IFMSA Policy Proposal
Mental Health for All

Proposed by Team of Officials

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IFMSA
International Federation of Medical Students' Associations

Policy Statement

Introduction

Mental health is a global issue, recognised as a human right and an essential component for sustainable development. In addition to a large part of the population being affected by mental health problems, there are numerous barriers, such as lack of funding, insufficient research, and limited training of healthcare providers. These challenges are further compounded by situations that increase vulnerability, such as crises and humanitarian emergencies, socioeconomic status, and other intersectional factors.

IFMSA position

The International Federation of Medical Students' Associations (IFMSA) emphasises that mental health is a fundamental human right and vital to overall health. IFMSA recognises that all individuals should access equitable, high-quality, and accessible mental health care integrated with other social and health services. Acknowledging the significant global burden of mental health disorders, it supports evidence-based initiatives focused on prevention, early intervention, and the elimination of stigma and discrimination. The importance of involving global health advocates and youth in decision-making processes and developing programmes and policies at all levels is emphasised. IFMSA urges actions aimed at providing public well-being policies for all, as there can be no health without mental well-being.

Call to Action

Therefore, the IFMSA calls on:

Governments and Health Ministries to:

- Implement an integrative "mental health in all policies" approach, adopting a cross-sectoral strategy emphasising the most vulnerable populations.
- Increase funding for mental health services and the development of related activities and research, ensuring that services are accessible, safe, and high-quality.
- Integrate mental health into universal health coverage (UHC) and primary healthcare (PHC) plans, and develop programs that cover all life stages.
- Meaningfully involve civil society in designing, implementing, developing, and evaluating programs and policies, ensuring that strategies are inclusive and tailored to the needs of the communities they target.
- Launch nationwide mental health literacy campaigns to combat stigma, promote help-seeking behaviours and tools, and educate civil society on mental health integration into overall well-being.
- Construct preparedness plans and ongoing initiatives sensitive to disasters and conflicts to ensure a swift and effective psychological first aid response and support trauma management and the specific needs of impacted communities.

Healthcare Institutions and Providers to:

- Develop comprehensive training programmes and strategies for health professionals, including an evidence-based, trauma-informed, and culturally sensitive approach to mental health care.
- Establish institutional protocols guiding the management of patients made particularly vulnerable to specific mental health challenges.
- Provide safe and equitable employment contracts and working conditions, support systems, anonymous reporting mechanisms, and resources for the mental health of healthcare staff members.

- Protect human rights by ensuring humane treatment and minimising unnecessary institutionalisation and bureaucracy.

United Nations Bodies, Non-Governmental Organisations (NGOs), and the Civil Society to:

- Continue advocating for integrating mental health at all levels, policies, and measures.
- Establish partnerships to ensure culturally appropriate mental health programs, empower communities, reduce stigma and discrimination, and promote an intersectional approach.
- Provide technical assistance to governments and decision-makers to develop inclusive legal frameworks that protect the rights of people with mental health conditions.
- Develop activities and measures to support vulnerable populations aimed at contributing to mental health services and raising awareness among the general population.

Medical Universities, Faculties, and Research Institutions to:

- Incorporate mental health and well-being education into medical training, including stress management, self-care, the connections between psychological and physical health, and the destigmatisation of help-seeking in academic and healthcare settings.
- Expand funding and prioritise inclusive, multidisciplinary mental health research in vulnerable groups globally and on innovative care models involving young people, women, people with disabilities, and people with lived experience.
- Provide accessible support services tailored to the unique challenges of medical students, healthcare workers and research staff.
- Foster student-led initiatives, mental health-focused groups, and faculty peer support systems.
- Encourage public-private partnerships for innovative care models to expand access, like telehealth and mobile treatment.

The Private Sector to:

- Develop and enforce workplace mental health policies and tools, promoting well-being, preventing burnout, and ensuring employees and team leaders feel safe seeking care.
- Invest in community mental health initiatives, especially in areas with limited access to care, to improve literacy and equitable access to services.
- Develop and support digital mental health tools that are more effective and accessible for detection, monitoring, and personalised care while ensuring privacy protection and security.

IFMSA National Member Organisations (NMOs) and Healthcare Students Worldwide to:

- Prioritise members' mental health and well-being through peer support systems, ensuring resources for prevention and early intervention.
- Advocate for better mental health resources and prevent stigma in schools, universities, and communities, ensuring that young people's needs are addressed.
- Work with academic institutions and other stakeholders to improve mental health training in curricula, including stress and burnout recognition and management, resilience, and mental health in global, regional, national, and local contexts.
- Lead activities, workshops, and peer-led support programmes to increase mental health literacy.
- Represent young voices in policy discussions to ensure young perspectives are included in mental health decision-making on national and global levels.

Position Paper

Background information

As an essential aspect of overall well-being, mental health is inseparably linked to both the physical and the social state. (1) Despite its value and significance, mental health is frequently disregarded, which results in significant challenges worldwide. Approximately 1 billion individuals globally are impacted by mental disorders, which are further worsened by stigma, discrimination, and insufficient access to care, especially in low- and middle-income countries. (1,2)

Non-communicable diseases and mental disorders frequently co-occur, leading to an ongoing cycle of adverse health outcomes, which emphasises the necessity of an integrated approach. Children, young people, older people, people in perinatal situations, and under-resourced population groups face specific barriers that make it challenging to seek and access support. Reducing inequities, increasing preventive and early intervention, and advancing culturally sensitive, equitable care models must be the primary objectives to address these challenges. Addressing these challenges is essential to improving individuals' and communities' quality of life and lowering the prevalence of mental health problems globally. (1,2)

Discussion

1. Mental Health as a Component of Health and Well-Being

According to the World Health Organization (WHO), health includes complete physical, mental, and social well-being, expanding beyond the mere absence of any illness (1). This emphasises the significance of mental health in overall well-being despite mental disorders remaining among the most overlooked health issues worldwide (2).

1.1 The Bidirectional Link between Physical and Mental Health

Both mental and physical health significantly influence each other, directly and indirectly. Mental health indirectly affects physical health through lifestyle behaviours and social interactions (3). Physical health impacts productivity, while mental health plays a role in decision-making, limiting access to health-related knowledge, prevention strategies, and quality healthcare, affecting physical well-being (3).

Individuals with severe mental health conditions — e.g. schizophrenia, bipolar disorder, and major depressive disorder — face an increased risk of developing additional major health issues, including metabolic disorders and cardiovascular or infectious diseases (4). Moreover, mental health influences a person's gut microbiota bidirectionally through the immune system (5). On the other hand, research has consistently demonstrated the benficial effects of physical activity on mental health through its protective effects regarding mental health challenges, which can be observed across all demographics, independent of age, sex, or location (6). This once more highlights the intricate connection between mental and physical health.

1.2 Mental Health and Non-Communicable Diseases

Non-communicable diseases (NCDs) have increased globally within the past century (7). It is known that cardiovascular diseases, diabetes, cancer, and respiratory conditions frequently develop as a comorbidity with mental disorders like depression, anxiety, schizophrenia, and bipolar disorder. Shared risk factors for both NCDs and mental health conditions include tobacco use, inadequate nutrition, a lack of physical activity, and hazardous alcohol consumption, which further compound physical and mental health challenges (8).

Integrated care approaches have delivered promising results in improving outcomes for NCDs, such as cardiovascular diseases and diabetes, by addressing co-existing mental disorders (9). Strengthening the integration of general medical care for individuals with severe mental disorders is essential to improving access, reducing care fragmentation, and tailoring treatment to individuals' needs. This approach is beneficial both in high-income settings where healthcare costs are rising and in low-and-middle-income countries (LMICs) where mental and physical health issues are often under-treated (10).

1.3 The Global Burden of Mental Health Challenges

Mental health challenges represent one of the greatest global burderns, affecting almost a billion people in the world, including 14% of adolescents (2). In 2019, mental disorders were the leading cause of disability, accounting for 1 in 6 years lived with disability (2). Suicide, which is often associated with mental disorders, accounts for more than 1 in 100 deaths, with 58% occurring before the age of 50 (2). The life expectancy of individuals with severe mental health conditions is statistically 10 to 20 years lower than that of the general population, mainly due to preventable physical diseases (2). The COVID-19 pandemic exacerbated these issues, with cases of depression and anxiety increasing by over 25% in the first year (2020) alone (2).

Despite the high prevalence, access to effective mental health care remains limited; for example, 71% of individuals with psychosis worldwide are not receiving necessary services (2). Stigma, discrimination, and human rights violations against people with mental health conditions are widespread, with the most vulnerable, underrepresented, and financially challenged people being most at risk and least likely to receive adequate services (2). Addressing this global burden requires a comprehensive approach, including increased investment in mental health services, integration of mental health into general healthcare, and efforts to reduce stigma and discrimination (2).

1.4 Regional Mental Health: Disparities and Inequities

The prevalence and burden of mental health disorders vary significantly across regions. In LMICs, an expansive treatment gap exists since many individuals lack access to necessary mental health care (11). This inequity is exacerbated by stigma, shortages of mental health professionals, and fragmented service delivery models. A systematic review from 2019 estimated that, globally, the prevalence of anxiety disorders among medical students is 33.8%, with higher rates among students from the Middle East and Asia (12). Similarly, the prevalence of depression among medical students is 28.0% (13), while studies from Africa report the highest rates at 38.80% (14). In the Asia-Pacific region, medical students have been found to experience high levels of anxiety and depression, influenced by factors such as academic pressure, fear of failure, sleep deprivation, workload and cultural stigma surrounding mental health, which leads to a negative perception about approaching mental health problems (15). Similar trends have also been observed in the Eastern Mediterranean Region (EMR), where a significant prevalence of anxiety and depression among medical students has been reported (16).

While prevalence rates vary in the Americas and Europe, the demanding nature of medical education contributes to elevated levels of psychological burden among students (12).

1.5 Mental Health in Medical Students and the Health Workforce

Medical students and healthcare professionals are particularly affected by mental health challenges. Studies have shown that, together, medical students experience higher rates of depression and anxiety disorders compared to the general population (12, 13). The intense pressures of medical education, along with the stigma surrounding mental health, make such difficulties even harder for students to cope with (17).

2. Mental Health Across the Lifecourse

Mental health is a vital component of overall well-being, influencing individuals across all stages of life (18). Understanding the unique challenges and needs at each stage of life is essential for promoting mental health and providing appropriate support (18).

2.1 Children, Adolescents, and Young Adults

Most mental health conditions emerge during childhood and adolescence and can significantly affect development and future well-being (19). Globally, it is estimated that 1 in 7 adolescents experience mental disorders, which corresponds to about 166 million adolescents (20). The State of the World's Children 2021 report by the United Nations Children's Fund (UNICEF) indicates that several contextual factors, such as family dynamics, economic status, and educational background, contribute to mental health problems in children and adolescents (21). Early life experiences, even before birth, shape the developing brain and lay the foundation for lifelong mental health (22). Adverse experiences during this critical period, including factors like toxic stress, persistent neglect, as well as the challenges of poverty, can affect a child's ability to learn and build relationships, impacting their well-being throughout their lifespan (23).

2.2 Maternal and Perinatal Mental Health

Maternal and perinatal Mental Health is a critical aspect of overall well-being, encompassing the mental health of individuals during pregnancy and the first year postpartum. It is estimated that 10% of pregnant individuals and 13% of individuals in the postpartum period experience a mental health disorder, mainly major depression (24). These figures are even higher in LMICs, with 15.6% during pregnancy and 19.8% postpartum (24). Severe cases can lead to suicide, and untreated maternal mental health issues can negatively impact children's growth and overall development. Integrating mental health care into routine maternal and child health services has demonstrated improved outcomes (25). However, many people able to get pregnant still do not have access to necessary care due to stigma, lack of awareness, and insufficient mental health services (24).

2.3 Older Adults

Mental health in older adults is often overlooked, yet conditions such as depression and dementia are comparably prevalent. The global prevalence of mental health disorders among people aged 60 years and above is about 14%, with major depression and anxiety being the most common (26). These conditions account for 10.6% of the total disability among older adults. Additionally, around 27.2% of deaths from suicide occur in this age group (26).

Most older adults do not receive adequate care despite the availability of effective treatments. The obstacles to care include stigma, lack of awareness, comorbid medical conditions, and inadequate mental health services (27). Public health strategies in dealing with mental health among older adults need to be multidimensional, with early screening, effective interventions, and support systems to ensure the well-being of this population group (26).

3. Access to Mental Health Care

3.1 Mental Health and Human Rights

Mental health is a fundamental human right promoted by international frameworks like the Universal Declaration of Human Rights and the UN Convention on the Rights of Persons with Disabilities (CRPD) (28, 29). Yet, many people with mental health conditions experience stigma and discrimination, being often left out of education, jobs and healthcare services (29, 30). They are also at risk of abuse, neglect, and forced treatment, especially in institutions (31, 32). The CRPD addresses these issues by promoting equity and autonomy and prohibiting discrimination. It supports community-based care, respect for personal choice, and informed consent in all treatments (28, 29).

The WHO QualityRights programme aims to change mental health systems by supporting approaches that respect people's rights and end forceful care (28, 32). This requires strengthening laws, increasing funding, and collaborating with people with lived experience in decision-making and policy-making (28, 33). Achieving these goals is slowed by structural obstacles, such as lack of investment, social stigma, and limited access to services in under-resourced settings (30, 32, 34). Prioritising the participation of individuals with lived experience can protect human rights, reduce inequities, and improve access to quality care (28, 33). Their roles should involve creating services, advisory positions, and peer-support models. Legal systems, capacity building, and inclusive policies are key to ensuring meaningful involvement (35).

3.2 Financial and Physical Resources

The availability of financial and physical resources is crucial in creating effective mental health systems. Poor funding remains a significant barrier, with over 75% of individuals with mental health conditions in LMICs unable to access care due to financial constraints (36–38). For example, as a middle-income country and Africa's largest economy and most populated nation (39), Nigeria has addressed these barriers by integrating mental health services into national health insurance reforms to reduce out-of-pocket expenditures and increase financial protection for individuals (40). Globally, financial insecurity is associated with poorer mental health outcomes, including increased rates of depression and anxiety. Policies that promote economic security and literacy could improve population health by reducing these risks (41).

The physical infrastructure of care delivery is also critical in mental health care. Community-based programmes, such as California's Full-Service Partnership, have shown that flexible funding and integrated models of care can reduce emergency department visits and improve patient outcomes (38, 42). However, facilities and training of professionals are inadequate in many regions globally, leading to gaps in access to care, particularly in rural areas (37, 41). Increasing physical resources and services through community-based care can ensure that people receive equitable and effective treatment closer to their homes (38, 41, 42).

3.3 Legislation and Policy

Adequate policies and legislation in mental health are essential to create equitable and efficient mental health systems. Evidence shows that mental health policies should be designed to place priority on integrating mental health services into primary care, reducing stigma, and increasing access among the most vulnerable populations (28, 43). According to the WHO, a comprehensive mental health policy prevents fragmented, inefficient care and ensures service coherence (28). Despite all this, as shown by the Community Mental Health Centers Act in the United States, poor planning and a lack of funding can undermine the best principles of community-based care (44).

Human rights must be the foundation of mental health legislation, focusing on autonomy, informed consent, and protection from coercion (43). The CRPD provides a framework to eliminate discriminatory practices and support the legal capacity of persons with mental health conditions (43). Broader policies must also address social determinants like housing, employment, and education, which are significant factors affecting mental health outcomes (45, 46). Success stories from Europe show how integrated frameworks involving individuals with lived experiences in decision-making can reduce inequities, promote recovery, and empower communities (43, 46). These legal and policy measures are enforced with adequate funding and regular monitoring to ensure effectiveness and sustainability (47).

3.4 Innovative Models of Care - Including Technology

Digital health technologies are transforming mental health care by making it easier for people to access support and reducing treatment gaps, especially in low-resource areas (48). Tools like apps and wearable devices help detect, diagnose, and manage mental health conditions early, making it practical for patients and providers (49). For instance, smartphone apps have proven effective in treating schizophrenia (50, 51). Patients can use these apps daily to monitor and manage their symptoms, making care more practical and consistent (51). In India, the SMART Mental Health project showed the successful use of mobile technology for screening and referral, helping to link primary care with specialised mental health services (52). Similarly, wearable gadgets and biofeedback tools are being developed to manage anxiety and chronic pain. Their primary advantage is that they allow sustained real-time monitoring of the body's functions (50, 53).

Telehealth is another disruptive model that offers consultations with a doctor remotely through videoconferencing, especially in areas with limited access to healthcare. Evidence shows that videoconferencing-based telemental health yields results identical to in-person therapy, with the added advantage of breaking down geographical barriers (50, 53). Social media-facilitated peer-to-peer support networks allow users to connect and share experiences, reducing stigma and improving community engagement. On the one hand, virtual reality offers immersive and interactive treatments for addiction research and psychotherapeutic interventions (53). On the other hand, artificial intelligence-powered tools can personalise care, monitor patient progress, and predict outcomes while making mental health services more efficient (35, 52, 53). Nevertheless, challenges persist, such as technological inequities and a lack of culturally adapted frameworks (48, 54).

Integrating digital innovations into mental health systems must address key challenges to ensure equitable and sustainable care. For instance, limited access to devices and connectivity, a hallmark of digital inequities, must be tackled to prevent widening inequality (54, 55). Privacy, data security, and culturally adapted frameworks are crucial for maintaining trust and meeting diverse patient needs (35, 56). WHO-guided policies should emphasise standardisation and interoperability alongside investments in infrastructure, workforce training, and community involvement to adapt technologies to local contexts (52). Overcoming these challenges will enable digital tools to deliver accessible, efficient, and personalised mental health care globally (54).

4. Barriers to Mental Health Care

4.1 Chronic Conditions and Comorbidities

Mental illnesses are a significant comorbidity in people with chronic diseases. Depression is about 2-3 times more common in individuals with chronic conditions compared to physically healthy populations (57, 58). People living with HIV can exhibit rates of depressive symptoms, which may be as high as 78%, while those with clinical anxiety stand at 25-33% (59). Cancer patients and survivors also show a high incidence of mental health illnesses (60–62). A study in the Chinese population showed that 48.2% of survivors experienced depressive disorders (63). Meanwhile, 73% of cancer patients already diagnosed with depression did not receive sufficient mental health treatment and support (62). This lack of care harmed their overall condition (62).

Concomitant diagnoses of depression and anxiety are relatively frequent in people with chronic diseases such as diabetes, hypertension, heart disease, asthma, and chronic obstructive pulmonary disease (60). These problems partly arise due to symptom burden, complex treatments, and uncertain prognosis (64). For example, people with type 2 diabetes are more than twice as likely to suffer depression, and people with asthma represent a higher rate of generalised anxiety disorder (GAD) and panic attacks (60, 63). Similarly, psychiatric disorders are comorbid with chronic pain: 30-60% of individuals can develop depression, and 28-48% may have suicidal ideation (65). Women with HIV are also among the groups at higher risk of mental health difficulties (66). 42% of them meet the criteria for post-traumatic stress disorder (PTSD), especially as a result of experiences of trauma and intimate partner violence (66). All these personal factors limit their activities of daily living and, consequently, reduce their quality of life (58, 60, 61, 64).

Some of the obstacles to mental health treatment of people with chronic diseases include underdiagnosis, poor integration of services, and inequity (57, 60, 62, 67). Many primary care health workers have not been trained to identify mental health disorders, while psychiatrists have neglected physical comorbidities, thus creating gaps in care (60, 68). Clinicians tend to confuse somatic symptoms with chronic disease, and this process of diagnostic overshadowing results in unnoticed and untreated mental health issues (57). On top of that, stigma related to mental health, particularly in HIV or cancer patients, prevents many from seeking the help they need, leading to a worsening of their condition (59, 62, 69). In LMICs, poverty, limited resources, cultural stigma, and lack of training are additional obstacles to accessing appropriate care (67).

4.2 Vulnerable Populations

4.2.1 People with disabilities

People with disabilities comprise 16% (over 1 billion people) of the global population, with a significant part of the healthcare system dedicated to their needs (70, 71). In the US, 39.9% of people with disabilities have been diagnosed with depression, compared to 15.3% of people without disabilities. Systemic restrictions such as poor referral systems, limited specialist expertise, and ableist discrimination worsen these inequities. Also, in the US, 32% of healthcare professionals openly prefer people without disabilities, and 84% hold implicit biases against individuals with disabilities, limiting access to equitable care (70). Structural ableism, including microaggressions that dismiss the autonomy of people with disabilities, also contributes to worsening their mental health (72).

Unlike the medical one, the social model of disability views disability as a societal issue, not an individual problem (71, 73, 74). Nonetheless, it has limits without the holistic perspective of the expanded social model, which also considers psychological and structural factors (71). Despite treaties like the CRPD, implementation gaps persist, such as Canada's reliance on substitute decision-making regimes, which undermine people with disabilities' legal capacity and autonomy (73). Moreover, mental health inequities for people with disabilities in Australia have remained unchanged from 2003 to 2020, with younger women with disabilities showing worsening trends (75).

4.2.2 People Experiencing Poverty

People living in poverty are more likely to struggle with mental health problems, depression, and anxiety at higher rates, 1.5-3 times those of higher-income groups (76). In addition, barriers such as unsatisfactory housing, food insecurity, and exposure to violence tend to worsen mental health outcomes (77). At least 80% of the population in LMICs do not receive treatment for common mental disorders, and those with fewer resources cannot even afford the care they require (78). Simultaneously, mental disorders affect productivity and increase unemployment rates and healthcare costs, promoting a vicious cycle that perpetuates poverty (76, 78, 79).

4.2.3 LGBTQIA+ Individuals

When accessing mental health care, the LGBTQIA+ community tend to face stigma, discrimination, and untrained caregivers (80–82). Many also have previous negative experiences in healthcare, making them less willing to rely on these services (80, 81, 83, 84). They also have to overcome minority stress, such as the pressure to hide their identities or fear of being rejected by their peers (83, 85). These challenges add up to a higher prevalence of anxiety and depression, which is 2.5 times greater overall (80, 84). Young people are in a particularly fragile position, with three times the likelihood of having suicidal thoughts (86). In the US, 31% of LGBTQIA+ adolescents exhibited suicidal behaviour compared to only 4.1% of cisheterosexual teenagers (86). Meanwhile, trans and non-binary persons suffer from distress at twice the rate of the general population and 39% present severe psychological symptoms (81, 85).

4.2.4 Black, Indigenous, and People of Colour (BIPOC)

Modern racism often manifests in covert ways, such as biased organisational policies and unintentional microaggressions in clinical settings, which lead to loss of trust and early termination of therapy with patients of colour (87). In the UK, mental health services are often seen as “Eurocentric” and exclusionary (88). This creates mistrust and prevents services from meeting the cultural and social needs of BIPOC individuals (88).

In South Africa, Africans experience more psychological distress than people from other racial groups (89). Over 24% live with three or more chronic stress factors like hunger and conflict, compared to just 1.8% of White South Africans (89).
In the Americas, one-third of the indigenous population in the US and 80% in Latin America did not receive treatment (90). Asian Americans are less likely to access mental health services, with only 8.6% seeking care compared to 18.1% of White individuals, mainly due to cultural stigma and language barriers (91). Simultaneously, continuous exposure to racial discrimination and harmful stereotypes is associated with higher rates of PTSD and depression among African Americans (92). They are 20% more likely than White Americans to showcase severe psychological distress, even though cultural mistrust and systemic barriers significantly prevent them from reaching out to care providers and engaging with mental health services (93–95).

4.2.5 Migrants

Language barriers are a significant obstacle for migrants seeking mental health care (96–99). In countries like Germany and the Netherlands, this results from budget cuts and a shortage of interpreters, and multilingual professionals (98). Many migrants endure acculturative stress, which includes symptoms of homesickness, anxiety, depression and sleep disorders, and identity struggles caused by cultural differences and the loss of emotional connections (97, 100, 101). These issues also affect children and teenagers, who often have worse mental health than native-born youth (102). Stigma and traditional beliefs about mental illness, such as those held in some African migrant communities, may prevent people from seeking help (103).

Legal and administrative constraints add to the problem (100). Undocumented migrants often live in unsafe conditions and lack access to healthcare (104). In Switzerland, many report high levels of anxiety (45%) and depression (50%) due to job insecurity, poor living conditions, and fear of deportation (105). It is also common for undocumented migrants to be at risk of detention, exploitation, and precarious forms of work (e.g., modern slavery and prostitution) (104). Therefore, economic challenges also affect mental health. More than 30% of migrants in Australia cannot use their skills or qualifications in jobs, which has been linked to increased stress and poor mental health (99). Female migrants, especially refugees, face even more significant risks (106). Refugee women are 37.5% more likely to experience prenatal depression (106). Many avoid seeking care because they fear deportation or losing custody of their children (106).

4.2.6 Displaced Persons and Refugees

Approximately 30% of refugees suffer from depression, while 29% experience PTSD, and the rates for anxiety and psychosis are 2-3 times higher than in host populations (107). Unaccompanied minors are especially vulnerable: studies indicate that 25-50% experience psychological distress and need targeted interventions (108). In addition, language barriers significantly limit access to mental health care, as they do for migrants (108, 109). Again, the lack of interpreters and limited funding for translation services worsen this problem (107, 108).

Socioeconomic deprivation further exacerbates the barriers, with refugees in high-deprivation areas reporting a 2.2-point drop in physical health scores and reduced access to primary care (110). Cognitive behavioural therapy in schools helps young refugees manage anxiety, depression, and PTSD effectively (111). Therefore, community-based approaches, including school-based interventions and cultural competence training for teaching staff and healthcare providers, are recommended to address these inequities (108, 111).

In addition, most providers in high-income countries are not trained to address the trauma-related needs of refugees, which jeopardises even more the quality of the care (107, 108).

4.3 Multiple and Overlapping Vulnerabilities

When addressing historically vulnerable populations, it is essential to acknowledge the social determinants of the health-disease process and psychological distress since mental health disorders are a growing factor in morbidity and mortality (112). Several factors, such as employability, education, poverty, experience of violence, e.g. gender-based violence, and others, determine the mental well-being of an individual. In the mental health context, an economic model based on profit contributes to the precarisation of historically vulnerable populations' living conditions, resulting in a lack of access to education, poverty, violence, and discrimination (113). The fight against the roots of the problem is of utmost importance to break with oppression and diminish social inequities and determinants that impact mental health (113).

5. Social and Cultural Dimensions of Mental Health

5.1 Stigmatisation and Individual and Societal Effects

Individuals with mental health disorders face widespread prejudice, discrimination and stigma in every culture and society (114). Researchers have identified a substantial degree of public stigma in all 15 countries studied across Africa, Asia, Australasia, Europe, and North and South America (115). Mental health stereotypes can have significant adverse effects on the everyday lives and general well-being of those who are experiencing mental health issues, frequently deteriorating their situations and preventing or postponing healthcare (115). Discrimination and stigma violate fundamental human rights and have detrimental, severe effects on individuals with mental health conditions, which worsens social exclusion and rejection, such as by limiting their ability to receive mental and physical healthcare and reducing possibilities for education and employment (116).

Within the broader literature on prejudice and discrimination, the examination of microaggressions in mental health is a recent and diverse topic inspired by previous research on race-related microaggressions (117). Since mental disorders are a more concealed aspect of one's identity, friends, relatives, and workforce members are the most common people who reportedly commit microaggressions (117).

The Lancet Commission on Ending Stigma and Discrimination in Mental Health has identified four key elements of stigma:

1. Self-stigma, also known as internalised stigma, when people living with mental health conditions comprehend and endorse the negative perceptions of others and apply them against themselves;
2. Stigma by association, which implies the assignation to harmful beliefs and practices targeted towards relatives (such as parents, spouses, or siblings) or mental health professionals;
3. Public and interpersonal stigma, which refers to the types of knowledge and stereotypes, negative attitudes (prejudice), and hostile behaviour (discrimination) that members of society have towards people with mental health conditions; and

4. Structural (systemic or institutional) stigma, which describes actions and policies that, whether on purpose or accidentally, damage the stigmatised group (117).

5.2 Media and Reporting on Mental Health

The media's portrayal of mental health conditions has been shown to affect public attitudes toward these conditions significantly (118). Some of the most compassionate, informative, and prestigious content about mental disorders and people who experience them has been created by the media (119). They have, however, also been at the forefront of producing a large amount of harmful material, even on children's television, including several alarming portrayals of mental health impairments and violent representations of their treatment (119).

Characters with mental health conditions are among those most likely to engage in violence. For instance, in entertainment media, 25% of the characters have been portrayed as killing someone and 50% as harming others (120). Framing of mental disorders in the media is often influenced by age, gender, and the type of mental health condition (121). The harmful portrayal is not only better remembered by the audience but is also often exaggerated and made harmful to mental health specialists, close relatives, and individuals with lived experience (119). People with mental health conditions are significantly affected by media representations, not only in regards to their self-perception, behaviours related to seeking help, and recovery, but also in terms of the degree of stigmatisation, dread, mistrust, and aversion they encounter when engaging with fellow citizens (122).

Proactive lobbying and anti-stigma initiatives may also find eager and receptive targets in the media. For example, increased interactions between journalists and individuals with mental disorders or expert providers of mental health care may make it easier for the audience to receive a less stigmatised image of mental health (123). Generally, news reporters often have a tolerant attitude regarding people with mental health conditions, even in the face of harmful portrayals (123). Due to several industry factors, including the desire to sensationalise, a shortage of time to do it differently, and an inability to reach mental health providers, there have been presumptions of adverse media coverage (123).

Research indicates that stigmatising attitudes can be lessened by mediated interaction with people living with stigmatised conditions, particularly those that are more common and less stigmatised, like depression (118). If employed correctly, media outlets may help eliminate stigma and promote mental health as an essential partner in combating societal perceptions (124). Yet, many vacant opportunities remain in incorporating community education and public media engagement into practical mental health care (124). Social media is becoming an increasingly important forum for dialogue regarding mental health problems (121). Another study suggests that news outlets and journalists provide the public with thorough and unbiased information regarding mental health conditions (121).

Self-harm and suicide are complex, varied, and both personal and social processes (125). In general, recent data suggests that discussions on suicide, including within media content, reduce rather than aggravate suicidal ideation and acts and lower the incidence of self-harm. (125) User-generated media has significantly expanded our exposure to and interaction with material that displays self-harming or suicidal behaviours. Nonetheless, the dramatic and emotionally charged media coverage portraying suicide content as relevant and worth reporting frequently alarms media experts, mental health specialists, and individuals with lived experiences of suicidality. Although future studies and expert discussions should address additional ethical dilemmas associated with digital health monitoring, e.g. safeguarding lives vs. invading private data, professionals express increasing anticipation surrounding artificial intelligence and machine learning systems as a revolutionising opportunity in media suicide prevention. (125)

Overall, the continuous need for sensible reporting on suicide, including specialised training of journalists and reporters as well as collaboration with mental health specialists, is particularly apparent (122).

5.3 Effects of Social Media

In recent years, there has been a notable rise in research on how social media use (SMU) affects the mental health of adolescents (126). This results from SMU's increasing influence on young people's daily life and their resistance to parental control (126). The most dynamic period of life is adolescence, when risk-taking peaks and psychological disorders such as depression manifest (126). According to meta-analytic findings, social media use is weakly linked to a higher degree of well-being and poorer mental health, indicating that well-being and ill-being are not mutually exclusive (126). However, dysfunctional SMU is a multifaceted issue which includes more than just the duration of social media usage (126). Divergent interpretations and only cross-sectional data are examples of research gaps in the field (126).

5.4 Social Isolation

Despite all recent digital achievements, social isolation has become one of the biggest mental health epidemics of this century (127, 128). 25% of the general population experiences loneliness, with rates rising to 33% in high-income nations (127, 129). The prevalence varies according to sociocultural factors and age groups (127). The absence of adequate social support is associated with long-term psychological outcomes like depression, anxiety, and suicidal ideation (127, 130–132). Although these issues are increasing in all age groups, some populations seem more vulnerable (127, 130).

According to data from 113 countries, 9.2-14.4% of adolescents reported feeling lonely (133). Common causes of social isolation, low self-esteem, and social anxiety in teenagers include discrimination, bullying, and body image concerns (130). Conversely, around 43% of adults over 60 experience loneliness (132). The scenario is more critical for older people in long-term care facilities, where higher depression rates are due to a lack of social engagement (128). Prisoners are also in a precarious situation, with low social support increasing the risk of depression by 1.7 times (134).

The COVID-19 pandemic worsened social isolation due to fewer interpersonal interactions (129). The lockdowns and all restrictions increased the levels of anxiety and emotional distress (129, 131). Yet the consequences of social isolation are not limited to mental health (127–129, 132). In truth, loneliness can raise the mortality risk by 26-29%, which is the same as smoking 15 cigarettes daily (128). Other effects include cardiovascular diseases, dementia, and functional decline in older individuals (127–129, 132). Recurring loneliness weakens the immune system and triggers inflammation, making long-term health problems worse (129, 131, 132).

6. Mental Health in Global Challenges

Global challenges, ranging from climate change (135) and pandemics (136) to armed conflicts (137), are defining issues of the 21st century. These crises are interconnected and disproportionately affect vulnerable populations, amplifying the consequences on their mental health and well-being.

6.1 Mental Health in Health Emergencies

Disaster-related catastrophes are commonly linked to mental health conditions such as GAD, depression, substance use disorders, adjustment disorders, and PTSD, with prevalence rates varying from 5.8% to 87.6% (138). Disasters destroy essential services, increase the need for relocation, and heighten psychological distress and overall mortality risks. Floods and storms are the most frequent disasters worldwide, with mental disorders being most prevalent in countries with less access to resources (138). Vulnerable groups, including those with lower incomes and higher rates of unemployment or pre-existing medical conditions, are at higher risk of psychological distress after disasters (138). Post-disaster psychotherapeutic interventions have proven effective by significantly reducing psychological distress and PTSD symptoms among survivors, such as depression, anxiety, insomnia, suicidal thoughts, and harmful substance use (139).

6.2 Conflict, Humanitarian Crises, and Mental Health

By mid-2024, an estimated 122.6 million people were forcibly displaced globally due to persecution, conflict, violence, human rights violations, and incidents that significantly disrupt public order, according to the UNHCR (137). Women and children in conflict zones face heightened exposure to violence, family disruption, and social disintegration. Displacement often includes prolonged stays in refugee camps, while urbanised, protracted conflicts increasingly expose civilians to trauma (140).

In addition, armed conflicts significantly increase anxiety disorders, PTSD, and depression among women, children, and adolescents, with prevalence rates two to four times higher than global averages (141). Women experience a disproportionate impact, often due to a higher prevalence of gender-based violence in conflict contexts (142). Children and adolescents, including child soldiers, face lasting mental health challenges due to family violence, disrupted structures, and caregiver mental health issues like maternal depression (143). Conflicts burden women, newborns, children, and adolescents both directly as casualties and indirectly through reduced access to essential services. These events disrupt critical neurodevelopmental periods for children, causing long-term and intergenerational effects (144).

Humanitarian crises in LMICs still face barriers to integrating mental health care, including limited trained personnel and insufficient public health funding (145).

6.3 The Climate Crisis and Mental Health

Many environmental, social, and economic factors significantly influence mental health, mainly through climate change (146).

In summary, acute direct or indirect implications are caused by catastrophic incidents with mostly immediate effects (such as heat waves) or sudden but indirect effects (such as storms, floods, forest fires, etc.), which abruptly expose defenceless and unprotected individuals to mental damage. Subacute implications include feelings of inhibition, confusion, and apathy, among other symptoms. Survivors' guilt and anxiety associated with uncertainty about species' survival, including humans, are also encountered by individuals who indirectly experience the impacts of the climate crisis. Long-term implications involve widespread social repercussions manifesting as conflict, violence, and competition for scarce resources. Other climate catastrophes, such as melting glaciers, ocean acidification, or biomass extinction, typically overlooked in research on the mental health of people from vulnerable populations, may also significantly impact mental health (147).

Based on research findings, it is anticipated that the severity of pre-existing mental health issues will increase as the climate crisis progresses, resulting in an increased burden on the overall population and a greater demand for mental health care (148). Heat, for example, exacerbates a range of mental disorders, which leads to higher rates of morbidity and mortality, including suicidality (148). Besides heat waves, air pollution is a relevant aggravating factor for respiratory conditions and reduced productivity and can lead to further mental health challenges, particularly in low-income areas (146). Among those impacted by environmental catastrophes, PTSD, depression, and anxiety disorders are particularly frequent. Droughts disrupt agriculture, cause poverty, and increase the risk of food insecurity, water scarcity, and malnutrition, all of which are linked to developmental delays, neurological issues, and intensified mental health conditions (149, 150). Subsequent displacement due to resource scarcity disrupts social ties and access to services, further exacerbating mental health risks (147).

Climate change can also aggravate conflict, especially in agriculture-dependent regions, and force migration or immobility, negatively impacting mental health (151, 152). One in 5 people exposed to conflict develops a mental health condition, while many others endure significant emotional distress (141).

The most vulnerable population groups to be most affected by the climate crisis include women, older adults, children, individuals with previous mental disorders who may subsequently experience deterioration of their mental health, individuals with low incomes or weak social networks, and Indigenous and native communities (147). The results listed indicate an urgent need to adapt healthcare systems to accommodate the expected increasing number and variety of mental health conditions, as well as the anticipated rise in psychiatric and psychotherapeutic demands driven by the climate crisis (148).

7. Research and Data on Mental Health

Research is integral to better understanding mental health and more advanced, inclusive, and accessible mental health care (153). Understanding the origins of mental disorders, adopting preventative measures and therapies, and advancing global mental well-being all depend heavily on research (153). It can also improve associated services' structure, organisation, effectiveness, and sustainability (153). Research increasingly contributes to both governmental and commercial policies and decisions, which impact not only persons living with psychiatric conditions and their close surroundings but also mental health services, insurance companies, and governmental organisations of all stages (153).

Barriers to mental health research include the lower representation of young people, women, people with disabilities, and those with lived experience within academic and research settings (154, 155). However, research leaders increasingly agree on the significance of and the need for including young people as partners in mental health research, which ensures that the projects are pertinent and sensitive to their needs (156).

7.1 Regional Inequities in Research and Data

There were significant differences among WHO regions in 2019 in the proportion of mental health research in the body of research produced (157). The African region had the lowest proportion (2.0% of overall research-creation), while the European Region recorded the highest proportion (8.2% of overall research creation) (157).

The burden of mental health disorders in every nation does not stand in proportion to the funding assigned to mental health care services in national budgets for health and funds invested in research on mental health in governmental science budgets (157). Psychiatric facilities receive most of the generally limited investment - fewer than one per cent of the national budget in low-income countries (157).

7.2 Involvement of People with Lived Experience

Involvement of people with lived experience is a method that allows persons affected by a specific condition or characteristic to participate in, voice their opinion on, and make decisions regarding matters concerning them. Participation degrees range from passive engagement as study participants to active planning and investigating as researchers (158). The approach is also called patient and public involvement in research (158). Its practice in each study stage, from preparation to implementation and transfer, is suggested to increase the significance, practicality, acceptance, execution, and sustainability of research (158). Furthermore, as a sign of democracy and empowerment within the research procedure, there is a general ethical requirement for patient involvement in studies (158, 159).

Despite limited definition and conceptual progress in the domain, scientific evidence has determined growing and significant proof of the beneficial effects of the involvement of people with lived experience in related research (159). Their expertise can improve various research stages, e.g., ensuring more effective recruitment of the focus community, especially in communities traditionally considered complex to reach (154, 160). For example, mutual respect and kindness in interaction are of core importance to the indigenous Māori people; their integration as part of the research team would improve the likelihood of acceptance among Māori and their subsequent engagement (161).

Recruitment of students, employees, and researchers with lived experience has to be proactive, similar to initiatives to increase employee diversity regarding gender and racial/ethnic backgrounds (154). When managing research environments where it is prevalent to refer to people with mental health conditions in excluding medicalised ways, students, associates, and scientific personnel with lived experience frequently encounter different types of emotional difficulties (154). Workplaces must welcome newly hired employees and students with lived experience and provide them with specialised assistance when required. Importantly, this has to involve a dedicated devotion to combating ableism and an accommodating approach to academic and labour settings (154).

8. Mental Health Literacy (MHL)

MHL is a concept that encompasses the ability of individuals to achieve and maintain good mental health, identify signs and symptoms of distress, and understand the necessary actions to deal with it (162). This debate has emerged as an essential aspect of healthcare recently and has not been handled equally globally (162). Therefore, to understand the importance of addressing this matter, it is necessary to discuss the possible tools to tackle the topic, guaranteeing its comprehension and relevance to health (162).

8.1 Empowering Communities Through Knowledge

The concept of MHL within communities involves (a) the public's competence in mental disorder prevention, (b) recognition of disorder development, (c) the understanding of help-seeking alternatives and available interventions, (d) expertise in functional self-help approaches for less severe concerns, and (e) first-aid competencies to support other individuals impacted by mental health challenges (163).

When approaching themes related to healthcare, especially mental health, it is essential to distance oneself from pre-established Western biomedical concepts to respond to the biological, cultural and social diversity of the societal members as potential subjects of care (164). With this understanding, the concept of knowledge as a tool for empowerment will vary from community to community. A multicultural attitude itself already helps communities with help-seeking behaviours (165). Therefore, comprehending these concepts, working closely with the communities of focus, and individualising the care based on their intersectional conception of health is pivotal for starting the debate on MHL and spreading specialised knowledge across population groups (165).

One of the leading causes of young people's prominent lack of formal help-seeking has been determined to be low MHL (166). Social media, despite its potentially detrimental impact on mental health, opens a window of opportunity to interact with and enhance the MHL of young people (166).

8.2 Mental-Health-Informed Training in Medical Education

In recent decades, psychiatric services have internationally been integrated into general healthcare to reduce institutionalisation and enhance holistic care (167). Simultaneously, studies have shown a relatively high prevalence of mental disorders in high- to low-income countries in different regions, highlighting the need for mental-health-informed training in medical education and continuing education. Multiple analyses indicate that one of the primary workforce problems is the inadequate educational training of general health practitioners (167).

Instead of training general health practitioners to deliver treatments, several authors recommend improving their intervention skills sufficiently to allow them to timely and appropriately refer individuals in need of care to mental health services. The method of acquiring knowledge from firsthand experience, or experiential learning, has been the most common educational strategy, sometimes blended with didactic techniques. In most instances, knowledge evaluations, assessment of attitude, self-reported shifts in practice behaviour, and documentation reviews of practice shifts and self-perceived competence have been utilised to evaluate the impact of the mental health education programme (167).

Programs containing supervised clinical experience have shown higher benefits. Previous research has highlighted essential aspects for discussion, including transdisciplinary education, involvement of people with lived experience both in training and healthcare services, encouraging the openness and commitment of healthcare professionals to provide support for individuals with mental health conditions, raising the scientific quality and methodology of the mental health education programme, and considering the social, economic, and political circumstances of its delivery (167).

Therefore, to addres various widespread shortcomings in the medical profession and the health and education systems that support it, including the comparatively higher prevalences of mental disorders and burnout among healthcare workers themselves, scientific literature also illustrates the present unique possibility and need for extending and researching mindfulness-based initiatives in medical education institutions worldwide (168).

8.3 Role of Health Professionals in Promoting MHL

The WHO identified increasing health literacy as crucial for improving public health (169). As the general public considers mental health professionals to be in an authoritative position due to their implied training and certified identification, there is presumably an inherent component to their credibility and reliability (166).

Social media profiles and channels offer opportunities to increase the accessibility of mental health information. This may promote enhanced MHL and contribute to surpassing some of the traditional barriers associated with speaking about mental health problems, such as stigma, accessibility, and a longing for autonomy (166). Due to the latter's connection with MHL, social media profiles and channels may also incentivise additional help-seeking (166).

Equivalent to health literacy, MHL needs to be suitable for developmental stages (e.g. tailored in its implementation across the lifespan), context-specific (e.g. constructed and utilised in common daily conditions), and successfully incorporated into the existing social and organisational systems, including community organisations and educational institutions (170).

9. Mental Health in All Policies

A scheme for action known as "Health in All Policies" attempts to link several sectors to work together towards a common objective. Aiming to promote public health and health equity, the framework is a cross-sector strategy for public policy that methodically considers the health consequences of actions, seeks collaboration, and avoids negative health implications. It combines components from widely utilised therapies in other areas that have been proven successful with evidence-based mental health intervention components that have been demonstrated to decrease mental health difficulties. The scheme guides the development of integrative intervention concepts, creating and modifying integrated interventions, task-shifting for implementation, collaborations, and capacity-building (171).

10. IFMSA Contributions

IFMSA has worked on Mental Health through its Standing Committee on Public Health (SCOPH) since its inception. The Standing Committee, founded in 1952, unites medical students globally to learn, develop skills, collaborate, explore and exchange ideas on addressing various public health concerns, including Mental Health (172). IFMSA has a dedicated Program in this area, which centralises activities organised by National Member Organizations and the IFMSA at the international, regional, national, and local levels (173). This Program addresses mental health promotion, advocacy, and integration into primary healthcare (174). As of 2024, over 270 activities have been reported under this program across all IFMSA regions. These diverse activities include campaigns for capacity building and educational initiatives, advocacy efforts in high-level meetings, publications, research, and more. More than 400,000 people have been engaged in these activities, including health students, healthcare professionals, and various target groups from the general public (175).

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