africa. Final report of the Mental Health investment case task team. Pretoria: Department of Health; 2021.
- 228** Prevention and management of mental health conditions in Uzbekistan: the case for investment. Copenhagen: World Health Organization Regional Office for Europe; 2021.
- 229** Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007 (<https://apps.who.int/iris/handle/10665/43918>, accessed 28 March 2022).
- 230** International standards on the right to physical and mental health. In: UN Human Rights [website]. New York: Office of the High Commissioner for Human Rights; 2021 (<https://www.ohchr.org/en/issues/health/pages/internationalstandards.aspx>, accessed 28 March 2022).
- 231** Resolution A/RES/70/1. In: Seventieth United Nations General Assembly, New York, 25 September 2015. Transforming our world: the 2030 Agenda for Sustainable Development. New York: United Nations General Assembly; 2015 (<https://sdgs.un.org/2030agenda>, accessed 28 March 2022).
- 232** Resolution A/RES/73/2. In: Seventy-third United Nations General Assembly, New York, 10 October 2018. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. New York: United Nations General Assembly; 2018 (<https://digitallibrary.un.org/record/1648984>, accessed 28 March 2022).
- 233** Resolution A/RES/74/2. In: Seventy-fourth United Nations General Assembly, New York, 10 October 2019. Political declaration of the high-level meeting on universal health coverage: New York: United Nations General Assembly; 2019 (<https://undocs.org/en/A/RES/74/2>, accessed 28 March 2022).
- 234** WHO Special Initiative for Mental Health. In: WHO/Initiatives [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/initiatives/who-special-initiative-for-mental-health>, accessed 28 March 2022).
- 235** Patel V, Saxena S. Achieving universal health coverage for mental disorders. *BMJ*. 2019;366:l4516. doi:10.1136/bmj.l4516.
- 236** Campion J, Knapp M. The economic case for improved coverage of public mental health interventions. *Lancet Psychiatry* 2018;5(2):103–105. doi:10.1016/S2215-0366(17)30433-9.
- 237** Caldas de Almeida JM, Minas H, Cayetano C. Generating political commitment for mental health system development. In: Patel V, Minas H, Cohen A, Prince M (editors). *Global mental health: principles and practice*. Oxford: Oxford University Press; 2013. doi:10.1093/med/9780199920181.003.0020.
- 238** The World Mental Health Survey Initiative [website]. Boston: Harvard University; 2021 (<https://www.hcp.med.harvard.edu/wmh>, accessed 28 March 2022).
- 239** Demyttenaere K, Bruffaerts R, Posada-Villa J, Gasquet I, Kovess V, Lepine JP, et al. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA*. 2004;291(21):2581–2590. doi:10.1001/jama.291.21.2581.
- 240** Kessler RC, Angermeyer M, Anthony JC, Graaf RDE, Demyttenaere K, Gasquet I, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*. 2007;6(3):168–176.
- 241** Dua T, Barbui C, Clark N, Fleischmann A, Poznyak V, van Ommeren M, et al. Evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: summary of WHO recommendations. 2011;8(11):e1001122. doi:10.1371/journal.pmed.1001122.
- 242** England MJ, Butler AS, Gonzalez ML (editors). *Psychosocial interventions for mental and substance use disorders: a framework for establishing evidence-based standards*. Washington DC: National Academies Press; 2015.
- 243** WHO model lists of essential medicines. In: WHO [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/groups/expert-committee-on-selection-and-use-of-essential-medicines/essential-medicines-lists>, accessed 28 March 2022).
- 244** mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: mental health Gap Action Programme (mhGAP), version 2.0. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/250239>, accessed 25 March 2022).
- 245** ICD-11: International Classification of Diseases 11th Revision [website]. Geneva: World Health Organization; 2020 (<https://icd.who.int>, accessed 28 March 2022).

- 246** Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural, and neurodevelopmental disorders. Geneva: World Health Organization; in press.
- 247** Reed GM, First MB, Kogan CS, Hyman SE, Gureje O, Gaebel W, et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. *World Psychiatry*. 2019;18(1):3–19. doi:10.1002/wps.20611.
- 248** Mental health information systems. Geneva: World Health Organization; 2005 (<https://apps.who.int/iris/handle/10665/43210>, accessed 28 March 2022)
- 249** Mayston R, Ebhohimen K, Jacob K. Measuring what matters – information systems for management of chronic disease in primary healthcare settings in low and middle-income countries: challenges and opportunities. *Epidemiol Psychiatr Sci*. 2020;20(e127):1–5. doi:10.1017/S204579602000030X.
- 250** Upadhyaya N, Jordans MJD, Abdulmalik J, Ahuja S, Alem A, Hanlon C, et al. Information systems for mental health in six low and middle income countries: cross country situation analysis. *Int J Ment Health Syst*. 2016;10:60. doi:10.1186/s13033-016-0094-2.
- 251** Collins PY, Patel V, Joestl SJ, March D, Insel TR, Daar AS, et al. Grand challenges in global mental health. *Nature*. 2011;475(7354):27–30. doi:10.1038/475027a.
- 252** Saraceno B. Mental health systems research is urgently needed. *Int J Ment Health Syst*. 2007;1(1):2. doi:10.1186/1752-4458-1-2.
- 253** Staley K, Kabin T, Szumukler G. Service users as collaborators in mental health research: less stick, more carrot. *Psychol Med*. 2013;43(6):1121–1125. doi:10.1017/S0033291712001663.
- 254** Votruba N, Grant J, Thornicroft G. The EVITA framework for evidence-based mental health policy agenda setting in low- and middle-income countries. *Health Policy Plan*. 2020;35(4):424–439. doi:10.1093/heapol/czz179.
- 255** Fox AM, Goldberg AB, Gore RJ, Bärnighausen T. Conceptual and methodological challenges to measuring political commitment to respond to HIV. *J Int AIDS Soc*. 2011;14(Suppl 2):S5. doi:10.1186/1758-2652-14-S2-S5.
- 256** Lemmi V. Motivation and methods of external organisations investing in mental health in low-income and middle-income countries: a qualitative study. *Lancet Psychiatry*. 2021;S2215-0366(20)30511-3. doi:10.1016/S2215-0366(20)30511-3.
- 257** Advocacy for mental health, disability and human rights: WHO QualityRights guidance module. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329587>, accessed 28 March 2022).
- 258** Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, et al. Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet*. 2007;370(9593):1164–1174. doi:10.1016/S0140-6736(07)61263-X.
- 259** World Mental Health Day. In: WHO [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/campaigns/world-mental-health-day>, accessed 28 March 2022).
- 260** Caldas de Almeida JM, Horvitz-Lennon M. Mental health care reforms in Latin America: an overview of mental health care reforms in Latin America and the Caribbean. *Psychiatr Serv*. 2010;61(3):218–221. doi:10.1176/ps.2010.61.3.218.
- 261** Building back better: sustainable mental health care after emergencies. Geneva: World Health Organization; 2013 (<https://apps.who.int/iris/handle/10665/85377>, accessed 28 March 2022).
- 262** Expansion of Mental health Services in Sri Lanka. Colombo: Ministry of Health Sri Lanka and WHO Country Office for Sri Lanka; 2021.
- 263** Promoting mental health preparedness and response for public health emergencies. In: 148th Session Executive Board, Geneva, 18–26 January 2021. Resolutions and decisions, annexes. Geneva: World Health Organization; 2021 (EB148(3); https://apps.who.int/gb/ebwha/pdf_files/EB148-REC1/B148_REC1-en.pdf#page=32, accessed 28 March 2022).
- 264** Shidhaye R, Murhar V, Gangale S, Aldridge L, Shastri R, Parikh R, et al. The effect of VISHRAM, a grass-roots community-based mental health programme, on the treatment gap for depression in rural communities in India: a population-based study. *Lancet Psychiatry*. 2017;4(2):128–135. doi:10.1016/S2215-0366(16)30424-2.
- 265** Jordans MJD, Luitel NP, Lund C, Kohrt BA. Evaluation of proactive community case detection to increase help seeking for mental health care: a pragmatic randomized controlled trial. *Psychiatr Serv*. 2020;71(8):810–815. doi:10.1176/appi.ps.201900377.
- 266** Naslund JA, Aschbrenner KA, Araya R, Marsch LA, Unützer J, Patel V, et al. Digital technology for treating and preventing mental disorders in low-income and middle-income countries: a narrative review of the literature. *Lancet Psychiatry*. 2017;4(6):486–500. doi:10.1016/S2215-0366(17)30096-2.
- 267** Martinez-Martin N, Dasgupta I, Carter A, Chandler JA, Kellmeyer P, Kreitmair K, et al. Ethics of digital mental health during COVID-19: crisis and opportunities. *JMIR Ment Health*. 2020;7(12):e23776. doi:10.2196/23776.
- 268** Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/311664>, accessed 8 April 2022).
- 269** Standards for healthy eating, physical activity, sedentary behaviour and sleep in early childhood education and care settings: a toolkit. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345926>, accessed 8 April 2022).
- 270** Mihara S, Higuchi S. Cross-sectional and longitudinal epidemiological studies of Internet gaming disorder: a systematic review of the literature. *Psychiatry Clin Neurosci*. 2017;71(7):425–444. doi:10.1111/pcn.12532.
- 271** Araya R, Rossi Menezes P, Garcia Claro H, Brandt LR, Daley KL, Quayle J, et al. Effect of a digital intervention on depressive symptoms in patients with comorbid hypertension or diabetes in Brazil and Peru: two randomized clinical trials. *JAMA*. 2021;325(18):1852–1862. doi:10.1001/jama.2021.4348.
- 272** Mental well-being: resources for the public. In: WHO [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/news-room/feature-stories/mental-well-being-resources-for-the-public>, accessed 28 March 2022).
- 273** Resources. In: Global Mental Health Peer Network [website]. Johannesburg: Global Mental Health Peer Network; 2021 (<https://www.gmhp.org/resources.html>, accessed 28 March 2022).
- 274** Liu S, Yang L, Zhang C, Xiang Y-T, Liu Z, Hu S, et al. Online mental health services in China during the COVID-19 outbreak. *Lancet Psychiatry*. 2020;7(4):e17–e18. doi:10.1016/S2215-0366(20)30077-8.
- 275** EMPOWER [website]. Boston: EMPOWER; 2021 (<https://empower-care.com>, accessed 28 March 2022).
- 276** Virtual Campus for Public Health [website]. Washington DC: Panamerican Health Organization; 2021 (<https://www.campusvirtualsp.org>, accessed 28 March 2022).
- 277** PAHO's virtual campus offers courses on COVID-19. PAHO/BIREME/WHO Bulletin 43. Washington DC; Pan American Health Organization; 2020 (<https://boletin.bireme.org/en/2020/04/30/pahos-virtual-campus-offers-courses-on-covid-19>, accessed 28 March 2022).
- 278** Khoja S, Scott R, Husyin N, Durran H, Arif M, Faqiri F, et al. Impact of simple conventional and telehealth solutions on improving mental health in Afghanistan. *J Telemed Telecare*. 2016;22(8):495–498. doi:10.1177/1357633X16674631.
- 279** Berryhill MB, Culmer N, Williams N, Halli-Tierney A, Betancourt A, Roberts H, et al. Videoconferencing psychotherapy and depression: a systematic review. *Telemed J E Health*. 2019;25:435–446. doi:10.1089/tmj.2018.0058.
- 280** FDA Circular No. 2020–007. Guidelines in the implementation of the use of electronic means of prescription for drugs for the benefit of individuals vulnerable to COVID-19. Manila: Food and Drug Administration Philippines; 2020 (<https://www.fda.gov/ph/fda-circular-no-2020-007-guidelines-in-the-implementation-of-the-use-of-electronic-means-of-prescription-for-drugs-for-the-benefit-of-individuals-vulnerable-to-covid-19>, accessed 28 March 2022).
- 281** Comparative effectiveness of different formats of psychological treatments for depressive disorder. Geneva: World Health Organization; 2015 (<https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre/depression/comparative-effectiveness-of-different-formats-of-psychological-treatments-for-depressive-disorder>, accessed 27 May 2022).



- 282** Sasaki N, Immura K, Thi Thu Tran T, Thanh Nguyen H, Kurabayashi K, Sakuraya A, et al. Effects of smartphone-based stress management on improving work engagement among nurses in Vietnam: secondary analysis of a three-arm randomized controlled trial. *J Med Internet Res.* 2021;23(2):e20445. doi:10.2196/20445.
- 283** Schaub MP, Tiburcio M, Martínez-Vélez N, Ambekar A, Bhad R, Wenger A, et al. The effectiveness of a web-based self-help program to reduce alcohol use among adults with drinking patterns considered harmful, hazardous, or suggestive of dependence in four low- and middle-income countries: randomized controlled trial. *J Med Internet Res.* 2021;23(8):e21686. doi:10.2196/21686.
- 284** McBride KA, Harrison S, Mahata S, Pfeffer K, Cardamone F, Ngigi T, et al. Building mental health and psychosocial support capacity during a pandemic: the process of adapting Problem Management Plus for remote training and implementation during COVID-19 in New York city, Europe and East Africa. *Intervention.* 2021;19(1):37–47. doi:10.4103/INTV.INTV_30_20.
- 285** Rosenberg T. Depressed? Here's a bench. Talk to me. *New York Times.* 22 July 2019 (<https://www.nytimes.com/2019/07/22/opinion/depressed-heres-a-bench-talk-to-me.html>, accessed 28 March 2022).
- 286** Financing global mental health. London: Lion's Head Global Partners; 2018 (<http://unitedgmh.org/sites/default/files/2020-09/Financing-for-Global-Mental-Health-2018.pdf>, accessed 28 March 2022).
- 287** March 2019 Epidemiological studies of mental health NIMH HDHN Elaboration: Mental Health Technical Team. Lima: OGTI MINSA; 2019.
- 288** Improving networks of community mental health services in the Asia-Pacific economies: Lima, Peru; 16–19 July 2019. Singapore: Asia-Pacific Economic Cooperation; 2020 (https://www.apec.org/docs/default-source/Publications/2020/11/Improving-Networks-of-Community-Mental-Health-Services-in-the-Asia-Pacific-Economies/220_HWG_Improving-Networks-of-Community-Mental-Health-Services-in-the-Asia-Pacific-Economies.pdf, accessed 28 March 2022).
- 289** Chisholm D. Dollars, DALYs and decisions: economic aspects of the mental health system. Geneva: World Health Organization; 2006 (<https://apps.who.int/iris/handle/10665/43574>, accessed 28 March 2022).
- 290** United Nations multi-partner trust fund to catalyze country action for non-communicable diseases and mental health. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341905>, accessed 28 March 2022).
- 291** Charlson FJ, Dieleman J, Singh L, Whiteford HA. Donor financing for global mental health, 1995–2015: an assessment of trends, channels, and alignment with the disease burden. *PLoS One.* 2017;12:e016938. doi:10.1371/journal.pone.0169384.
- 292** Lemmi V. Philanthropy for global mental health 2000–2015. *Glob Ment Health (Camb).* 2020;7:e9. doi:10.1017/gmh.2020.2.
- 293** Pursukoon Zindagi “Peaceful Life” COVID-19 Mental Health Response. In: MHN/Innovations [website]. Geneva: Mental Health Innovation Network; 2021 (<https://www.mhinnovation.net/innovations/pursukoon-zindagi-peaceful-life-covid-19-mental-health-response>, accessed 28 March 2022).
- 294** IRD. Pursukoon Zindagi – ‘Peaceful Life’. Durham: Innovations in Healthcare; 2021 (<https://www.innovationsinhealthcare.org/IRD%20Innovator%20Profile.pdf>, accessed 28 March 2022).
- 295** Kohrt B, Asher L, Bhardwaj A, Fazel M, Jordans MJD, Mutamba BB, et al. The role of communities in mental health care in low- and middle-income countries: a meta-review of components and competencies. *Int J Environ Res Public Health.* 2018;15(6):1279. doi:10.3390/ijerph15061279.
- 296** Van Ginneken N, Yee Chin W, Chian Lim Y, Ussif A, Singh R, Shahmalak U, et al. Primary-level worker interventions for the care of people living with mental disorders and distress in low- and middle-income countries. *Cochrane Database Syst Rev.* 2021;8(CD009149). doi:10.1002/14651858.CD009149.pub3.
- 297** Petersen I, Lund C, Bhana A, Flisher AJ. The Mental Health and Poverty Research Programme Consortium. A task shifting approach to primary mental health care for adults in South Africa: human resource requirements and costs for rural settings. *Health Policy Plan.* 2012;27(1):42–51. doi:10.1093/heapol/czr012.
- 298** Kakuma R, Minas H, van Ginneken N, Dal Poz MR, Desiraju K, Morris JE, et al. Human resources for mental health care: current situation and strategies for action. *The Lancet.* 2011;378(9803):1654–1663. doi:10.1016/S0140-6736(11)61093-3.
- 299** Gureje O, Hollins S, Botbol M, Javed A, Jorge M, Okech V, et al. Report of the WPA task force on brain drain. *World Psychiatry.* 2009;8(2):115–118. doi:10.1002/j.2051-5545.2009.tb00225.x.
- 300** Atlas: Psychiatric education and training across the world. Geneva: World Health Organization; 2005 (<https://apps.who.int/iris/handle/10665/43345>, accessed 28 March 2022).
- 301** Wondimagegn D, Pain C, Baheretibeb Y, Hodges B, Wakma M, Rose M, et al. Toronto Addis Ababa academic collaboration: a relational, partnership model for building educational capacity between a high- and low-income university. *Acad Med.* 2018;93(12):1795–1801. doi:10.1097/ACM.0000000000002352.
- 302** Psychiatry. In: University of Toronto [website]. Toronto: University of Toronto; 2021 (<https://taaac.ca/psychiatry>, accessed 28 March 2022).
- 303** Gwaikolo WS, Kohrt BA, Cooper JL. Health system preparedness for integration of mental health services in rural Liberia. *BMC health services research.* 2017;17(1):508. doi:10.1186/s12913-017-2447-1.
- 304** Fernando N, Suveendran T, de Silva C. Decentralizing provision of mental health care in Sri Lanka. *WHO South-East Asia J Pub Health.* 2017;6(1):18–21. doi:10.4103/2224-3151.206159.
- 305** Spagnolo J, Lal S. Implementation and use of the Mental Health Gap Action Programme Intervention Guide (mhGAP-IG): a review of the grey literature. *J Glob Health.* 2021;11:04022. doi:10.7189/jogh.11.04022.
- 306** Enhancing mental health pre-service training with the mhGAP intervention guide: experiences and lessons learned. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/333970>, accessed 28 March 2022).
- 307** mhGAP training manuals for the mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/259161>, accessed 28 March 2022).
- 308** Keynejad R, Spagnolo J, Thornicroft G. WHO mental health gap action programme (mhGAP) intervention guide: updated systematic review on evidence and impact. *Evid Based Ment Health.* 2021;24(3):124–130. doi:10.1136/ebmental-2021-300254.
- 309** Caulfield A, Catانsev D, Lambert G, Van Bortel T. WHO guidance on mental health training: a systematic review of the progress for non-specialist health workers. *BMJ Open.* 2019;9:e024059. doi:10.1136/bmjopen-2018-024059.
- 310** mhGAP community toolkit. Mental Health Gap Action Programme (mhGAP). Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/328742>, accessed 28 March 2022).
- 311** Psychological first aid: facilitator’s manual for orienting field workers. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/102380/9789241548618_eng.pdf?sequence=1, accessed 28 March 2022).
- 312** One-to-one peer support by and for people with lived experience: WHO QualityRights guidance module: module slides. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329643>, accessed 28 March 2022).
- 313** Keet R, de Vetten-McMahon M, Shields-Zeeman L, Ruud T, van Weeghel J, Bahler M, et al. Recovery for all in the community; position paper on principles and key elements of community-based mental health care. *BMC Psychiatry.* 2019;19(1):174. doi:10.1186/s12888-019-2162-z.
- 314** Singla DR, Kohrt BA, Murray LK, Anand A, Chorpita BF, Patel V. Psychological treatments for the world: lessons from low- and middle-income countries. *Annu Rev Clin Psychol.* 2017;13:149–181. doi:10.1146/annurev-clinpsy-032816-045217.
- 315** Kohrt BA, Schafer A, Willhoite A, van’t Hof E, Pedersen GA, Watts S, et al. Ensuring Quality in Psychological Support (WHO EQUIP): developing a competent global workforce. *World Psychiatry.* 2020;19(1):115–116. doi:10.1002/wps.20704.

- 316** Kohrt BA, Jordans MJD, Rai S, Shrestha P, Luitel NP, Ramaiya M, et al. Therapist competence in global mental health: development of the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale. *Behav Res Ther.* 2015;69:11–21. doi:10.1016/j.brat.2015.03.009.
- 317** Organization of services for mental health. Geneva: World Health Organization; 2003 (<https://apps.who.int/iris/handle/10665/333104>, accessed 28 March 2022).
- 318** The optimal mix of services for mental health. Geneva: World Health Organization; 2003 (https://www.mhinnovation.net/sites/default/files/files/2_Optimal%20Mix%20of%20Services_Infosheet%5B1%5D.pdf, accessed 6 May 2022).
- 319** Living with the times: a mental health and psychosocial support toolkit for older adults during the COVID-19 pandemic. In: IASC [website]. Geneva: Inter-Agency Standing Committee; 2021 (<https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/living-times-mental-health-and-psychosocial-support-toolkit-older-adults-during-covid-19-pandemic>, accessed 19 March 2022).
- 320** Cuijpers P, Donker T, van Straten A, Li J, Andersson G. Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychol Med.* 2010;40(12):1943–1957. doi:10.1017/S0033291710000772.
- 321** Person-centred recovery planning for mental health and well-being: self-help tool: WHO QualityRights. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329598>, accessed 29 March 2022).
- 322** Cronin P, Stein-Parbury J, Sommer J, Gill KH. What about value for money? A cost benefit analysis of the South Eastern Sydney Recovery and Wellbeing College. *J Ment Health.* 2021;1–8. doi:10.1080/09638237.2021.1922625.
- 323** Crowther A, Taylor A, Toney R, Meddings S, Whale T, Jennings H, et al. The impact of recovery colleges on mental health staff, services and society. *Epidemiol Psychiatr Sci.* 2019;28(5):481–488. doi:10.1017/S204579601800063X.
- 324** Le LK-D, Esturas AC, Mihalopoulos C, Chiotelis O, Bucholz J, Chatterton ML, et al. Cost-effectiveness evidence of mental health prevention and promotion interventions: a systematic review of economic evaluations. *PLoS Med.* 2021;18(5):e1003606. doi:10.1371/journal.pmed.1003606.
- 325** Friedli L. Mental health, resilience and inequalities. Copenhagen: World Health Organization Regional Office for Europe; 2009 (<https://apps.who.int/iris/handle/10665/107925>, accessed 28 March 2022).
- 326** Act Belong Commit [website]. Perth: Curtin University; 2021 (<https://www.actbelongcommit.org.au>, accessed 28 March 2022).
- 327** Anwar-McHenry J, Donovan R. Case study: Act-Belong-Commit. In: Barry MM, Clarke AM, Petersen I, Jenkins R (editors). Implementing mental health promotion. Second edition. Cham: Springer; 2019. doi:10.1007/978-3-030-23455-3.
- 328** Ho FKW, Louie LHT, Wong WH, Chan KL, Tiwari A, Chow CB, et al. A sports-based youth development program, teen mental health, and physical fitness: an RCT. *Pediatrics.* 2017;140(4):e20171543. doi:10.1542/peds.2017-1543.
- 329** Firth J, Solmi M, Wootton RE, Vancampfort D, Schuch FB, Hoare E, et al. A meta-review of “lifestyle psychiatry”: the role of exercise, smoking, diet and sleep in the prevention and treatment of mental disorders. *World Psychiatry.* 2020;19(3):360–380. doi:10.1002/wps.20773.
- 330** Gage SH, Hickman M, Zammit S. Association between cannabis and psychosis: epidemiologic evidence. *Biol Psychiatry.* 2016;79(7):549–556. doi:10.1016/j.biopsych.2015.08.001.
- 331** WHO independent high-level commission on noncommunicable diseases: final report. It's time to walk the talk. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/330023>, accessed 28 March 2022).
- 332** Murray RM, David AS, Ajnakina O. Prevention of psychosis: moving on from the at-risk mental state to universal primary prevention. *Psychol Med.* 2021;51(1):223–227. doi:10.1017/S003329172000313X.
- 333** Putnam RD, Leonardi R, Nanetti RY. Making democracy work: civic traditions in modern Italy. Princeton: Princeton University Press; 1993.
- 334** Forsman AK, Nordmyr J, Wahlbeck K. Psychosocial interventions for the promotion of mental health and the prevention of depression among older adults. *Health Promot Int.* 2011;26(Suppl 1):i85–i107. doi:10.1093/heapro/dar074.
- 335** Devries K, Watts C, Yoshihama M, Kiss L, Blima Schraiber L, Deyessa N, et al. Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women. *Soc Sci Med.* 2011;73(1):79–86. doi:10.1016/j.socscimed.2011.05.006.
- 336** Respect women: preventing violence against women. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/312261>, accessed 28 March 2022).
- 337** INSPIRE: seven strategies for ending violence against children. Geneva: World Health Organization and partners; 2016 (<https://apps.who.int/iris/handle/10665/207717>, accessed 28 March 2022).
- 338** Hawkins JD, Catalano RF, Kuklinski MR. Communities that care. In: Bruinsma G, Weisburd D (editors). Encyclopedia of criminology and criminal justice. New York: Springer; 2014. doi:10.1007/978-1-4614-5690-2_581.
- 339** Oesterle S, Kuklinski MR, Hawkins JD, Skinner ML, Guttmannova K, Rhew IC. Long-term effects of the Communities That Care trial on substance use, antisocial behavior and violence through age 21 years. *Am J Public Health.* 2018;108(5):659–665. doi:10.2105/AJPH.2018.304320.
- 340** Prevention of mental disorders: effective interventions and policy options. Geneva: World Health Organization; 2004 (<https://apps.who.int/iris/handle/10665/43027>, accessed 28 March 2022).
- 341** McGuire J, Kaiser C, Bach-Mortensen AM. A systematic review and meta-analysis of the impact of cash transfers on subjective well-being and mental health in low- and middle-income countries. *Nat Hum Behav.* 2022. doi:10.1038/s41562-021-01252-z.
- 342** Modini M, Joyce S, Mykletun A, Christensen H, Bryant RA, Mitchell PB, et al. The mental health benefits of employment: results of a systematic meta-review. *Australas Psychiatry.* 2016;24(4):331–336. doi:10.1177/1039856215618523.
- 343** Puig-Barrachina V, Giró P, Artazcoz L, Bartoll X, Cortés-Franch I, Fernández A, et al. The impact of Active Labour Market Policies on health outcomes: a scoping review. *Eur J Public Health.* 2020;30(1):36–42. doi:10.1093/ejph/rpz026.
- 344** Thomson H, Thomas S, Sellstrom E, Petticrew M. Housing improvements for health and associated socio-economic outcomes. *Cochrane Database Syst Rev.* 2013;(2):CD008657. doi:10.1002/14651858.CD008657.
- 345** McDaid D, Forsman A, Matosevic T, Park A-L, Wahlbeck K. Independence and mental wellbeing (including social and emotional wellbeing) for older people. Review 1: what are the most effective ways to improve or protect the mental wellbeing and/or independence of older people? London: National Institute for Health and Care Excellence; 2015 (<https://www.nice.org.uk/guidance/ng32/evidence/evidence-review-1-review-of-effects-2242568562>, accessed 28 March 2022).
- 346** The mental health and psychosocial support minimum services package [website]. Geneva: World Health Organization, UNICEF, United Nations High Commissioner for Refugees and United Nations Population Fund; 2022. (<https://mhppssmsp.org/en>, accessed 28 March 2022).
- 347** Cuijpers P, Pineda BS, Quero S, Karyotaki E, Struijs SY, Figueroa CA, et al. Psychological interventions to prevent the onset of depressive disorders: a meta-analysis of randomized controlled trials. *Clinical Psychology Review.* 2020;83, 101955. doi:10.1016/j.cpr.2020.101955.
- 348** Moreno-Peral P, Conejo-Cerón S, Rubio-Valera M, Fernández A, Navas-Campana D, Rodríguez-Morejón A, et al. Effectiveness of psychological and/or educational interventions in the prevention of anxiety: a systematic review, meta-analysis, and meta-regression. *JAMA Psychiatry.* 2017;74(10):1021–1029. doi:10.1001/jamapsychiatry.2017.2509.
- 349** Correll CU, Galling B, Pawar A, Krivko A, Bonetto C, Ruggeri M, et al. Comparison of early intervention services vs treatment as usual for early-phase psychosis: a systematic review, meta-analysis and meta-regression. *JAMA Psychiatry.* 2018;75(6):555–565. doi:10.1001/jamapsychiatry.2018.0623.
- 350** Aceituno D, Vera N, Prina AM, McCrone P. Cost-effectiveness of early intervention in psychosis: systematic review. *Br J Psychiatry.* 2019;215(1):388–394. doi:10.1192/bj.p.2018.298.



- 351** Sedeqzadah S, Portnoy A, Kim JJ, Keshavan M, Pandya A. Cost-effectiveness of early intervention in psychosis: a modeling study. *Psychiatr Serv.* 2022;appips202100161. doi:10.1176/appi.ps.202100161.
- 352** Acarturk C, Uygun E, Ilkkusun Z, Carswell K, Tedeschi F, Batu M, et al. Effectiveness of a WHO self-help psychological intervention for preventing mental disorders among Syrian refugees in Turkey: a randomized controlled trial. *World Psychiatry.* 2022;21(1):88–95. doi:10.1002/wps.20939.
- 353** Purgato M, Carswell K, Tedeschi F, Acarturk C, Anttila M, Au T, et al. Effectiveness of self-help plus in preventing mental disorders in refugees and asylum seekers in Western Europe: a multinational randomized controlled trial. *Psychother Psychosom.* 2021;1–12. doi:10.1159/000517504.
- 354** Health in all policies. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/112636/9789241506908_eng.pdf, accessed 28 March 2022).
- 355** WHO Global Health Estimates: suicide rates, 2000–2019. Geneva: World Health Organization; 2019 (<https://www.who.int/gho/data/themes/mental-health/suicide-rates>, accessed 28 March 2022).
- 356** Decriminalising suicide: saving lives, reducing stigma. London: United for Global Mental Health; 2021 (<https://unitedgmh.org/suicide-decriminalisation>, accessed 28 March 2022).
- 357** LIVE LIFE: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341726>, accessed 28 March 2022).
- 358** Gunnell D, Lewis G. Studying suicide from the life-course perspective: implications for prevention. *Br J Psychiatry.* 2005;187:206–208. doi:10.1192/bjp.187.3.206.
- 359** Carroll R, Metcalfe C, Gunnell D. Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. *PLoS One.* 2014;9(2):e89944. doi:10.1371/journal.pone.0089944.
- 360** Mew EJ, Padmanathan P, Konradsen F, Eddleston M, Chang S-S, Phillips MR, et al. The global burden of fatal self-poisoning with pesticides 2006–15: systematic review. *J Affect Disord.* 2017;219:93–104. doi:10.1016/j.jad.2017.05.002.
- 361** Lee YY, Chisholm D, Eddleston M, Gunnell D, Fleischmann A, Konradsen F, et al. The cost-effectiveness of banning highly hazardous pesticides to prevent suicides due to pesticide self-ingestion across 14 countries: an economic modelling study. *Lancet Glob Health.* 2021;9(3):E291–E300. doi:10.1016/S2214-109X(20)30493-9.
- 362** Gunnell D, Knipe D, Chang S-S, Pearson M, Konradsen F, Lee WJ, et al. Prevention of suicide with regulations aimed at restricting access to highly hazardous pesticides: a systematic review of the international evidence. *Lancet Glob Health.* 2017;5(10):e1026–e1037. doi:10.1016/S2214-109X(17)30299-1.
- 363** Sethi A, Lin C-Y, Madhavan I, Davis M, Alexander P, Eddleston M, et al. Impact of regional bans of highly hazardous pesticides on agricultural yields: the case of Kerala. *Agric Food Security.* 2022;11:9. doi:10.1186/s40066-021-00348-z.
- 364** World health statistics 2017: monitoring health for the SDGs, Sustainable Development Goals. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/255336>, accessed 28 March 2022).
- 365** Knipe DW, Gunnell D, Eddleston M. Preventing deaths from pesticide self-poisoning – learning from Sri Lanka’s success. *Lancet Glob Health.* 2017;5(7):e651–e652. doi:10.1016/S2214-109X(17)30208-5.
- 366** Jeyaratnam J, de Alwis Seneviratne RS, Copplestone JF. Survey of pesticide poisoning in Sri Lanka. *Bull World Health Organ.* 1982;60(4):615–619.
- 367** Pearson M, Zwi AB, Buckley NA, Manuweera G, Fernando R, Dawson AH, et al. Policymaking ‘under the radar’: a case study of pesticide regulation to prevent intentional poisoning in Sri Lanka. *Health Policy Plan.* 2015;30(1):56–67. doi:10.1093/heapol/czt096.
- 368** Niederkrotenthaler T, Braun M, Pirkis J, Till B, Stack S, Sinyor M et al. Association between suicide reporting in the media and suicide: systematic review and meta-analysis. *BMJ.* 2020;368:m575. doi:10.1136/bmjm575.
- 369** Niederkrotenthaler T, Reidenberg DJ, Till B, Gould MS. Increasing help-seeking and referrals for individuals at risk for suicide by decreasing stigma: the role of mass media. *Am J Prev Med.* 2014;47(3 Suppl 2):S235–S243. doi:10.1016/j.amepre.2014.06.010.
- 370** Improving early childhood development: WHO guideline. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/331306>, accessed 28 March 2022).
- 371** Guidelines on mental health promotive and preventive interventions for adolescents: helping adolescents thrive. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/336864>, accessed 28 March 2022).
- 372** Helping Adolescents Thrive toolkit: strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours. Geneva: World Health Organization and UNICEF; 2021 (<https://apps.who.int/iris/handle/10665/341327>, accessed 28 March 2022).
- 373** Bock J, Wainstock T, Braun K, Segal M. Stress in utero: prenatal programming of brain plasticity and cognition. *Biol Psychiatry.* 2015;78(5):315–326. doi:10.1016/j.biopsych.2015.02.036.
- 374** Turner R, Honikman S. Maternal mental health and the first 1 000 days. *South African Medical J.* 2016;106(12):1164–1167. doi:10.7196/SAMJ.2017.v106i12.12129.
- 375** Arango C, Díaz-Caneja CM, McGorry PD, Rapoport J, Sommer IE, Vorstman JA, et al. Preventive strategies for mental health. *Lancet Psychiatry.* 2018;5(7):591–604. doi:10.1016/S2215-0366(18)30057-9.
- 376** Siegenthaler E, Munder T, Egger M. Effect of preventive interventions in mentally ill parents on the mental health of the offspring: systematic review and meta-analysis. *J Am Acad Child Adolesc Psychiatry.* 2012;51(1):8–17. doi:10.1016/j.jaac.2011.10.018.
- 377** Henderson C, Dixon S, Bauer A, Knapp M, Morrell CJ, Slade P, et al. Cost-effectiveness of PoNDER health visitor training for mothers at lower risk of depression: findings on prevention of postnatal depression from a cluster-randomised controlled trial. *Psychol Med.* 2019;49:1324–34. doi:10.1017/S0033291718001940.
- 378** Parenting for Lifelong Health: COVID-19 parenting resources. In: WHO [website]. Geneva: World Health Organization; 2022 (<https://www.who.int/teams/social-determinants-of-health/parenting-for-lifelong-health/covid-19-parenting-resources>, accessed 28 March 2022).
- 379** Britto PR, Lye SJ, Proulx K, Yousafzai AK, Matthews SG, Vaivada T, et al. Nurturing care: promoting early childhood development. *Lancet.* 2017;389(10064):91–102. doi:10.1016/S0140-6736(16)31390-3.
- 380** Hutchings J, Williams, M. Case study: Incredible Years – disseminating the Incredible years basic parenting programme in Wales. In: Barry MM, Clarke AM, Peterson I, Jenkins R (editors). *Implementing mental health promotion.* Cham: Springer; 2019. doi:10.1007/978-3-030-23455-3.
- 381** Salomone E, Pacione L, Shire S, Brown FL, Reichow B, Servili C. Development of the WHO Caregiver Skills Training program for developmental disorders or delays. *Front Psychiatry.* 2019;10:769. doi:10.3389/fpsyg.2019.00769.
- 382** WHO eLearning caregiver skills training for families of children with developmental delays or disabilities. Geneva: World Health Organization; 2022 (<https://openwho.org/courses/caregiver-skills-training>, accessed 9 April 2022).
- 383** Report of the first virtual meeting of the External Advisory Group (EAG) for the development of global standards for health promoting schools and their implementation guidance. Geneva: World Health Organization & United Nations Educational Scientific and Cultural Organization; 2020 (<https://apps.who.int/iris/handle/10665/339614>, accessed 28 March 2022).
- 384** Mental health in schools: a manual. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/9789290225652-eng.pdf>, accessed 28 March 2022).
- 385** Barry MM, Clarke AM, Dowling K. Promoting social and emotional well-being in schools. *Health Education.* 2017;117(5):434–451. doi:10.1108/HE-11-2016-0057.
- 386** Greenberg MT, Domitrovich CE, Weissberg RP, Durlak JA. Social and emotional learning as a public health approach to education. *Future of Children.* 2017;27(1):13–32. doi:10.1353/foc.2017.0001.



- 387** Teacher's guide to the Magnificent Mei and friends comic series. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341349>, accessed 10 April 2022).
- 388** Kutcher S, Gilberds H, Morgan C, Greene R, Hamwaka K, Perkins K. Improving Malawian teachers' mental health knowledge and attitudes: an integrated school mental health literacy approach. *Glob Ment Health.* 2015;2:e1. doi:10.1017/gmh.2014.8.
- 389** Ravindran AV, Herrera A, da Silva TL, Henderson J, Castrillo ME, Kutcher S. Evaluating the benefits of a youth mental health curriculum for students in Nicaragua: a parallel-group, controlled pilot investigation. *Glob Ment Health.* 2018;5:e4. doi:10.1017/gmh.2017.27.
- 390** Kutcher S, Wei Y, Gilberds H, Ubuguyu O, Njau T, Brown A, et al. A school mental health literacy curriculum resource training approach: effects on Tanzanian teachers' mental health knowledge, stigma and help-seeking efficacy. *Int J Ment Health Syst.* 2016;10:50. doi:10.1186/s13033-016-0082-6.
- 391** Biswas T, Scott JG, Munir K, Thomas HJ, Mamun Huda M, Mehedi Hasan M, et al. Global variation in the prevalence of bullying victimisation amongst adolescents: role of peer and parental supports. *E Clinical Medicine.* 2020;20:100276. doi:10.1016/j.eclinm.2020.100276.
- 392** Smokowski PR, Kopasz KH. Bullying in school: an overview of types, effects, family characteristics, and intervention strategies. *Child and Sch.* 2005;27:101–109. doi:10.1093/cs/27.2.101.
- 393** Stephens MM, Cook-Fasano HT, Sibbaluca K. Childhood bullying: implications for physicians. *Am Fam Physician.* 2018;97(3):187–192.
- 394** Campion J. Public mental health: evidence, practice and commissioning. London: Royal Society for Public Health; 2022 (<https://www.rspph.org.uk/our-work/policy/wellbeing/public-mental-health-evidence-practice-and-commissioning.html>, accessed 28 March 2022).
- 395** Gaffney H, Ttofi MM, Farrington DP. Evaluating the effectiveness of school-bullying prevention programs: an updated meta-analytical review. *Aggress Violent Behav.* 2019;45:111–133. doi:10.1016/j.avb.2018.07.001.
- 396** Williford A, Boulton A, Noland B, Little TD, Karna A, Salmivalli C. Effects of the KiVa anti-bullying program on adolescents' depression, anxiety, and perception of peers. *J Abnorm Child Psychol.* 2012;40(2):289–300. doi:10.1007/s10802-011-9551-1.
- 397** Kelleher I, Keeley H, Corcoran P, Ramsay H, Wasserman C, Carli V, et al. Childhood trauma and psychosis in a prospective cohort study: cause, effect, and directionality. *Am J Psychiatry.* 2013;170(7):734–741. doi:10.1176/appi.ajp.2012.12091169.
- 398** Hermosilla S, Metzler J, Savage K, Musa M, Ager A. Child friendly spaces impact across five humanitarian settings: a meta-analysis. *BMC Public Health.* 2019;19(1):576. doi:10.1186/s12889-019-6939-2.
- 399** Kickbusch I, Piselli D, Agrawal A, Balicer R, Banner O, Adelhardt M, et al. The Lancet and Financial Times Commission on governing health futures 2030: growing up in a digital world. *Lancet.* 2021;398(10312):1727–1776. doi:10.1016/S0140-6736(21)01824-9.
- 400** My hero is you. Storybook for children on COVID-19. Inter-Agency Standing Committee; 2020 (<https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/my-hero-you-storybook-children-covid-19>, accessed 28 March 2022).
- 401** My hero is you 2021. How kids can hope with COVID-19. Inter-Agency Standing Committee; 2021 (<https://interagencystandingcommittee.org/my-hero-is-you-2021>, accessed 29 March 2022).
- 402** Alonso R, Hussain J, Stranges S, Anderson KK. Interplay between social media use, sleep quality and mental health in youth: a systematic review. *Sleep Med Rev.* 2021;56:101414. doi:10.1016/j.smrv.2020.101414.
- 403** Keles B, McCrae N, Grelish A. A systematic review: the influence of social media on depression, anxiety and psychological distress in adolescents. *Int J Adolesc Youth.* 2019;79–93. doi:10.1080/02673843.2019.1590851.
- 404** Khanh-Dao Le L, Cuevas Esturas A, Mihalopoulos C, Chiotelis O, Bucholc J, Chatterton ML, et al. Cost-effectiveness evidence of mental health prevention and promotion interventions: a systematic review of economic evaluations. *PLoS Med.* 2021;18(5):e1003606. doi:10.1371/journal.pmed.1003606.
- 405** Mata DA, Ramos MA, Bansal N, Khan R, Guille C, Di Angelantonio E, et al. Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. *JAMA.* 2015;314(22):2373–2383. doi:10.1001/jama.2015.15845.
- 406** Petrie K, Milligan-Saville J, Gayed A, Deady M, Phelps A, Dell L, et al. Prevalence of PTSD and common mental disorders amongst ambulance personnel: a systematic review and meta-analysis. *Soc Psychiatry Psychiatr Epidemiol.* 2018;53(9):897–909. doi:10.1007/s00127-018-1539-5.
- 407** Dutheil F, Aubert C, Pereira B, Dambrun M, Moustafa F, Mermilliod M, et al. Suicide among physicians and health-care workers: a systematic review and meta-analysis. *PLoS One.* 2019;14(12):e0226361. doi:10.1371/journal.pone.0226361.
- 408** Women and men in the informal economy: a statistical picture (third edition). Geneva: International Labour Organization; 2018 (https://www.ilo.org/global/publications/books/WCMS_626831/lang--en/index.htm, accessed 28 March 2022).
- 409** Putting science to work: understanding what works for workplace mental health. London: Wellcome Trust; 2021 (<https://wellcome.org/reports/understanding-what-works-workplace-mental-health>, accessed 28 March 2022).
- 410** Article 27: Work and employment. In: Convention on the Rights of Persons with Disabilities (CRPD). United Nations (<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-27-work-and-employment.html>, accessed 28 March 2022).
- 411** Biggs D, Hovey N, Tyson PJ, MacDonald S. Employer and employment agency attitudes towards employing individuals with mental health needs. *J Mental Health.* 2010;19(6):505–516. doi:10.3109/09638237.2010.507683.
- 412** Guidelines for the implementation of mental health workplace policies and programs for the private sector. Manila: Department of Labor and Employment; 2020 (<https://www.dole.gov.ph/news/do-208-20-guidelines-for-the-implementation-of-mental-health-workplace-policies-and-programs-for-the-private-sector>, accessed 28 March 2022).
- 413** Psychosocial factors at work: recognition and control. Occupational Safety and Health Series No 56. Geneva: International Labour Organization; 1986 (<https://digitallibrary.un.org/record/194660?ln=en>, accessed 28 March 2022).
- 414** Nielsen MB, Einarsen S. Outcomes of exposure to workplace bullying: a meta-analytic review. *Work Stress.* 2012;26(4):309–332. doi:10.1080/02678373.2012.734709.
- 415** Workplace stress: a collective challenge. Geneva: International Labour Organization; 2016 (https://www.ilo.org/safework/info/publications/WCMS_466547/lang--en/index.htm, accessed 28 March 2022).
- 416** SOLVE: integrating health promotion into workplace OSH policies. Trainers' guide. Geneva: International Labour Organization; 2012 (https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_178397.pdf, accessed 28 March 2022).
- 417** Probst TM, Gold D, Caborn J. A preliminary evaluation of SOLVE: addressing psychosocial problems at work. *J Occup Health Psychol.* 2008;13(1):32–42. doi:10.1037/1076-8998.13.1.32.
- 418** Kröll C, Doeblер P, Nüesch S. Meta-analytic evidence of the effectiveness of stress management at work. *Eur J Work Organ Psychol.* 2017;26:677–693. doi:10.1080/1359432X.2017.1347157.
- 419** Panagioti M, Panagopoulou E, Bower P, Lewith G, Kontopantelis E, Chew-Graham C, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. *JAMA Intern Med.* 2017;177:195–205. doi:10.1001/jamainternmed.2016.7674.
- 420** Zafar N, Rotenberg M, Rudnick A. A systematic review of work accommodations for people with mental disorders. *Work.* 2019;64(3):461–475. doi:10.3233/WOR-193008.
- 421** Gayed A, Milligan-Saville JS, Nicholas J, Bryan BT, LaMontagne AD, Milner A, et al. Effectiveness of training workplace managers to understand and support the mental health needs of employees: a systematic review and meta-analysis. *Occup Environ Med.* 2018;75(6):462–470. doi:10.1136/oemed-2017-104789.



- 422** Stratton E, Lampit A, Choi I, Calvo RA, Harvey SB, Glozier N. Effectiveness of eHealth interventions for reducing mental health conditions in employees: a systematic review and meta-analysis. *PLoS One*. 2017;12(12):e0189904. doi:10.1371/journal.pone.0189904.
- 423** Comprehensive mental health service networks: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341646>, accessed 29 March 2022).
- 424** Funk M, Drew N, Saraceno B, Caldas de Almeida JM, Agossou T, Wang X, et al. A framework for mental health policy, legislation and service development: addressing needs and improving services. *Harvard Health Policy Review*. 2005;6:57–69.
- 425** Kearns M, Muldoon OT, Msetfi RM, Surgeon PWG. The impact of community-based mental health service provision on stigma and attitudes towards professional help-seeking. *J Mental Health*. 2019;28(3):289–295. doi:10.1080/09638237.2018.1521928.
- 426** Leff J, Trieman N. Long-stay patients discharged from psychiatric hospitals: social and clinical outcomes after five years in the community. The TAPS Project 46. *Br J Psychiatry*. 2000;176:217–223. doi:10.1192/bjp.176.3.217.
- 427** Framework on integrated, people-centred health services. Sixty-ninth World Health Assembly, Geneva, 15 April 2016. Provisional agenda item 16.1. Geneva: World Health Organization; 2016 (https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1, accessed 29 March 2022).
- 428** Lewis-Fernández R, Kirmayer LJ. Cultural concepts of distress and psychiatric disorders: understanding symptom experience and expression in context. *Transcult Psychiatry*. 2019;56(4):786–803. doi:10.1177/1363461519861795.
- 429** The potential benefits of integrated people-centred health services. Geneva: World Health Organization; 2021 ([https://cdn.who.int/media/docs/default-source/integrated-health-services-\(ihs\)/csy/ipchs/ipchsbenefits.pdf](https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/csy/ipchs/ipchsbenefits.pdf), accessed 29 March 2022).
- 430** Recovery practices for mental health and well-being: WHO QualityRights specialized training: course guide. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329602>, accessed 29 March 2022).
- 431** Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosoc Rehab J*. 1993;16(4):11–23. doi:10.1037/h0095655.
- 432** Recovery and the right to health: WHO QualityRights core training: mental health and social services: course slides. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329652>, accessed 29 March 2022).
- 433** Mueser KT, Corrigan PW, Hilton DW, Tanzman B, Schaub A, Gingerich S, et al. Illness management and recovery: a review of the research. *Psychiatr Serv*. 2002;53(10):1272–1284. doi:10.1176/appi.ps.53.10.1272
- 434** Lean M, Fornells-Ambrojo M, Milton A, Lloyd-Evans B, Harrison-Steward B, Yesufu-Udechukwu A, et al. Self-management interventions for people with severe mental illness: systematic review and meta-analysis. *Br J Psychiatry*. 2019;214(5):260–268. doi:10.1192/bjp.2019.54.
- 435** Strategies to end seclusion and restraint: WHO QualityRights Specialized training: course guide. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329605>, accessed 29 March 2022).
- 436** Caldas de Almeida JM, Mateus P, Tomé G. Joint action on mental health and well-being: towards community-based and socially inclusive mental health care. Lisbon: The Joint Action for Mental Health and Wellbeing; 2015 (https://ec.europa.eu/health/sites/default/files/mental_health/docs/2017_towardsmhcare_en.pdf, accessed 29 March 2022).
- 437** Thornicroft G, Tansella M. The balanced care model for global mental health. *Psychol Med*. 2013;43(4):849–863. doi:10.1017/S0033291712001420.
- 438** Peer support mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240025783>, accessed 29 March 2022).
- 439** Nortje G, Oladeji B, Gureje O, Seedat S. Effectiveness of traditional healers in treating mental disorders: a systematic review. *Lancet Psychiatry*. 2016;3(2):154–170. doi:10.1016/S2215-0366(15)00515-5.
- 440** Like a death sentence: abuses against persons with mental disabilities in Ghana. New York: Human Rights Watch; 2012 (<https://www.hrw.org/sites/default/files/reports/ghana1012webwcover.pdf>, accessed 29 March 2022).
- 441** Van der Watt ASJ, van de Water T, Nortje G, Oladeji BD, Seedat S, Gureje O, et al. The perceived effectiveness of traditional and faith healing in the treatment of mental illness: a systematic review of qualitative studies. *Soc Psychiatry Psychiatr Epidemiol*. 2018;53(6):555–566. doi:10.1007/s00127-018-1519-9.
- 442** Gureje O, Appiah-Poku J, Bello T, Kola L, Araya R, Chisholm D, et al. Effect of collaborative care between traditional and faith healers and primary health-care workers on psychosis outcomes in Nigeria and Ghana (COSIMPO): a cluster randomised controlled trial. *Lancet*. 2020;396(10251):612–622. doi:10.1016/S0140-6736(20)30634-6.
- 443** Planning and budgeting to deliver services for mental health. Geneva: World Health Organization; 2003 (<https://apps.who.int/iris/handle/10665/333115>, accessed 29 March 2022).
- 444** World Health Organization. World Health Organization Assessment Instrument For Mental Health Systems. 2005.
- 445** Hanlon C, Fekadu A, Jordans M, Kigozi F, Petersen I, Shidhaye R, et al. District mental healthcare plans for five low-and middle-income countries: commonalities, variations and evidence gaps. *Br J Psychiatry*. 2016;208(S56):S47–S54. doi:10.1192/bjp.bp.114.153767.
- 446** Together on the road to universal health coverage: a call to action. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/258962>, accessed 29 March 2022).
- 447** WHO and Calouste Gulbenkian Foundation. Innovation in deinstitutionalization: a WHO expert survey. Geneva: World Health Organization; 2014 (<https://apps.who.int/iris/handle/10665/112829>, accessed 29 March 2022).
- 448** Freeman MC. Global lessons for deinstitutionalisation from the ill-fated transfer of mental health-care users in Gauteng, South Africa. *Lancet Psychiatry*. 2018;5(9):765–768. doi:10.1016/S2215-0366(18)30211-6.
- 449** Knapp M, Beecham J, McDaid D, Matosevic T, Smith M. The economic consequences of deinstitutionalisation of mental health services: lessons from a systematic review of European experience. *Health Soc Care Community*. 2011;19(2):113–125. doi:10.1111/j.1365-2524.2010.00969.x.
- 450** Winkler P, Barrett B, McCrone P, Csémy L, Janoušková M, Höschl C. Deinstitutionalised patients, homelessness and imprisonment: systematic review. *Br J Psychiatry*. 2016;208(5):421–428. doi:10.1192/bjp.bp.114.161943.
- 451** Clifford P, Charman A, Webb Y, Craig TJ, Cowan D. Planning for community care: the Community Placement Questionnaire. *Br J Clin Psychol*. 1991;30(3):193–211. doi:10.1111/j.2044-8260.1991.tb00938.x.
- 452** Locikis de Araújo, C. Mental health system reform in Brazil. Brasília: Ministério da Saúde; 2016 (https://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/Brazil_Policy%20Brief_Final.pdf, accessed 29 March 2022).
- 453** Ministério da Saúde divulga resultados preliminares de pesquisa sobre saúde mental na pandemia. In: Governo do Brasil/Notícias [website]. Brasília: Ministério da Saúde; 2020 (<https://www.gov.br/pt-br/noticias/saude-e-vigilancia-sanitaria/2020/01/investimento-em-saude-mental-cresceu-quase-200>, accessed 29 March 2022).
- 454** Barbui C, Papola D, Saraceno B. Forty years without mental hospitals in Italy. *Int J Mental Health Sys*. 2018;12(43). doi:10.1186/s13033-018-0223-1.
- 455** Mezzina R. Forty years of the Law 180: the aspirations of a great reform, its successes and continuing need. *Epidemiol Psychiatr Sci*. 2018;27(4):336–345. doi:10.1017/S2045796018000070.
- 456** Mezzina R. Community mental health care in Trieste and beyond: an “open door-no restraint” system of care for recovery and citizenship. *J Nerv Ment Dis*. 2014;202(6):440–445. doi:10.1097/NMD.0000000000000142.
- 457** I servizi di salute mentale territoriali dell’ASUI di Trieste, anno 2018. Trieste: Dipartimento di Salute Mentale; 2019.
- 458** Monitoreo de los procesos de atención y adecuación y adecuación de los hospitales neuropsiquiátricos públicos de la Provincia de Buenos Aires. Informe año 2021. Buenos Aires: Ministerio de Salud; 2021.

- 459** Our Results: stopping the depression epidemic in Africa. In: StrongMinds [website]. Lusaka: StrongMinds; 2022 (<https://strongminds.org/our-impact/>, accessed 29 March 2022).
- 460** Bolton P, Bass J, Neugebauer R, Verdeli H, Clougherty KF, Wickramaratne P, et al. Group interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. *JAMA*. 2003;289(23):3117–3124. doi:10.1001/jama.289.23.3117.
- 461** Hamdani SU, Huma Z-E, Masood A, Zhou K, Ahmed Z, Nazier H, et al. Effect of adding a psychological intervention to routine care of common mental disorders in a specialized mental healthcare facility in Pakistan: a randomized controlled trial. *Int J Ment Health Syst*. 2021;15(1):11. doi:10.1186/s13033-020-00434-y.
- 462** Petersen I, Bhana A, Fairal L, Selohilwe O, Kathree T, Baron EC, et al. Evaluation of a collaborative care model for integrated primary care of common mental disorders comorbid with chronic conditions in South Africa. *BMC Psychiatry*. 2019;19(1):107. doi:10.1186/s12888-019-2081-z.
- 463** Joag K, Shields-Zeeman L, Kapadia-Kundu N, Kawade R, Balaji M, Pathare S. Feasibility and acceptability of a novel community-based mental health intervention delivered by community volunteers in Maharashtra, India: the Atmiyata programme. 2020;20(1):48. doi:10.1186/s12888-020-2466-z.
- 464** Community outreach mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341644>, accessed 29 March 2022).
- 465** Bogdanov S, Augustinavicius J, Bass JK, Metz K, Skavenski S, Singh NS, et al. A randomized-controlled trial of community-based transdiagnostic psychotherapy for veterans and internally displaced persons in Ukraine. *Glob Ment Health (Camb)*. 2021;8:e32. doi:10.1017/gmh.2021.27.
- 466** Bolton P, Lee C, Haroz EE, Murray L, Dorsey S, Robinson C, et al. A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLoS Med*. 2014;11(11):e1001757. doi:10.1371/journal.pmed.1001757.
- 467** Chibanda D, Weiss HA, Verhey R, Simms V, Munjoma R, Rusakaniko S, et al. Effect of a primary care-based psychological intervention on symptoms of common mental disorders in Zimbabwe: a randomized clinical trial. *JAMA*. 2016;316(24):2618–2626. doi:10.1001/jama.2016.19102.
- 468** Wallén A, Eberhard S, Landgren K. The experiences of counsellors offering problem-solving therapy for common mental health issues at the youth friendship bench in Zimbabwe. *Issues Ment Health Nurs*. 2021;1–18. doi:10.1080/01612840.2021.1879977.
- 469** Wakefield S, Kellett S, Simmonds-Buckley M, Stockton D, Bradbury A, Delgadillo J. Improving Access to Psychological Therapies (IAPT) in the United Kingdom: a systematic review and meta-analysis of 10 years of practice-based evidence. *Br J Clin Psychol*. 2021;60(1):1–37. doi:10.1111/bjcp.12259.
- 470** Gualano MR, Bert F, Martorana M, Voglino G, Andriolo V, Thomas R, et al. The long-term effects of bibliotherapy in depression treatment: systematic review of randomized clinical trials. *Clin Psychol Rev*. 2017;58:49–58. doi:10.1016/j.cpr.2017.09.006.
- 471** Cuijpers P, Noma H, Karyotaki E, Cipriani A, Furukawa T. Effectiveness and acceptability of cognitive behavior therapy delivery formats in adults with depression: a network meta-analysis. *JAMA Psychiatry*. 2019;76:700–707. doi:10.1001/jamapsychiatry.2019.0268.
- 472** Cuijpers P, Heim E, Abi Ramia J, Burchert S, Carswell K, Cornelisz I, et al. Effects of a WHO guided digital health intervention for depression in Syrian refugees in Lebanon: a randomized controlled trial. *PLoS Med*. In press.
- 473** Integrating mental health into primary care: a global perspective. Geneva: World Health Organization and World Organization of Family Doctors; 2008 (<https://apps.who.int/iris/handle/10665/43935>, accessed 29 March 2022).
- 474** Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR. 6–12 September 1978. Geneva: World Health Organization; 1978 (<https://apps.who.int/iris/handle/10665/39228>, accessed 29 March 2022).
- 475** Coates D, Coppleson D, Schmied V. Integrated physical and mental healthcare: an overview of models and their evaluation findings. *Int J Evid Based Healthc*. 2020;18(1):38–57. doi:10.1097/XEB.0000000000000215.
- 476** Cubillos L, Bartels SM, Torrey WC, Naslund J, Uribe-Restrepo JM, Gaviola C, et al. The effectiveness and cost effectiveness of integrating mental health services in primary care in low- and middle-income countries: systematic review. *B J Psych Bull*. 2021;45(1):40–52. doi:10.1192/bjb.2020.235.
- 477** Heath B, Wise Romero P, Reynolds K. A standard framework for levels of integrated healthcare. Washington D.C: SAMHSA-HRSA Center for Integrated Health Solutions; 2013 (<https://www.pcpcc.org/resource/standard-framework-levels-integrated-healthcare>, accessed 29 March 2022).
- 478** Patel V, Chisholm D, Parikh R, Charlson FJ, Degenhardt L, Dua T, et al. Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, third edition. *Lancet*. 2016;387(10028):1672–1685. doi:10.1016/S0140-6736(15)00390-6.
- 479** Wakida EK, Talib ZM, Akena D Okello ES, Kinengyere K, Mindra A, et al. Barriers and facilitators to the integration of mental health services into primary health care: a systematic review. *Syst Rev*. 2018;7:211. doi:10.1186/s13643-018-0882-7.
- 480** Smith AK. The integration of mental health care in rural Iran. *Iranian Studies*. 2020; 53(1–2):93–111. doi:10.1080/00210862.2019.1670625.
- 481** mhGAP Humanitarian Intervention Guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/162960>, accessed 29 March 2022).
- 482** Stories of change in four countries: building capacity for integrating mental health care. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/349939>, accessed 29 March 2022).
- 483** Luitel NP, Breuer E, Adhikari A, Kohrt BA, Lund C, Komproe IH, et al. Process evaluation of a district mental healthcare plan in Nepal: a mixed-methods case study. *BJPsych Open*. 2020;6(4):e77. doi:10.1192/bjpo.2020.2060.
- 484** Kahilogulları AK, Alataş E, Ertuğrul F, Malaj A. Responding to mental health needs of Syrian refugees in Turkey: mhGAP training impact assessment. *Int J Ment Health Syst*. 2020;14(1):84. doi:10.1186/s13033-020-00416-0.
- 485** Ünützer J, Carlo AD, Collins PY. Leveraging collaborative care to improve access to mental health care on a global scale. *World Psychiatry*. 2020;19(1):36–37. doi:10.1002/wps.20696.
- 486** Ali MK, Chwastiak L, Poongothai S, Emmert-Fees KMF, Patel SA, Mohan Anjana R, et al. Effect of a collaborative care model on depressive symptoms and glycated hemoglobin, blood pressure, and serum cholesterol among patients with depression and diabetes in India: the INDEPENDENT randomized clinical trial. *JAMA*. 2020; 18;324(7):651–662. doi:10.1001/jama.2020.11747.
- 487** Rimal P, Choudhury N, Agrawal P, Basnet M, Bohara B, Citrin D, et al. Collaborative care model for depression in rural Nepal: a mixed methods implementation research study. *BMJ Open*. 2021;11:e048481. doi:10.1136/bmjopen-2020-048481.
- 488** Araya R, Flynn T, Rojas G, Fritsch R, Simon G. Cost-effectiveness of a primary care treatment program for depression in low-income women in Santiago, Chile. *Am J Psychiatry*. 2006;163(8):1379–1387. doi:10.1176/ajp.2006.163.8.1379.
- 489** Chuah FLH, Haldane VE, Cervero-Liceran F, Ong SE, Sigfrid LA, Murphy G, et al. Interventions and approaches to integrating HIV and mental health services: a systematic review. *Health Policy Plan*. 2017;32(Suppl4):iv27–iv47. doi:10.1093/heapol/czw169.
- 490** Simas TAM, Flynn MP, Kroll-Desrosiers AR, Carvalho SM, Levin LL, Beibel K, et al. A systematic review of integrated care interventions addressing perinatal depression care in ambulatory obstetric care settings. *Clin Obstet Gynecol*. 2018;61(3):573–590. doi:10.1097/GRF.0000000000000360.
- 491** End Inequalities, End AIDS. Global AIDS Strategy 2021–2026. Geneva: UN AIDS; 2021 (<https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy>, accessed 29 March 2022).



- 492** Nakimul-Mpungu E, Musisi S, Wamala K, Okello J, Ndyanabangi S, Birungi J, et al. Effectiveness and cost-effectiveness of group support psychotherapy delivered by trained lay health workers for depression treatment among people with HIV in Uganda: a cluster-randomised trial. *Lancet Glob Health*. 2020;8(3):E387–E398. doi:10.1016/S2214-109X(19)30548-0.
- 493** Pasha A, Siddiqui H, Ali S, Brooks MB, Maqbool NR, Khan AJ. Impact of integrating mental health services within existing tuberculosis treatment facilities. *J Med Access*. 2021;5. doi:10.1177/23992026211011314.
- 494** Bending the curve: the impact of integrating mental health services on HIV and TB outcomes. London: United for Global Mental Health; 2021 (<https://unitedgmh.org/bending-curve-hiv>, accessed 29 March 2022).
- 495** Mahomed OH, Asmall S, Freeman M. An integrated chronic disease management model: a diagonal approach to health system strengthening in South Africa. *J Health Care Poor Underserved*. 2014;25(4):1723–1729. doi:10.1353/hpu.2014.0176.
- 496** Carbone NB, Njala J, Jackson DJ, Eliya MT, Chilangwa C, Tseka J, et al. “I would love if there was a young woman to encourage us, to ease our anxiety which we would have if we were alone”: adapting the Mothers2Mothers Mentor Mother Model for adolescent mothers living with HIV in Malawi. *PLoS One*. 2019;14(6):e02176. doi:10.1371/journal.pone.0217693.
- 497** Burger M, Hoosain M, Einspieler C, Unger M, Niehaus D. Maternal perinatal mental health and infant and toddler neurodevelopment – evidence from low and middle-income countries. A systematic review. *J Affect Disord*. 2020;268:158–172. doi:10.1016/j.jad.2020.03.023.
- 498** Morrell CJ, Slade P, Warner R, Paley G, Dixon S, Walters SJ, et al. Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: pragmatic cluster randomised trial in primary care. *BMJ*. 2009;338:a3045. doi:10.1136/bmj.a3045.
- 499** Nakku JEM, Nalwadda O, Garman E, Honikman S, Hanlon C, Kigozi F, et al. Group problem solving therapy for perinatal depression in primary health care settings in rural Uganda: an intervention cohort study. *BMC Pregnancy Childbirth*. 2021;21(1):584. doi:10.1186/s12884-021-04043-6.
- 500** Hospital-based mental health services: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341647>, 29 March 2022).
- 501** Plan Nacional de Salud Mental: República Dominicana 2019–2022. Santo Domingo: Ministerio de Salud Pública; 2019 (<https://repositorio.msp.gob.do/handle/123456789/1660>, accessed 29 March 2022).
- 502** Centros de Salud Mental Comunitaria (CSMC) In: Peru Ministerio de Salud [website]. Lima: Peru Ministry of Health; 2017 (<http://bvs.minsa.gob.pe/local/MINSA/4499.pdf>, accessed 29 March 2022).
- 503** Community mental health centres: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341642>, accessed 29 March 2022).
- 504** Singh SP, Javed A. Early intervention in psychosis in low- and middle-income countries: a WPA initiative. *World Psychiatry*. 2020;19(1):122–122. doi:10.1002/wps.20708.
- 505** A global framework for youth mental health: investing in future mental capital for individuals, communities and economies. Geneva: World Economic Forum; 2020 (<https://www.oxygen.org.au/About/Oxygen-Global/Files/Oxygen-WEF-global-framework-for-youth-mental-health.aspx>, accessed 29 March 2022).
- 506** EPPIC (Early Psychosis Prevention & Intervention Centre). In: Oxygen Youth Health [website]. Melbourne: Oxygen Youth Health; 2021 (<https://oyh.org.au/our-services/clinical-program/continuing-care-teams/eppic-early-psychosis-prevention-intervention>, accessed 29 March 2022).
- 507** Malone D, Marriott SVL, Newton-Howes G, Simmonds S, Tyrer P. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. *Cochrane Database Syst Rev*. 2007;3:CD000270. doi:10.1002/14651858.CD000270.pub2.
- 508** Thorning H, Dixon L. Forty-five years later: the challenge of optimizing assertive community treatment. *Curr Opin Psychiatry*. 2020;33(4):397–406. doi:10.1097/YCO.00000000000000615.
- 509** Peer support groups by and for people with lived experience: WHO QualityRights guidance module: module slides. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/329644>, accessed 29 March 2022).
- 510** Mental health helplines and resources [website]. Kuala Lumpur: AIA Malaysia; 2021 (<https://www.aia.com.my/en/what-matters/seetheotherside/mental-health-helpline-resources.html>, accessed 29 March 2022).
- 511** Kaos J. COVID-19: Health Ministry's support hotline receives over 100,000 calls seeking counselling. *The Star*. 25 June 2021 (<https://www.thestar.com.my/news/nation/2021/06/25/covid-19-health-ministries-support-hotline-receives-over-100000-calls-seeking-counselling>, accessed 29 March 2022).
- 512** Zhou W, Ouyang F, Nergui OE, Bangura JB, Acheampong K, Massey IY, et al. Child and adolescent mental health policy in low- and middle-income countries: challenges and lessons for policy development and implementation. *Front Psychiatry*. 2020;11:150. doi:10.3389/fpsyg.2020.00150.
- 513** Headspace [website]. Melbourne and Copenhagen: Headspace; 2022 (<https://headspace.org.au/> and <https://headspace.dk/en>, accessed 29 March 2022).
- 514** Rickwood D, Paraskakis M, Quin D, Hobbs N, Ryall V, Trethowan J, et al. Australia's innovation in youth mental health care: the headspace centre model. *Early Interv Psychiatry*. 2019;13(1):159–166. doi:10.1111/eip.12740.
- 515** Parikh SV, Taubman DS, Antoun C, Cranford J, Foster CE, Grambeau M, et al. The Michigan peer-to-peer depression awareness program: school-based prevention to address depression among teens. *Psychiatr Serv*. 2018;69(4):487–491. doi:10.1176/appi.ps.201700101.
- 516** Peer support groups. In: USP Kenya [website]. Nairobi: Users and Survivors of Psychiatry Kenya; 2022 (<https://www.uspkenya.org/peer-support-groups/>, accessed 29 March 2022).
- 517** Psychosocial rehabilitation: a consensus statement. Geneva: World Health Organization; 1996 (<https://apps.who.int/iris/handle/10665/60630>, accessed 29 March 2022).
- 518** Community-based rehabilitation: CBR guidelines. Geneva: World Health Organization, UNESCO, International Labour Organization & International Disability Development Consortium; 2010 (<https://apps.who.int/iris/handle/10665/44405>, accessed 29 March 2022).
- 519** McKay C, Nugent KL, Johnsen M, Eaton WW, Lidz CW. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Adm Policy Ment Health*. 2018;45:28–47. doi:10.1007/s10488-016-0760-3.
- 520** Pardi J, Willis M. How young adults in London experience the clubhouse model of mental health recovery: a thematic analysis. *J Psychosoc Rehabil Ment Health*. 2018;5:169–182. doi:10.1007/s40737-018-0124-2.
- 521** Chatterjee S, Patel V, Chatterjee A, Weiss HA. Evaluation of a community-based rehabilitation model for chronic schizophrenia in rural India. *Br J Psychiatry*. 2003;182(1):57–62. doi:10.1192/bjp.182.1.57.
- 522** Chatterjee S, Pillai A, Jain S, Cohen A, Patel V. Outcomes of people with psychotic disorders in a community-based rehabilitation programme in rural India. *Br J Psychiatry*. 2009;195(5):433–439. doi:10.1192/bjp.bp.108.057596.
- 523** Guerrero AVP, Bessoni EA, Cardoso AJC, Vaz BC, Braga-Campos FC, Badaró MIM. De Volta para Casa programme (Back Home programme) in its beneficiaries' daily lives. *Saúde Soc São Paulo*. 2019;28(3):11–20. doi:10.1590/S0104-12902019190435.
- 524** Personal health budgets for mental health. In: National Health Service [website]. London: National Health Service; 2022 (<https://www.england.nhs.uk/personal-health-budgets/personal-health-budgets-for-mental-health/>, accessed 29 March 2022).
- 525** Sivakumar T, Thirthalli J, Gangadhar BN. Rehabilitation of long-stay patients in state mental hospitals: role for social welfare sector. *Indian J Psychiatry*. 2020;62(2):202–206. doi:10.4103/psychiatry.IJP_332_19.
- 526** Fakhoury W, Priebe S. Deinstitutionalization and reinstitutionalization: major changes in the provision of mental healthcare. *Psychiatry*. 2007;6(8):313–316. doi:10.1016/j.mppsy.2007.05.008.



- 527** Supported living services for mental health: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/item/9789240025820>), accessed 29 March 2022).
- 528** Delivering support in Housing First. In: Housing First Europe Hub [website]. Brussels: Housing First Europe Hub; 2022 (<https://housingfirsteurope.eu/guide/delivering-support-housing-first/>), accessed 29 March 2022).
- 529** Baxter AJ, Tweed EJ, Vittal Katikireddi S, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *J Epidemiol Community Health*. 2019;73(5):379–387. doi:10.1136/jech-2018-210981.
- 530** Woodhall-Melnik JR, Dunn JR. A systematic review of outcomes associated with participation in Housing First programs. *Housing Studies*. 2016;31(3):287–304. doi:10.1080/02673037.2015.1080816.
- 531** Becker KD, Brandt NE, Stephan SH, Chorpita BF. A review of educational outcomes in the children's mental health treatment literature. *Adv School Ment Health Promotion*. 2014;7(1):5–23. doi:10.1017/S1754730X.2013.851980.
- 532** Kase C, Hoover S, Boyd G, West KD, Dubenitz J, Trivedi PA, et al. Educational outcomes associated with school behavioral health interventions: a review of the literature. *J Sch Health*. 2017;87(7):554–562. doi:10.1111/josh.12524.
- 533** WHO guideline on school health services. Geneva: World Health Organization and UNESCO; 2021 (<https://apps.who.int/iris/handle/10665/341910>), accessed 29 March 2022).
- 534** Lim CG, Loh H, Renjan V, Tan J. Child community mental health services in Asia Pacific and Singapore's REACH model. *Brain Sci*. 2017;7(10):126. doi:10.3390/brainsci7100126.
- 535** Baranyi G, Scholl C, Fazel S, Patel V, Priebe S, Mundt AP. Severe mental illness and substance use disorders in prisoners in low-income and middle-income countries: a systematic review and meta-analysis of prevalence studies. *Lancet Glob Health*. 2019;7(4):e461–e471. doi:10.1016/S2214-109X(18)30539-4.
- 536** A/HRC/32/32. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In: Thirty-second session of the Human Rights Council; Agenda item 3. Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development. New York: United Nations General Assembly; 2016 (<https://undocs.org/A/HRC/32/32>), accessed 29 March 2022).
- 537** Our hearts have gone dark: the mental health impact of South Sudan's conflict. London: Amnesty International; 2016 (<https://www.amnesty.org/en/wp-content/uploads/2021/05/AFR6532032016ENGLISH.pdf>), accessed 29 March 2022).
- 538** Sampson S, Edworthy R, Völlm B, Bulten E. Long-term forensic mental health services: an exploratory comparison of 18 European countries. *Int J Forensic Mental Health*. 2016;15(4):1–19. doi:10.1080/1499013.2016.1221484.
- 539** Gureje O, Abdulmalik J. Severe mental disorders among prisoners in low-income and middle-income countries: reaching the difficult to reach. *Lancet Glob Health*. 2019;7(4):e392–e393. doi:10.1016/S2214-109X(19)30057-9.
- 540** Essential services package for women and girls subject to violence module 4: social services. New York: United Nations Population Fund; 2015 (<https://www.unfpa.org/resources/essential-services-package-women-and-girls-subject-violence-module-4>), accessed 29 March 2022).
- 541** IASC guidelines on mental health and psychosocial support in emergency settings. Geneva: Inter-Agency Standing Committee; 2007 (<https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007>), accessed 29 March 2022).
- 542** The Sphere handbook: humanitarian charter and minimum standards in humanitarian response, fourth edition. Geneva: Sphere Association; 2018 (www.spherestandards.org/handbook), accessed 29 March 2022).
- 543** Early childhood development and disability: a discussion paper. Geneva: World Health Organization and UNICEF; 2012 (<https://apps.who.int/iris/handle/10665/75355>), accessed 29 March 2022).
- 544** Hale DR, Bevilacqua L, Viner RM. Adolescent health and adult education and employment: a systematic review. *Pediatrics* 2015;136(1):128–140. doi:10.1542/peds.2014-2105.
- 545** Ringeisen H, Langer Ellison M, Ryder-Burge A, Biebel K, Alikhan S, Jones E. Supported education for individuals with psychiatric disabilities: state of the practice and policy implications. *Psychiatr Rehabil J*. 2017;40(2):197–206. doi:10.1037/prj0000233.
- 546** Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *Lancet*. 2009;373(9661):408–415. doi:10.1016/S0140-6736(08)61817-6.
- 547** Crowther RE, Marshall M, Bond GR, Huxley P. Helping people with severe mental illness to obtain work: systematic review. *BMJ*. 2001;322(7280):204–208. doi:10.1136/bmj.322.7280.204.
- 548** Community Recovery Achieved Through Entrepreneurism (CREATE). In: Grand Challenges Canada/Innovations [website]. Toronto: Grand Challenges Canada; 2016 (<https://www.grandchallenges.ca/grantee-stars/0641-01-10/>), accessed 29 March 2022).
- 549** Cohen A, Raja S, Underhill C, Yaro BP, Dokurugu AY, de Silva M, et al. Sitting with others: mental health self-help groups in northern Ghana. *Int J Mental Health Syst*. 2012;6(1):1. doi:10.1186/1752-4458-6-1.
- 550** Galloway A, Boland B, Williams G. Mental health problems, benefits and tackling discrimination. *BJPsych Bull*. 2018;42(5):200–205. doi:10.1192/bj.b.2018.43.
- 551** Pybus K, Pickett KE, Prady SL, Lloyd C, Wilkinson R. Discrediting experiences: outcomes of eligibility assessments for claimants with psychiatric compared with non-psychiatric conditions transferring to personal independence payments in England. *BJPsych Open*. 2019;5(E19):1–5. doi:10.1192/bj.o.2019.3.
- 552** The benefits assault course: making the UK benefits system more accessible for people with mental health problems. London: Money and Mental Health Policy Institute; 2019 (<https://www.moneyandmentalhealth.org/publications/benefits/>), accessed 29 March 2022).
- 553** Senior SL, Caan W, Gamsu M. Welfare and well-being: towards mental health-promoting welfare systems. *Br J Psychiatry*. 2020;216(1):4–5. doi:10.1192/bjp.2019.242.
- 554** Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, et al. Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *Lancet*. 2011;378(9801):1502–1514. doi:10.1016/S0140-6736(11)60754-X.
- 555** McGuire J, Kaiser C, Bach-Mortensen AM. A systematic review and meta-analysis of the impact of cash transfers on subjective well-being and mental health in low- and middle-income countries. *Nat Hum Behav*. 2022;6(3):359–370. doi:10.1038/s41562-021-01252-z.
- 556** Zimmerman A, Garman E, Avendano-Pabon M, Araya R, Lacko S, McDaid D, et al. The impact of cash transfers on mental health in children and young people in low-income and middle-income countries: a systematic review and meta-analysis. *BMJ Glob Health*. 2021;6(4):e004661. doi:10.1136/bmjgh-2020-004661.
- 557** Fernald LCH, Gertler PJ, Neufeld LM. Role of cash in conditional cash transfer programmes for child health, growth, and development: an analysis of Mexico's Oportunidades. *Lancet*. 2008;371:828–837. doi:10.1016/S0140-6736(08)60382-7.
- 558** Webber M, Treacy S, Carr S, Clark M, Parker G. The effectiveness of personal budgets for people with mental health problems: a systematic review. *J Ment Health*. 2014;23(3):146–155. doi:10.3109/09638237.2014.910642.
- 559** Ljungqvist I, Topor A, Forssell H, Svensson I, Davidson L. Money and mental illness: a study of the relationship between poverty and serious psychological problems. *Community Mental Health J*. 2015;52:842–850. doi:10.1007/s10597-015-9950-9.
- 560** Oliveira Alves FJ, Borges Machado D, Barreto ML. Effect of the Brazilian cash transfer programme on suicide rates: a longitudinal analysis of the Brazilian municipalities. *Soc Psychiatry Psychiatr Epidemiol*. 2019;54(5):599–606. doi:10.1007/s00127-018-1627-6.

561 Angeles G, de Hoop J, Handa S, Kilburn K, Milazzo A, Peterman A. Government of Malawi's unconditional cash transfer improves youth mental health. *Social Science & Medicine*. 2019;225:108–119. doi:10.1016/j.socscimed.2019.01.037.

562 Kilburn K, Thirumurthy H, Halpern CT, Pettifor A, Handa S. Effects of a large-scale unconditional cash transfer program on mental health outcomes of young people in Kenya. *Adolesc Health*. 2016;58(2):223–229. doi:10.1016/j.jadohealth.2015.09.023.

563 Powell-Jackson T, Pereira SK, Dutt V, Tougher S, Haldar K, Kumar P. Cash transfers, maternal depression and emotional well-being: Quasi-experimental evidence from India's Janani Suraksha Yojana programme. *Soc Sci Med*. 2016;162:210–218. doi:10.1016/j.socscimed.2016.06.034.

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Mental health is critically important to everyone, everywhere. All over the world, mental health needs are high but responses are insufficient and inadequate. The *World mental health report: transforming mental health for all* is designed to inspire and inform better mental health for everyone everywhere. Drawing on the latest evidence available, showcasing examples of good practice from around the world, and voicing people's lived experience, it highlights why and where change is most needed and how it can best be achieved. It calls on all stakeholders to work together to deepen the value and commitment given to mental health, reshape the environments that influence mental health, and strengthen the systems that care for mental health.

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