World Health Organization

World mental health report

Transforming mental health for all

1

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.

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

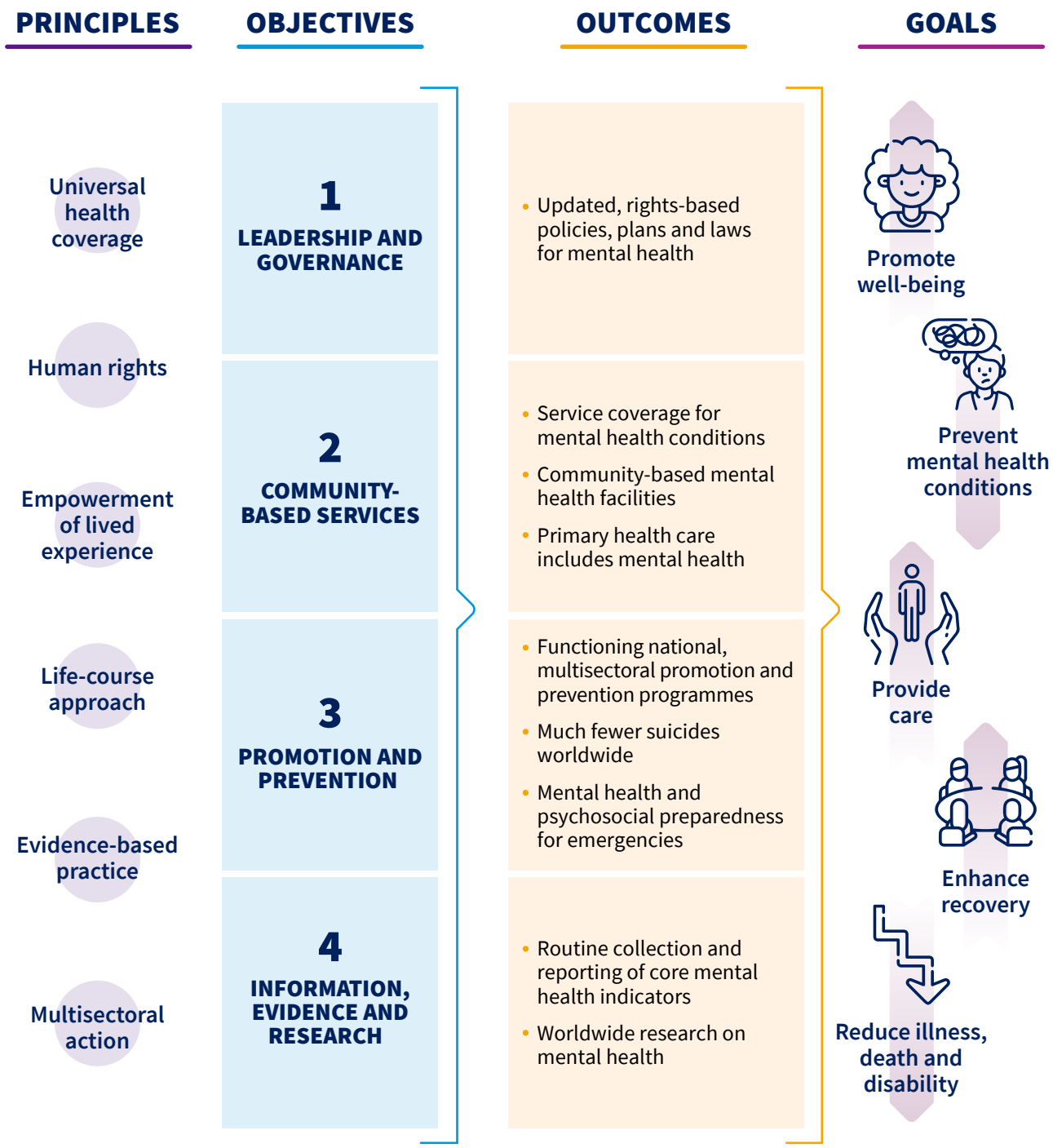
Since the 2001 report, countries around the world have formally adopted international frameworks that guide them to act for mental health. Most notably, WHO Member States have adopted the *Comprehensive mental health action plan 2013–2030* committing them to meet ten global targets for improved mental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

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

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

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.

2

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

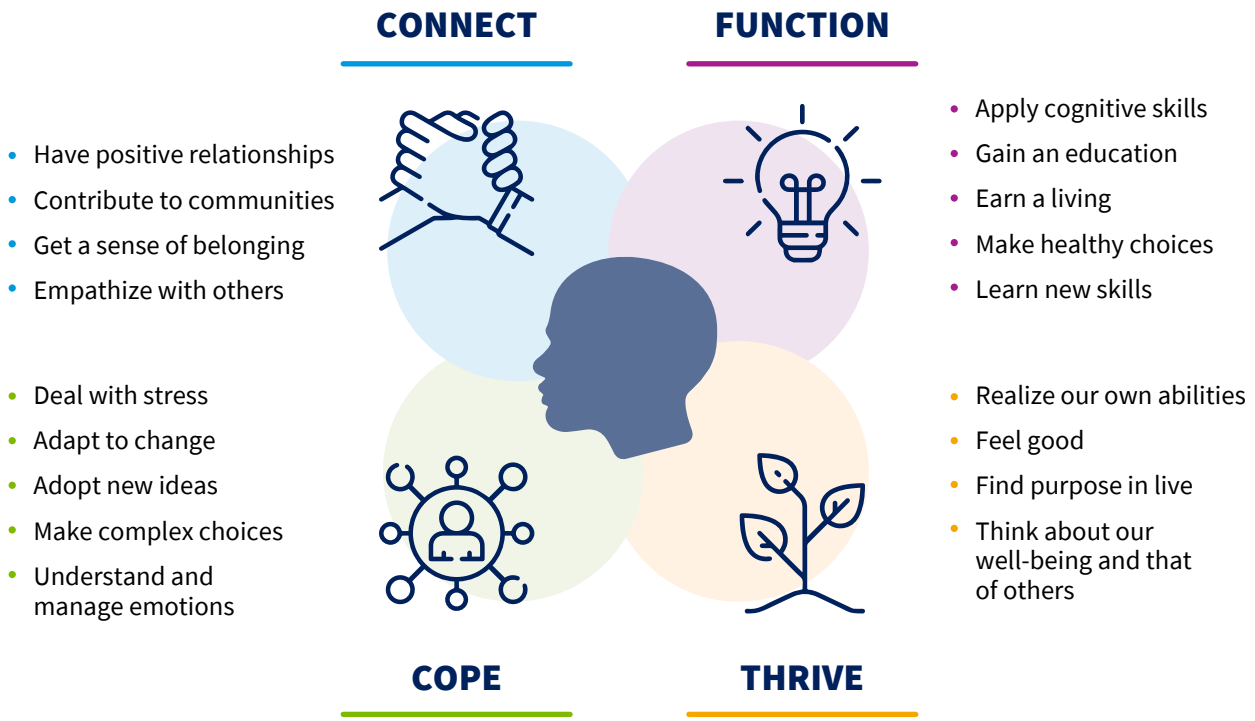
Mental health is intrinsic and instrumental to the lives of all people. It influences how we think, feel and act. It underpins our ability to make decisions, build relationships and shape the world we live in. Mental health is also a basic human right. And it is crucial to personal, community and socio-economic 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

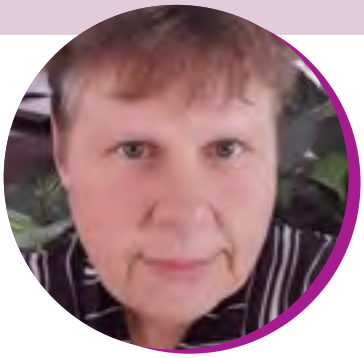


Living with a mental health condition can impose a substantial financial burden on individuals and households *(10)*. People experiencing mental health conditions are also often stigmatized, shunned, discriminated against and denied basic rights, including access to essential care *(11)*. Partly because 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)*.

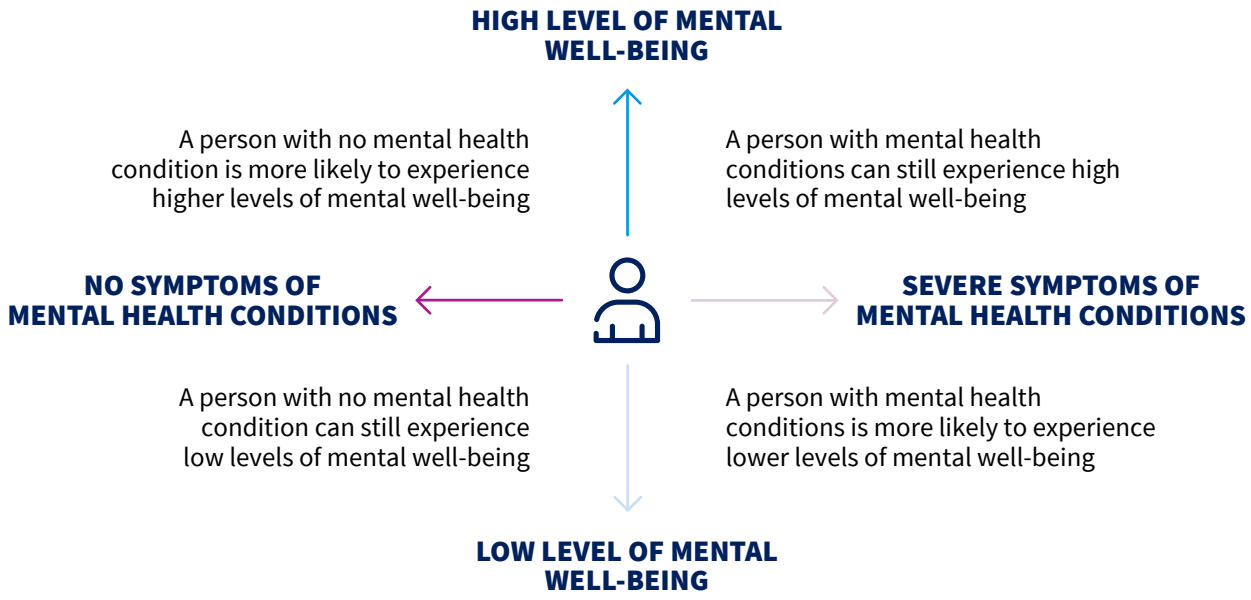
Mental health is not a binary state: we are not either mentally healthy or mentally ill. Rather, mental health exists on a complex continuum with experiences ranging from an optimal state of well-being to debilitating states of great suffering and emotional pain *(15)*. So mental health is not defined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

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

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

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

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)*.

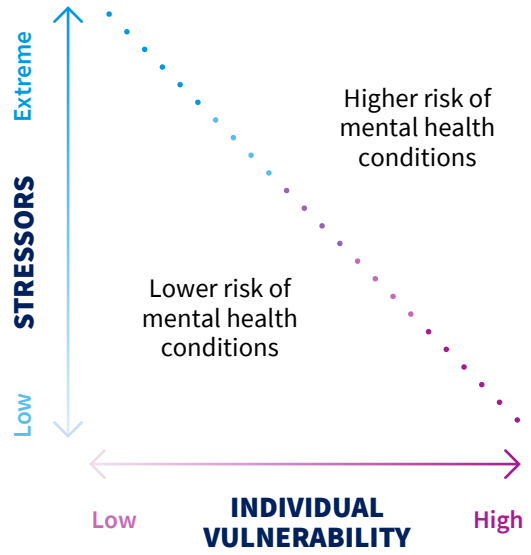
2.2.1 Spheres of influence

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

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

FIG. 2.3

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



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

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

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

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

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

2.2.2 Risks undermine mental health

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

FIG. 2.4

Examples of risks and protective factors that determine mental health

PROTECTIVE FACTORS
Enhance mental health

INDIVIDUAL

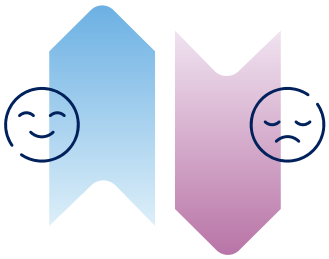
- Genetic factors
- Social and emotional skills
- Sense of self-worth and mastery
- Good physical health
- Physical activity

FAMILY AND COMMUNITY

- Good perinatal nutrition
- Good parenting
- Physical security and safety
- Positive social networks, social capital and social supports
- Green spaces

STRUCTURAL

- Economic security
- Good quality infrastructure
- Equal access to services
- Quality natural environment
- Social justice and integration
- Income and social protection
- Social and gender equality



RISKS
Undermine mental health

INDIVIDUAL

- Genetic factors
- Low education
- Alcohol and drug use
- Unhealthy diet
- Obesity and other metabolic risks
- Chronic disease
- Vitamin D deficiency
- Body dissatisfaction
- Sleep disturbances
- Obstetric complications at birth

FAMILY AND COMMUNITY

- Sexual abuse and violence
- Emotional and physical abuse and neglect
- Substance use by mother during pregnancy
- Bullying
- Intimate partner violence
- Being a war veteran
- Sudden loss of a loved one
- Job strain
- Job loss and unemployment
- Urban living
- Being from an ethnic minority

STRUCTURAL

- Climate crisis, pollution or environmental degradation
- Poor quality infrastructure
- Poor access to services
- Injustice, discrimination and social exclusion
- Social, economic and gender inequalities
- Conflict and forced displacement
- Health emergencies

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

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

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

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

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

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

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

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

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

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

The vicious cycle of disadvantage

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

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

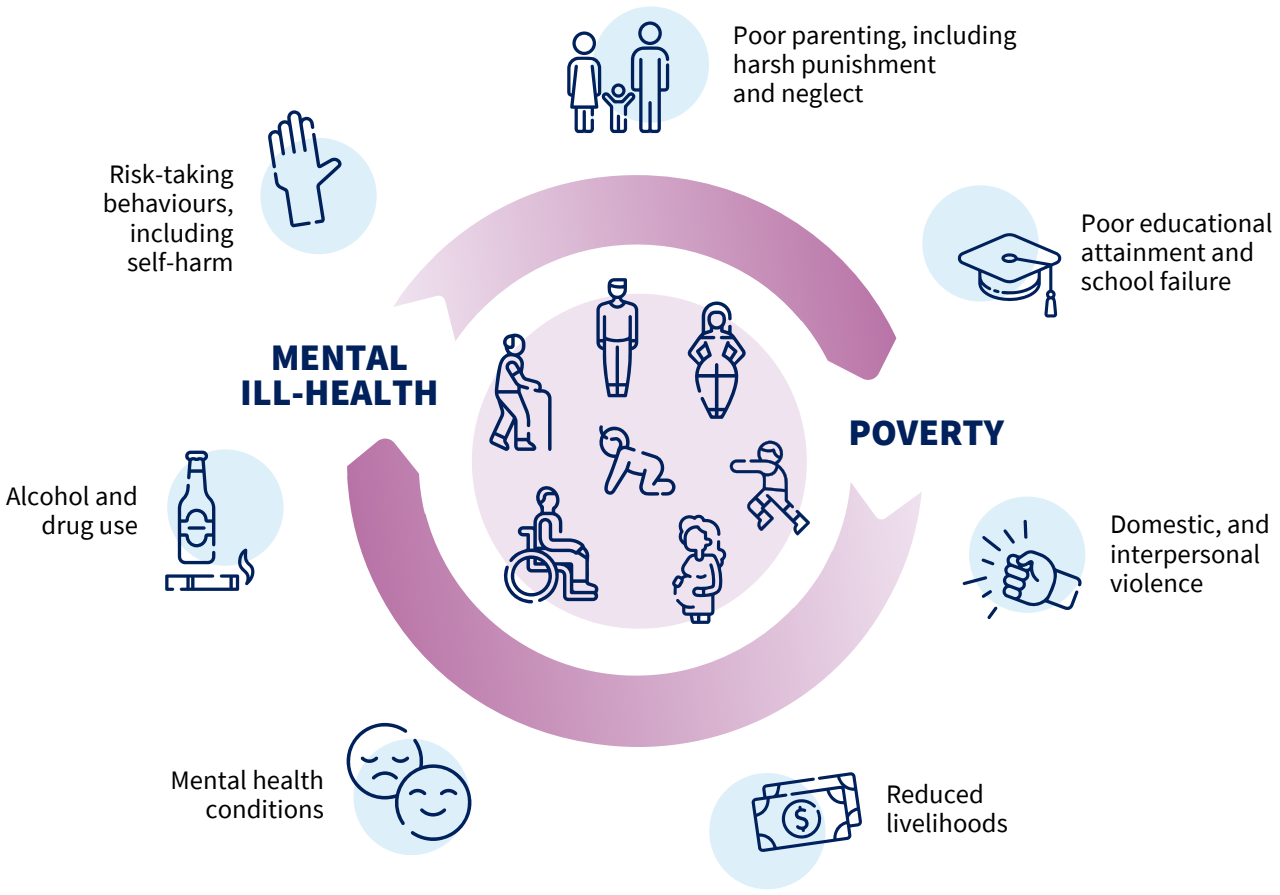
Similarly, people experiencing severe mental health conditions are more likely to fall into poverty through loss of employment and increased health expenditures. Stigma and discrimination may also undermine their social support structures. They are vulnerable to a downward spiral of lost resources and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

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

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

FIG. 2.5

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



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.

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

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

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

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

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

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

2.3.4 Climate crisis

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

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

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

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

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

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

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

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

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