



World mental health report

Transforming mental health for all

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World Health Organization

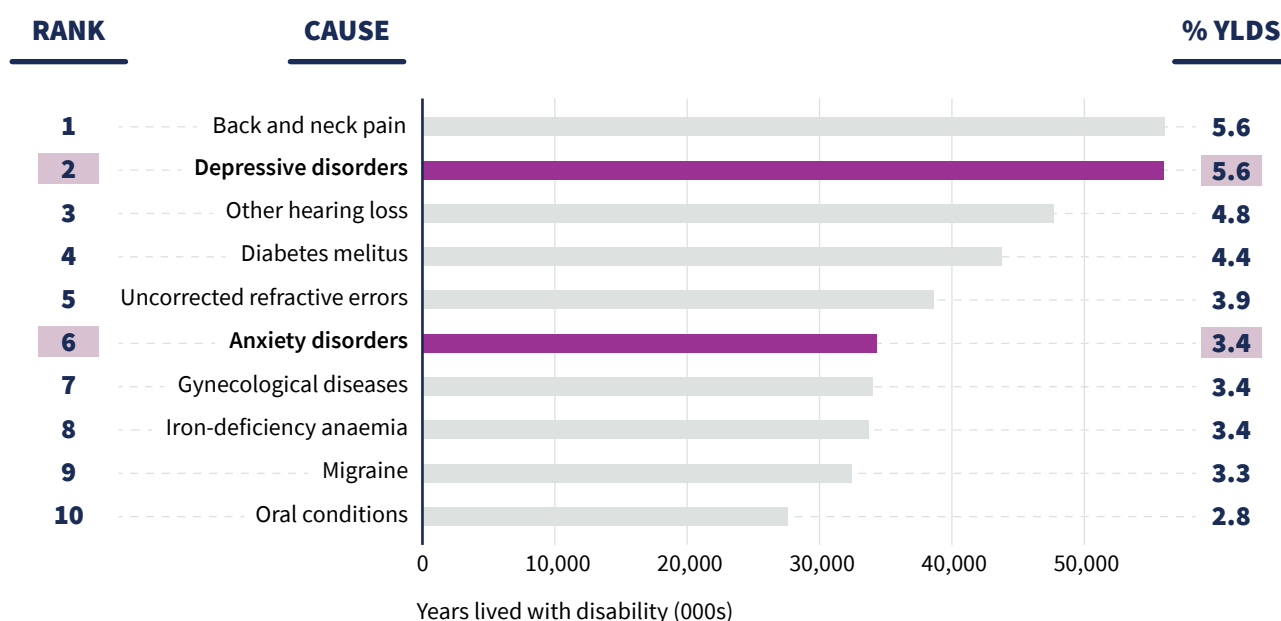


Depressive disorders alone are the second leading cause of global YLDs, accounting for 5.6% of all YLDs in 2019 (see Fig. 3.7). Two important risk factors for these common mental disorders have been quantified as part of GBD 2019: childhood sexual abuse (exposure before 15 years to any unwanted sexual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

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

FIG. 3.7

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



Source: WHO, 2019 (129).

3.2 Economic consequences

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

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

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

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

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

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

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

3.3 Gaps in public mental health

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

3.3.1 The information gap

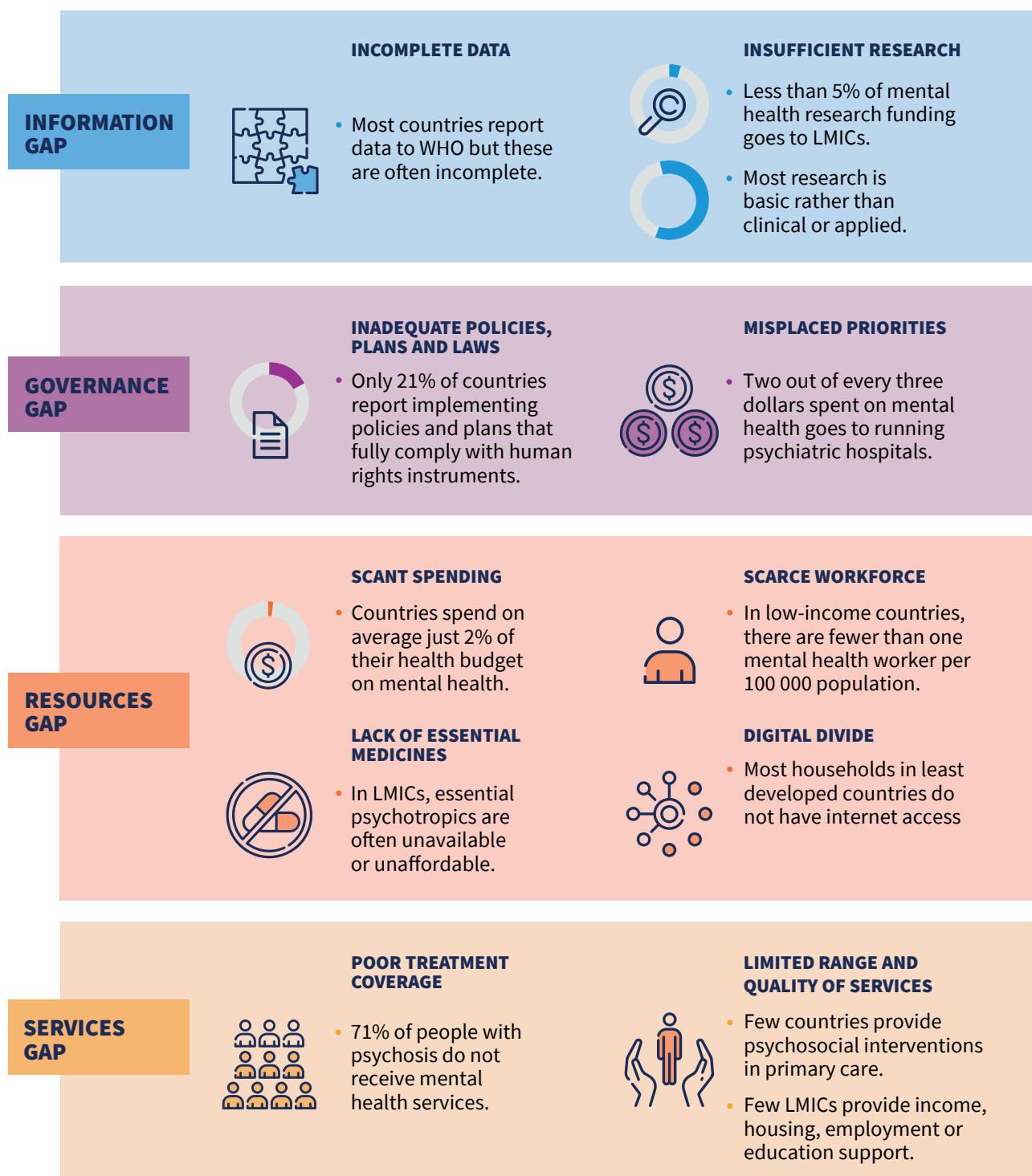
Limited mental health data

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

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

FIG. 3.8

A snapshot of key gaps in public mental health



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

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

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

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

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

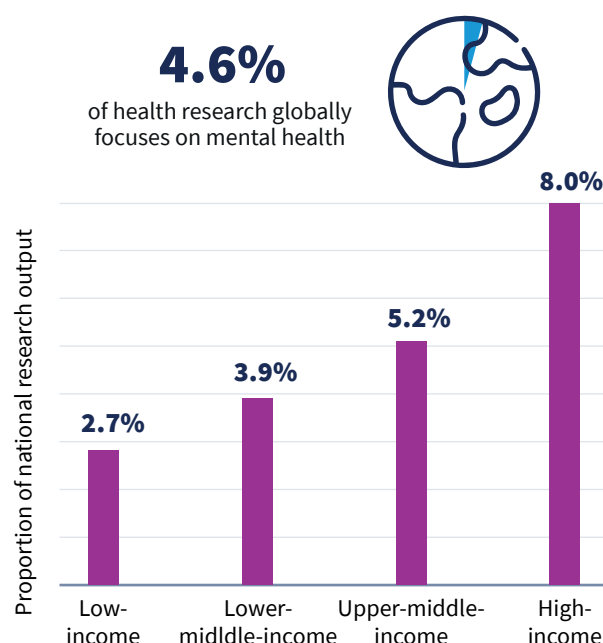
Insufficient and imbalanced research

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

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

FIG. 3.9

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



Source: WHO, 2021 (5).

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

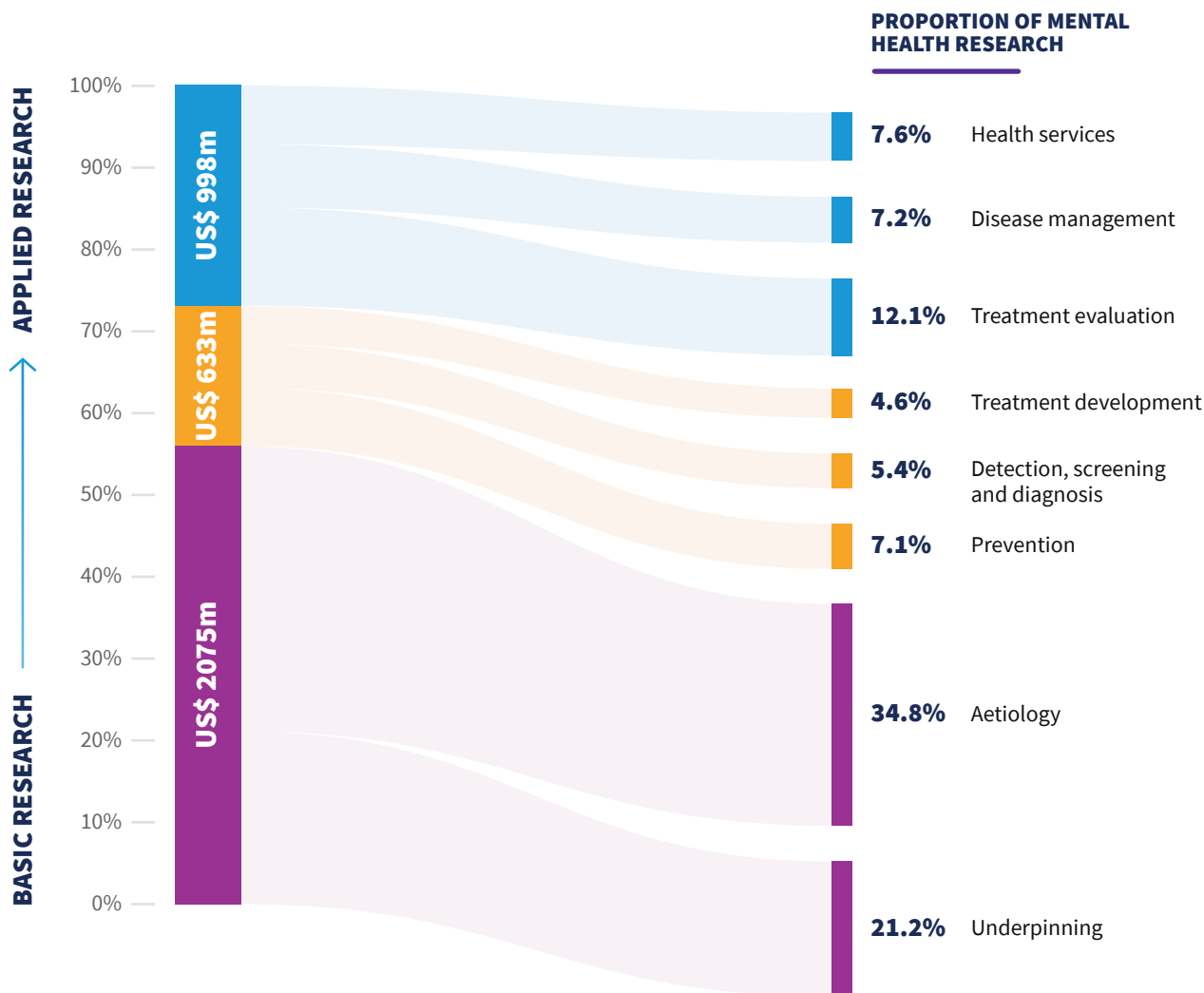
About US\$ 3.7 billion a year is spent globally on mental health research worldwide – an estimated 7% of global health research funding (137). Overall, more than half (56%) of all global funding for mental health research is spent on

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

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

FIG. 3.10

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



Source: Woelbert et al, 2020 (137).

3.3.2 The governance gap

Inadequate policies, plans and laws

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

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

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

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

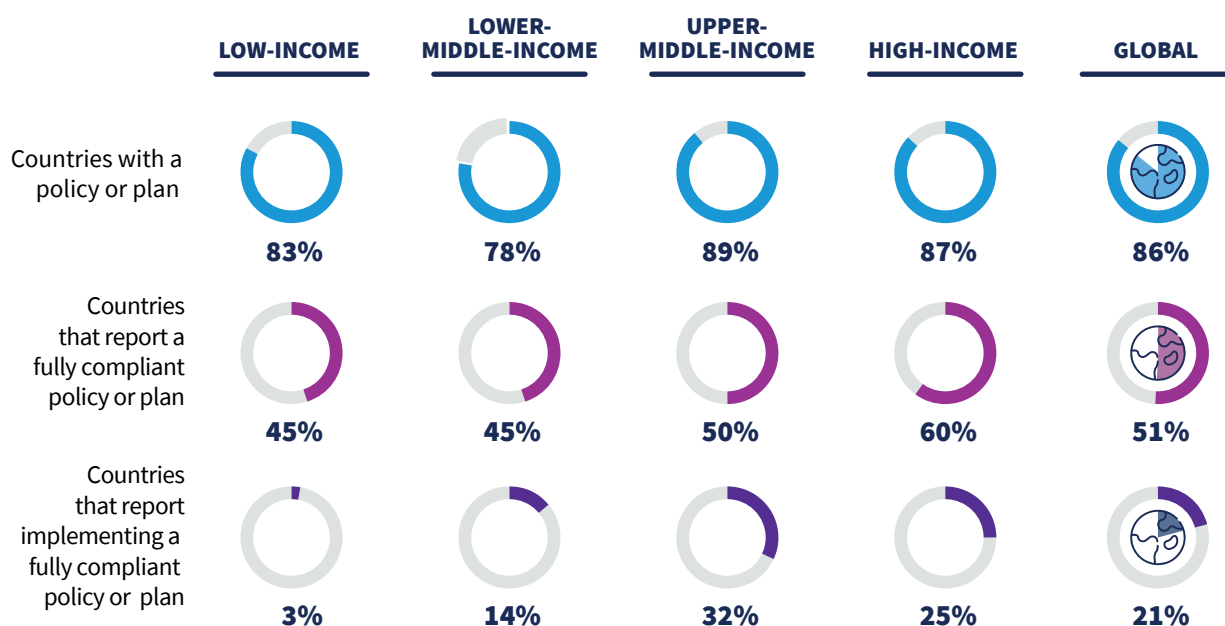
Only half (51%) of WHO Member States reported that their mental health policies or plans fully complied with human rights instruments. About a third (31%) reported plans that were being implemented. And only 21% of WHO Member States reported policies

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

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

FIG. 3.11

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



Source: WHO, 2021 (5).

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

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



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

Disparities and misplaced priorities

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

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

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

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

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

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

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