World mental health today

Latest data

World Health Organization

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Contents

Foreword v

Acknowledgements vi

Executive summary vii

1. Introduction 1

1.1 Overview 2

1.2 Data for assessing world mental health 3

2. Epidemiological overview 5

2.1 Prevalence 6

2.1.1 Prevalence in males and females 13

2.1.2 Prevalence in children and adolescents 14

2.1.3 Prevalence in older adults 15

2.1.4 Geographical disparities 16

2.2 Mortality 19

2.2.1 Premature mortality 19

2.2.2 Suicide 20

2.3 Burden 23

3. Economic consequences 27

4. Gaps in mental health systems 31

4.1 The information gap 33

4.1.1 Limited mental health data 33

4.1.2 Insufficient and imbalanced research 33

4.2 The governance gap 35

4.2.1 Inadequate policies, plans and laws 35

4.2.2 Disparities and misplaced priorities 37

4.3 The resources gap 38

4.3.1 Scant spending 40

4.3.2 Scarce workforce for mental health 41

4.3.3 Lack of essential medicines 42

4.3.4 A digital divide 43

4.4 The services gap 44

4.4.1 Poor treatment coverage 44

4.4.2 Variable quality and range of services available 44

5. Conclusion 47

References 49

Foreword

Mental health is an essential component of health, well-being and sustainable development. Yet mental health remains one of the most neglected areas of public health and health services delivery. Ongoing crises, socioeconomic uncertainties and pressures on young people have only deepened the urgency to act.

This publication is an update of the data chapter of our 2022 *World mental health report: transforming mental health for all*. It brings together the most recent global data on the prevalence, burden, and cost of mental health conditions – data that are indispensable for shaping effective, evidence-informed responses. Drawing on the *Mental health atlas 2024* by the World Health Organization (WHO), it also sheds light on resource availability for mental health, including persistent gaps in service coverage, financing, and workforce capacity.

The 2025 United Nations High-Level Meeting on Noncommunicable Diseases and Mental Health highlights the central importance of this issue and this report offers a comprehensive basis for discussions on actions to improve mental health around the world. It reminds us that mental health is not a peripheral issue but central to improving health and well-being globally and to achieving universal health coverage and other Sustainable Development Goals.

I commend this update to all – governments, health professionals, researchers and civil society – and encourage its use to drive the transformative change we need. Let it serve not only as a status report, but as a catalyst for stronger commitment, smarter investment, and more equitable mental health policies. As I have stated many times before, there is no health without mental health.

Dr Tedros Adhanom Ghebreyesus
Director-General
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The *World mental health report: transforming mental health for all* (2022) provided the foundational text for this publication.

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Executive summary

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

This document draws on the latest information available to outline the state of mental health and mental health systems in the world. It shows that mental health conditions remain highly prevalent, with more than a billion people worldwide living with a mental disorder. The prevalence of different mental disorders varies with sex, with females most affected overall. In both males and females, anxiety disorders and depressive disorders are the most common.

> **More than 1 billion**
> people worldwide live with a mental disorder.

Suicide affects people from all countries and contexts and is a major cause of death among young people. Globally, suicide accounts for more than one in every 100 deaths and for each death there are 20 suicide attempts.

Mental disorders account for one in twenty disability-adjusted life years (DALYs) globally. They are also the second leading cause of years lived with disability (YLDs), accounting for one in every six YLDs globally. Depressive and anxiety disorders are major contributors to YLDs in all age groups (except 0–5-year-olds), and especially for 15–29-year-olds. Schizophrenia and bipolar disorder, which affect about 1 in 200 and 1 in 150 adults respectively, are a primary concern. Schizophrenia in its acute state is modelled to be the most impairing of all health conditions. People with schizophrenia die on average nine years earlier than the general population, often of preventable noncommunicable diseases. People with bipolar disorder die on average 13 years earlier.

The economic consequences of mental health conditions are enormous. Productivity losses and other indirect costs to society far outstrip health care costs. Financially, schizophrenia is the costliest mental disorder per person to society. Depressive and anxiety disorders are less costly per person; but since they are much more prevalent, these collectively contribute majorly to overall national costs. Annual global productivity losses for these two disorders alone are estimated to be US$ 1 trillion.

People with mental health conditions remain severely underserved. Mental health systems all over the world are marked by large gaps and imbalances in resources, services, information and research, as well as governance, especially in low-income countries. Other health conditions are often prioritized over mental health and, within mental health budgets, community-based mental health care is consistently underfunded.

> **US$ 1 trillion**
> in annual productivity losses due to depression and anxiety.

On average, countries dedicate just 2% of their health budgets to mental health. More than half of mental health expenditure in low- and middle-income countries still goes towards psychiatric hospitals. In low-income countries there are little more than one mental health worker of any kind per 100 000 population, compared with more than 60 in high-income countries. Two-thirds of countries have just one psychiatrist to serve 200 000 or more people. And the availability of affordable essential psychotropic medicines and psychological interventions remains limited, especially in low-income countries.

Only 9%
of people with depression receive adequate treatment.

Most people with mental health conditions do not receive formal mental health care. In all countries, gaps in service coverage are compounded by gaps in quality of care. Fewer than one in ten (9%) people with major depressive disorder have been estimated to receive minimally adequate treatment globally.

This report provides essential data to guide national and global dialogue, including during the 2025 United Nations High-Level Meeting on Noncommunicable Diseases and Mental Health in New York. It highlights where progress is being made – and where critical gaps persist. This report should serve as a vital tool for policy-makers, implementers and advocates alike.

1 Introduction

In 2022, WHO published *World mental health report: transforming mental health for all*, providing a landmark overview of mental health globally, grounded in the best available evidence at the time *(1)*. Since then, the world has continued to change and new data have emerged.

In this report, we present the latest data available on both the prevalence and burden of mental disorders, looking beyond the impact of mortality and disability to also capture the immense economic and social costs involved. We also highlight findings from WHO's Mental Health Atlas 2024 *(2)* to reveal some of the enduring critical gaps and barriers in mental health care worldwide.

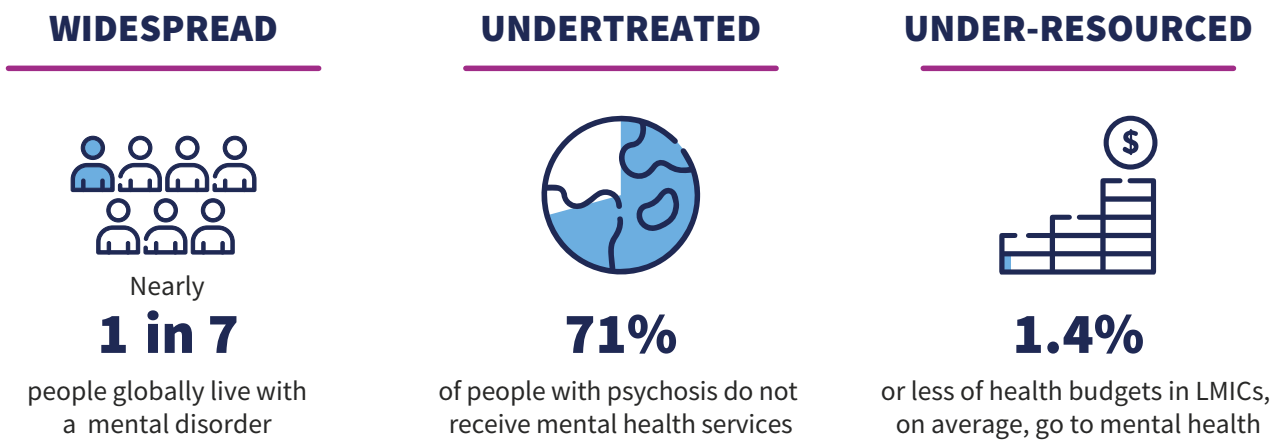
1.1 Overview

Mental health conditions remain widespread, often misunderstood and significantly undertreated, with services to address them being insufficiently resourced (see Fig. 1.1). The latest data show that despite mental health's critical role in health and well-being, too many people still do not get the support they need. In 2021, nearly one in seven people globally were living with a mental disorder *(3, 4)*. Almost half of mental disorders begin before the age of 18 years *(5)*. At the same time, the services, skills and funding available for mental health remain in short supply, falling far below what is needed, especially in low- and middle-income countries (LMICs) (see chapter 4).

Across the world, mental health conditions are influenced by interacting factors, ranging from individual challenges such as genetic vulnerability or low self-worth to community issues such as social disconnection or interpersonal violence and broad stressors such as poverty, conflict and social inequality *(1)*. The interplay of these factors will continue to generate threats to mental health for the foreseeable future. Promotion and prevention programmes to tackle the social determinants of mental health remain scarce.

FIG. 1.1

Mental health conditions are widespread, undertreated and under-resourced



Source: IHME, 2024 *(3, 4)*; WHO, 2025 *(2)*.

Photo credit (previous page): A farmer in a small village near Qinghai Lake, China. © Getty Images / double_p

1.2 Data and terminology for assessing world mental health

To speak to the broadest group of stakeholders possible, we generally use the umbrella term "mental health conditions", which covers mental disorders, psychosocial disabilities and other mental states associated with significant distress, impairment in functioning, or risk of self-harm. But when describing prevalence rates and global health estimates, we use the term "mental disorders", as it more accurately reflects the data that are collected and reported, and its scope is clearly defined by WHO's International Classification of Diseases 11th Revision (ICD-11) *(6)*.

Neurological and substance use disorders are not a focus of this report yet these are briefly mentioned to reflect the broader needs that mental health decision-makers in LMICs are often responsible for.

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

Epidemiological data – covering disease incidence, prevalence, mortality, distribution and determinants – are important for understanding health trends and for planning, delivering and evaluating health services and programmes. And mental health systems data – on policies, legislation, resources and care delivery – are especially vital for these processes.

This report presents the most recent data available at the time of writing and primarily draws on three international sources:

- WHO's Global Health Estimates 2021 (GHE 2021): used to report mortality and burden of disease data *(7)*;
- the Global Burden of Diseases, Injuries and Risk Factors Study 2021 (GBD 2021) by the Institute of Health Metrics and Evaluation (IHME): used to report prevalence data *(3, 8)*; and
- WHO's Mental Health Atlas 2024: used to report country data on gaps in mental health systems *(2)*.

GBD and GHE are closely linked in terms of mental health estimates. Together, they provide point prevalence[1] and disease burden estimates for mental disorders and suicide, with data up to and including 2021.[2] The Mental Health Atlas 2024, which includes both quantitative and qualitative country-reported data, provides system-level information up to and including 2024. Mental Health Atlas data are validated by WHO in collaboration with reporting countries.

While these three long-standing studies offer the best available global evidence, their estimates should be interpreted with caution. Gaps in data, outdated or low-quality inputs, and cultural differences in conceptualizing mental health all contribute to uncertainty. Many countries lack comprehensive data on mental health conditions and systems.

1 Except for bipolar disorder where the prevalence modelled in GBD 2021 reflects annual prevalence due to this disorder's episodic nature.

2 For comparison, the GBD and GHE data presented in the 2022 *World mental health report* was from 2019, which was the latest available at the time of publication.

The GBD and GHE data in this updated report replace those in the original *World mental health report: transforming mental health for all* (2022) and are not directly comparable with previously published WHO estimates. Any differences from previous reports should not be interpreted as time trends. This is because each iteration of both the GHE and GBD studies incorporates new data sources, revised analytical methods and updated disease classifications that are *retrospectively* applied to the entire time series *(9, 10)*. While these changes in methods enhance the accuracy and relevance of current estimates, they can lead to differences with previous reports.

Similarly, caution is advised when interpreting trends in Mental Health Atlas data as differences between survey rounds may reflect variations in country participation or reporting, rather than actual changes in mental health systems.

Photo credit (next page): A teenager carries laundry in a village near Birgunj, Nepal. © Getty Images / Christian Ender / Contributor

2

Epidemiological overview

2.1 Prevalence[3]

In 2021, 14% of the global population – more than one billion individuals – were estimated to be living with a mental disorder, most of whom were in LMICs, where most of the world's population live *(3, 4)*.[4] Additionally, according to various estimates, 400 million people (7% of people over 15 years of age) had alcohol use disorders in 2019 *(11)* and 64 million people had other drug use disorders (not including tobacco) in 2022 *(12)*. In 2021, nearly 57 million people had dementia *(13)* and more than 24 million people had epilepsy *(13)*. In many countries, mental health care systems are responsible for the care of people with these conditions.

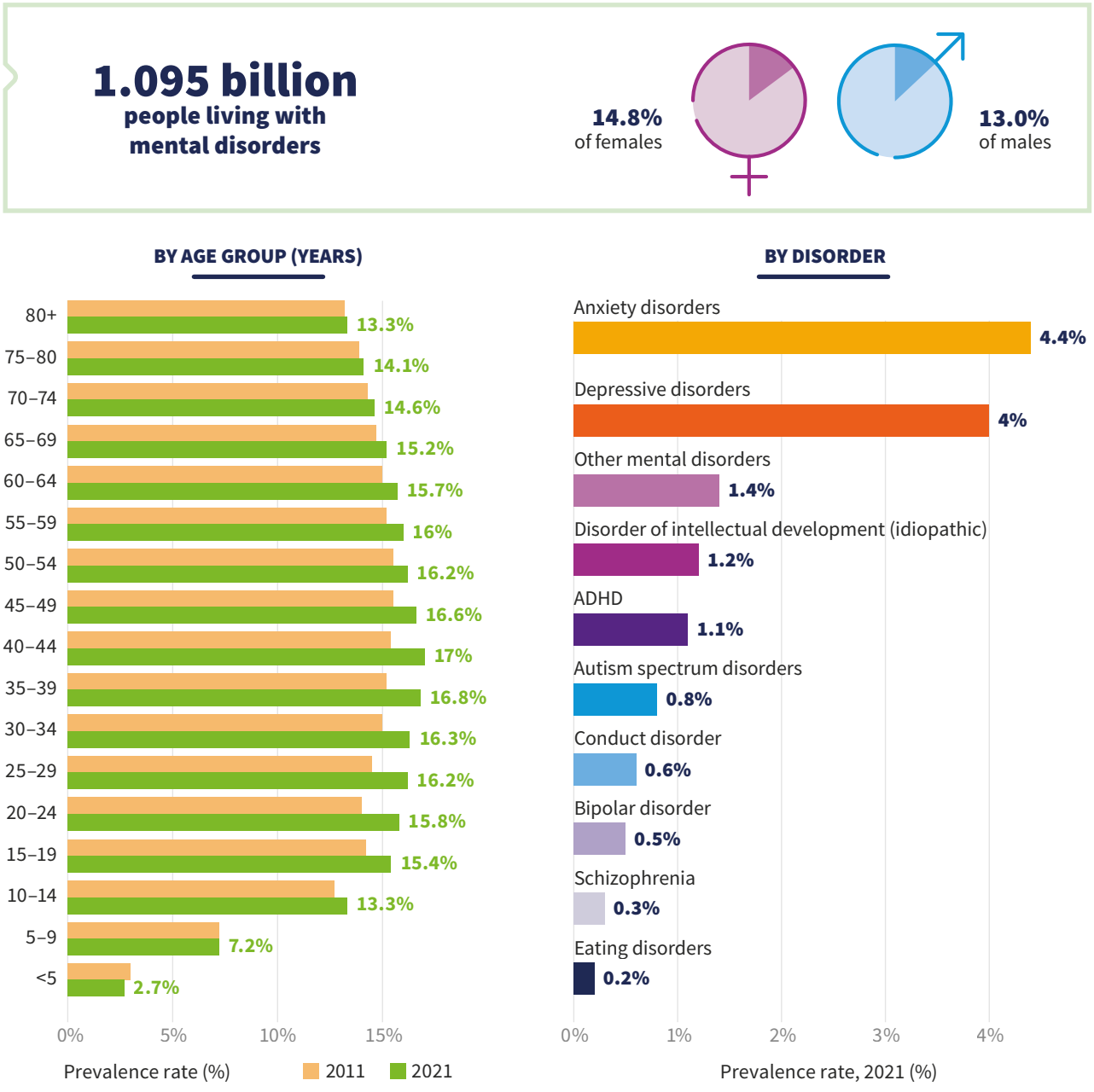
The most common mental disorders are anxiety and depressive disorders, which together accounted for more than two-thirds of all mental health conditions in 2021 (see Fig. 2.1). Between 2011 and 2021, the number of people living with mental disorders increased faster than the global population. As a result, the global age-standardized point prevalence of mental disorders reached 13.6%, which is 0.9% higher than a decade ago. Younger adults aged 20–29 years are estimated to have the largest increases (1.8%) in prevalence since 2011 (see Fig. 2.1).

3 Prevalence estimates in this section come from GBD 2021 (https://vizhub.healthdata.org/gbd-results/).

4 This estimate includes people living with schizophrenia, depressive disorders (representing major depressive disorder and dysthymia), anxiety disorders, bipolar disorder, autism spectrum disorders, attention-deficit/hyperactivity disorder, conduct disorder, idiopathic disorder of intellectual development (comprising intellectual disability from any unknown source and called idiopathic developmental intellectual disability in GBD 2021), eating disorders (representing anorexia nervosa and bulimia nervosa) and a residual group of other mental disorders (including personality disorders), as covered in GBD 2021.

FIG. 2.1

The global prevalence of mental disorders in 2021



Source: IHME, 2024 *(3)*.

The prevalence of mental disorders varies by sex and age (see Table 2.1 and Table 2.2). For example, males are estimated to more commonly have attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorders, idiopathic disorder of intellectual development (comprising intellectual disability from any unknown source, see footnote 4), and other mental disorders.

Females are estimated to more often experience anxiety, depressive and eating disorders. Anxiety disorders typically emerge earlier than depressive disorders, which are rare before ten years of age (see Fig. 2.2). After the age of 40 years, depressive disorders become more prevalent than anxiety disorders, peaking between ages 50 and 69 years.

Photo credit (previous page): Six-year-old twin refugee living in Spain. © WHO / Uka Borregaard

TABLE 2.1

Global prevalence cases and rates (%) of mental disorders by sex (2021)

		AGE-STANDARDIZED (%)			AGED 20+ YEARS (%)		
	ALL AGES (MILLION)	**ALL**	**MALE**	**FEMALE**	**ALL**	**MALE**	**FEMALE**
Mental disorders	1 095	13.6	12.7	14.3	16.0	14.5	17.5
Schizophrenia	23	0.3	0.3	0.3	0.4	0.5	0.4
Depressive disorders[a]	332	4.0	3.2	4.8	5.7	4.6	6.9
Bipolar disorder	37	0.5	0.4	0.5	0.6	0.6	0.7
Anxiety disorders[b]	359	4.4	3.3	5.5	5.5	4.1	6.8
Eating disorders[c]	16	0.2	0.1	0.3	0.2	0.2	0.3
Autism spectrum disorders	62	0.8	1.1	0.5	0.7	1.0	0.5
ADHD	85	1.1	1.6	0.6	0.7	1.0	0.4
Conduct disorder	41	0.6	0.7	0.4	0.0	0.0	0.0
Disorder of intellectual development (idiopathic)[d]	88	1.2	1.1	1.2	0.9	0.8	0.9
Other mental disorders[e]	122	1.4	1.7	1.2	2.3	2.7	1.9

Source: IHME, 2024 *(3)*.

Notes:

[a] Includes major depressive disorder and dysthymia.

[b] Includes anxiety disorders and post-traumatic stress disorder (PTSD).

[c] Includes anorexia and bulimia nervosa.

[d] This category is called idiopathic developmental intellectual disability in GBD 2021. See also WHO and UNICEF's 2023 *Global report on children with developmental disabilities (14)*.

[e] A residual category within GBD 2021 which includes personality disorders without a comorbid mental or substance use disorder.

These are GBD 2021 data and do not necessarily represent ICD-11 categorization. Rates are adjusted for independent comorbidity but not for dependent comorbidity. All prevalence data reflect point prevalence, except for bipolar disorder for which a 12-month prevalence was calculated.

TABLE 2.2

Global prevalence rates (%) of mental disorders by age (2021)

AGE IN YEARS	<5	5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–70	70–74	75–79	80+
Mental disorders	2.7	7.2	13.3	15.4	15.8	16.2	16.3	16.8	17.0	16.6	16.2	16.0	15.7	15.2	14.6	14.1	13.3
Schizophrenia	0.0	0.0	0.0	0.1	0.3	0.4	0.5	0.6	0.6	0.5	0.5	0.4	0.4	0.3	0.3	0.2	0.1
Depressive disorders[a]	0.0	0.1	1.3	3.4	4.7	5.0	5.2	5.7	6.1	6.2	6.3	6.4	6.5	6.4	6.1	6.0	5.7
Bipolar disorder	0.0	0.0	0.1	0.5	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.6	0.5	0.5	0.4
Anxiety disorders[b]	0.1	1.6	4.1	5.3	5.7	5.8	5.7	5.8	5.8	5.5	5.4	5.3	5.2	5.0	4.8	4.7	4.3
Eating disorders[c]	0.0	0.0	0.1	0.4	0.6	0.5	0.5	0.3	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Autism spectrum disorders	0.9	0.9	0.8	0.8	0.8	0.8	0.8	**0.8**	0.8	0.8	0.8	0.7	0.7	0.7	0.6	0.5	0.4
ADHD	0.2	2.0	2.7	2.2	1.6	1.2	1.0	0.8	0.7	0.6	0.5	0.3	0.2	0.1	0.0	0.0	0.0
Conduct disorder	0.0	1.1	3.3	1.8	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Disorder of intellectual development (idiopathic)[d]	1.6	1.7	1.6	1.6	1.5	1.3	1.1	1.0	0.9	0.8	0.6	0.5	0.5	0.4	0.3	0.3	0.2
Other mental disorders[e]	0.0	0.0	0.1	0.4	1.0	1.6	2.1	2.4	2.5	2.6	2.7	2.7	2.7	2.7	2.7	2.8	3.0

Source: IHME, 2024 *(3)*.

Notes:

[a] Includes major depressive disorder and dysthymia.

[b] Includes anxiety disorders and post-traumatic stress disorder (PTSD).

[c] Includes anorexia and bulimia nervosa.

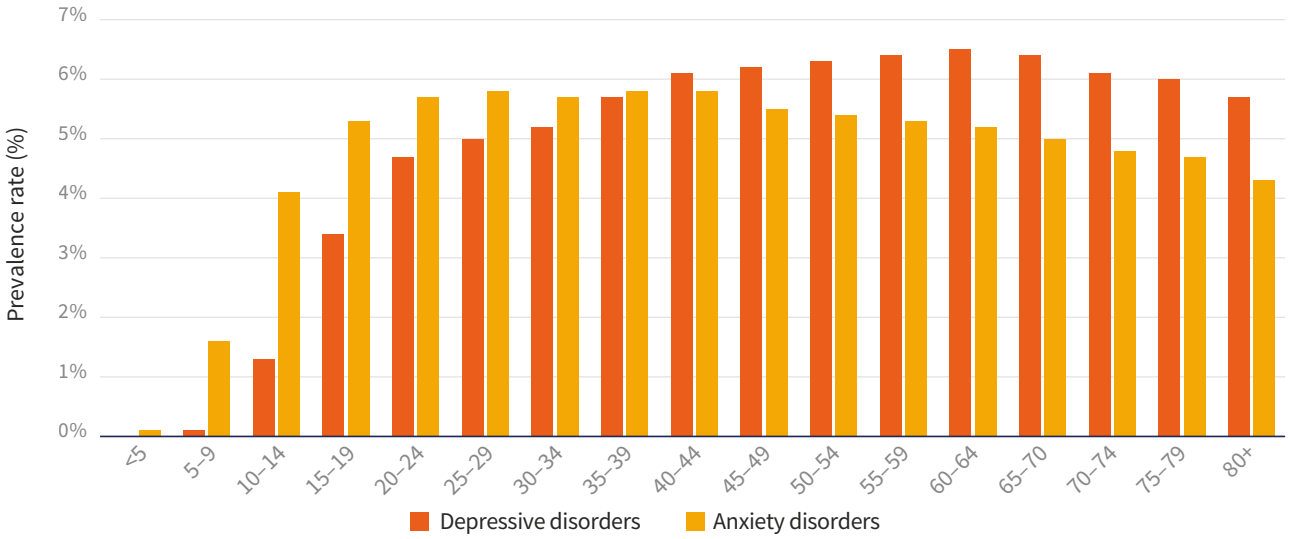
[d] This category is called idiopathic developmental intellectual disability in GBD 2021. See also WHO and UNICEF's 2023 *Global report on children with developmental disabilities (14)*.

[e] A residual category within GBD 2021 which includes personality disorders without a comorbid mental or substance use disorder.

These are GBD 2021 data and do not necessarily represent ICD-11 categorization. Rates are adjusted for independent comorbidity but not for dependent comorbidity. All prevalence data reflect point prevalence, except for bipolar disorder for which a 12-month prevalence was calculated.

FIG. 2.2

Global prevalence of anxiety and depressive disorders over the life-course (2021)



Source: IHME, 2024 *(3)*.

Notes: Rates are adjusted for independent comorbidity but not for dependent comorbidity. While some children under five years of age have depressive disorders, these are too few to be reflected here.

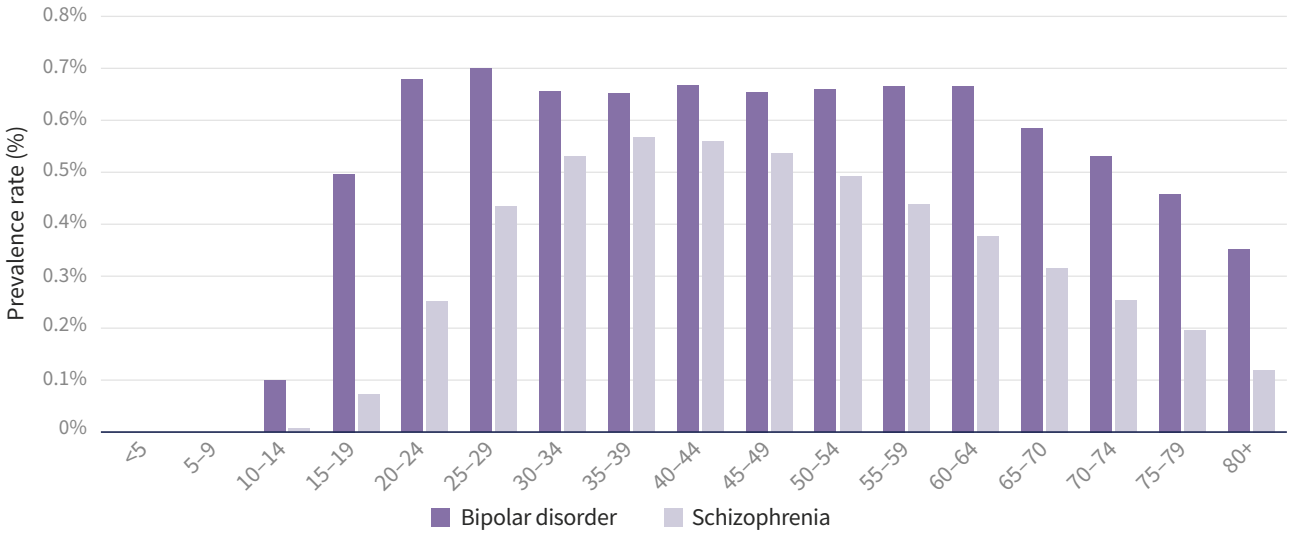
Schizophrenia and bipolar disorder are much less prevalent than anxiety and depression but they tend to have a much more severe impact on people's lives and remain a primary concern of mental health services in all countries. Schizophrenia mainly affects working-age populations (see Fig. 2.3). In 2021, it occurred in 23 million people, including approximately 1 in 200 adults aged 20 years and over. In its acute state, schizophrenia is considered the most impairing of all health conditions (see Box 2.1). Bipolar disorder, which is also highly impairing, occurred in 37 million people globally in 2021, including 1 in 150 adults (see Table 2.1). Its prevalence remains steady across age groups, from adolescence to older adulthood (see Fig. 2.3).

Eating disorders occur mainly among older adolescents and young adults and are more common among females (for example, 0.8% in females aged 20–24 years compared with 0.4% in males in the same age group) (see Fig. 2.4).

ADHD, disorder of intellectual development (idiopathic) and eating disorders primarily affect younger age groups (see section 2.1.2 Prevalence in children and adolescents). The prevalence of autism spectrum disorders remains consistent at 0.7% to 0.9% across age groups until 70 years of age (see Table 2.2).

FIG. 2.3

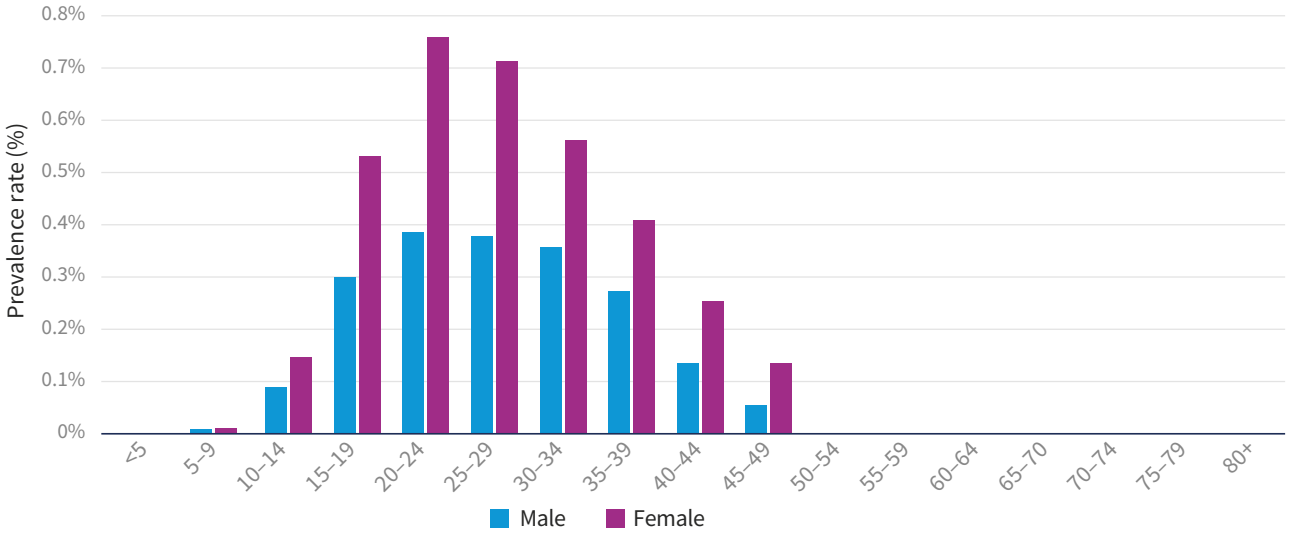
Global prevalence of schizophrenia and bipolar disorder over the life-course (2021)



Source: IHME, 2024 *(3)*.

FIG. 2.4

Global prevalence of eating disorders over the life-course (2021)



Source: IHME, 2024 *(3)*.

BOX 2.1

Vertical equity: prioritizing care based on health loss

A key component of WHO's Global Health Estimates (GHE) modelling is the use of health state weights, which quantify the level of impairment associated with different health conditions on a scale of 0 (full health) to 1 (the maximum possible health loss).

In GHE 2021, acute schizophrenia is rated as the most impairing health state, with a health state weight of 0.78. Severe depressive episodes rank fifth in terms of health loss, and the residual state of schizophrenia ranks tenth.

These weights are obtained from population surveys and may reflect cultural value judgements.

Nonetheless they can help to inform discussions on vertical equity, which emphasizes prioritizing care for those with the greatest need. It is distinct from horizontal equity, which focuses on equal access or treatment for equal need (such as ensuring equal access to care in urban and rural areas).

Several countries now use severity of a disease's estimated impairment as a key criterion for setting health priorities. From a vertical equity perspective, care for schizophrenia, bipolar disorder and severe episodes of depressive disorders should be prioritized due to their high levels of impairment.

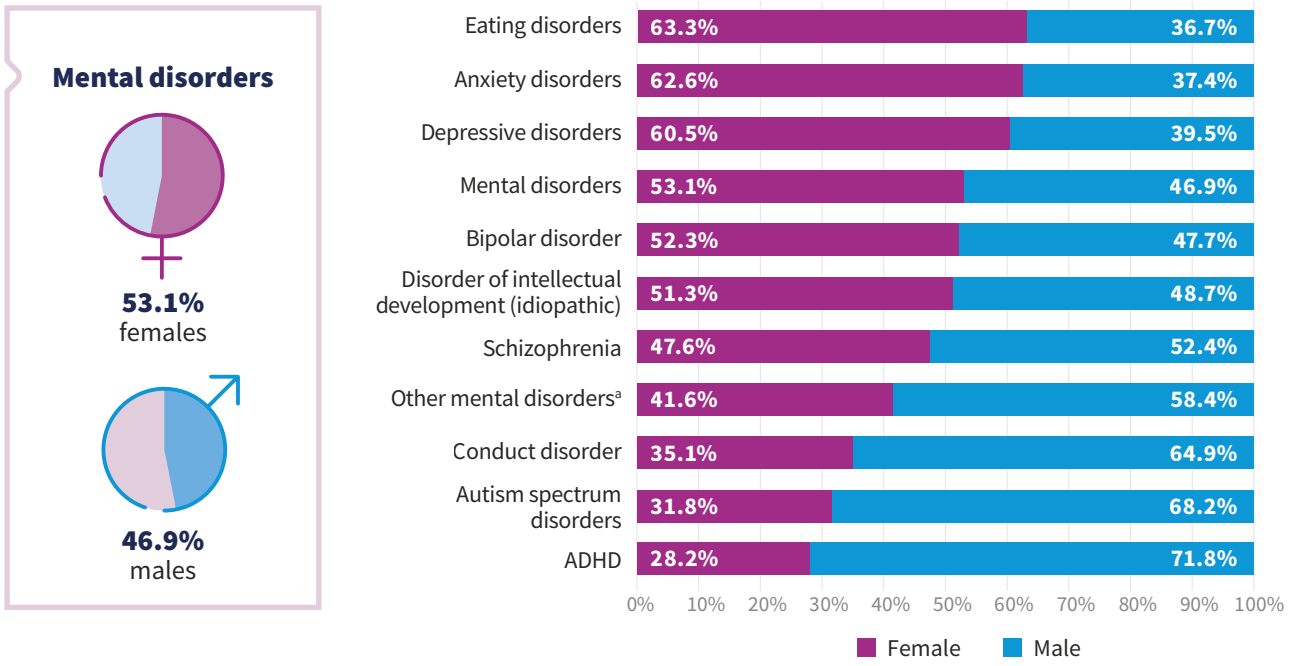
Sources: WHO, 2021 *(10)*; Barra et al, 2020 *(15)*.

2.1.1 Prevalence in males and females

Depressive and anxiety disorders are more common among females than males throughout the life-course, while males are much more likely to have disorder of intellectual development (idiopathic), autism spectrum disorders, conduct disorder and ADHD (see Fig. 2.5). Males are also twice as likely to have ADHD or autism spectrum disorders than females (see Table 2.1). As depressive and anxiety disorders account for most cases of mental disorder, overall, more females (581.5 million) than males (513.9 million) live with a mental disorder *(3)*.

FIG. 2.5

Proportion of males versus females in mental disorders (2021)



Source: IHME, 2024 *(3)*.

Notes: [a] A residual category within GBD21 which includes personality disorders without a comorbid mental or substance use disorder.

The COVID-19 pandemic exacerbated gender differences in mental health. GBD 2020 estimated a 29.8% increase in major depressive disorder and a 27.9% increase in anxiety disorders among females during 2020, compared with rises of 24.0% and 21.7% among males, respectively *(16)*.

Mental disorders are common among pregnant women and women in the year after birth, often with severe impacts for both mothers and babies. Worldwide, more than 10% of pregnant women and women in the year after birth experience depression *(17)*. In LMICs this figure is estimated to be substantially higher *(18)*.

Women who have experienced intimate partner violence or sexual violence are particularly vulnerable to developing a mental health condition, with significant associations found between exposure to violence and depression, anxiety, stress conditions including post-traumatic stress disorder, and suicidal ideation *(19)*. Women living with a severe mental health condition are much more likely to have experienced domestic and sexual violence during their life than other women *(20)*.

Photo credit (previous page): A family at their homestead in Masvingo, Zimbabwe. © WHO / Uka Borregaard

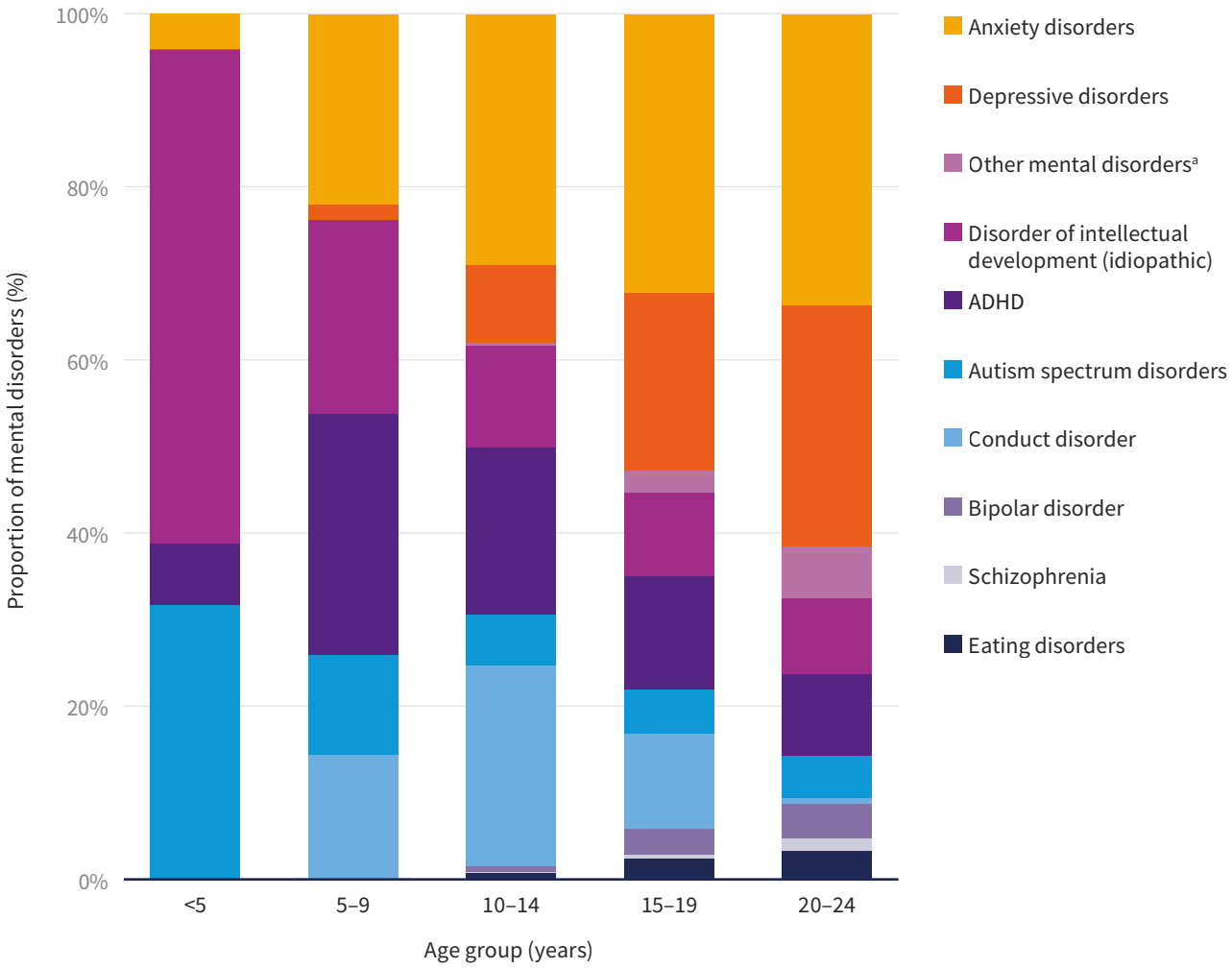
2.1.2 Prevalence in children and adolescents

In 2021, around 7% of the world's young children (aged 5–9 years) and 14% of the world's adolescents (aged 10–19 years) lived with a mental disorder *(3)*. Overall, around a third of mental disorders present in adulthood have developed by the age of 14 years; half appear by the age of 18 years; and nearly two thirds appear by the age of 25 years *(5)*.

Disorder of intellectual development (idiopathic) is the most common type of mental disorder in young children (see Fig. 2.6). Its prevalence significantly decreases with age because of early mortality. By contrast, the estimated prevalence of autism spectrum disorders remains steady throughout the life course.

FIG. 2.6

Global prevalence of mental disorders among children and young people (2021)

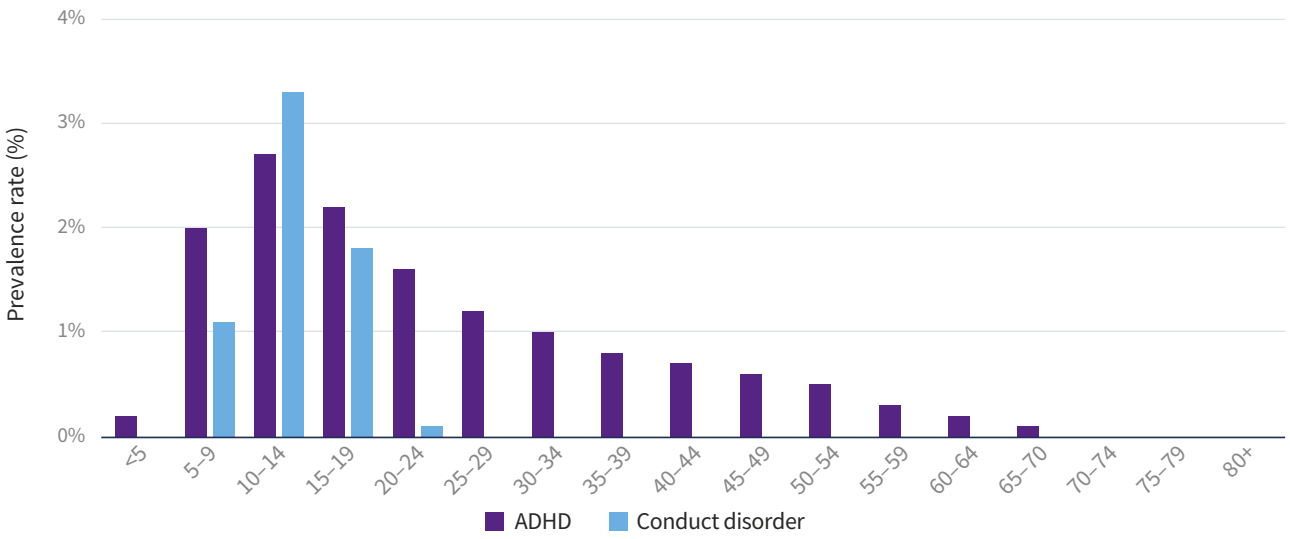


Source: IHME, 2024 *(3)*.

Notes: [a] A residual category within GBD21 which includes personality disorders without a comorbid mental or substance use disorder.

FIG. 2.7

Global prevalence of ADHD and conduct disorder over the life-course (2021)



Source: IHME, 2024 *(3)*.

ADHD and conduct disorder are most prevalent in late childhood and adolescence, especially among younger boys (3.8% and 4.0%, respectively in boys 10–14 years of age) (see Fig. 2.7).

Anxiety disorders are the most prevalent mental disorders among older adolescents and young adults (4.7% and 5.7% in those aged 10–19 years and 20–24 years respectively) (see Fig. 2.6 and Table 2.2). It is even more prevalent among adolescent females (5.8% in girls aged 10–19 years and 7.1% in females aged 20–24 years). By comparison, depressive disorders have a prevalence of 4.2% in 15–19-year-olds and 5.7% in 20–24-year-olds.

2.1.3 Prevalence in older adults

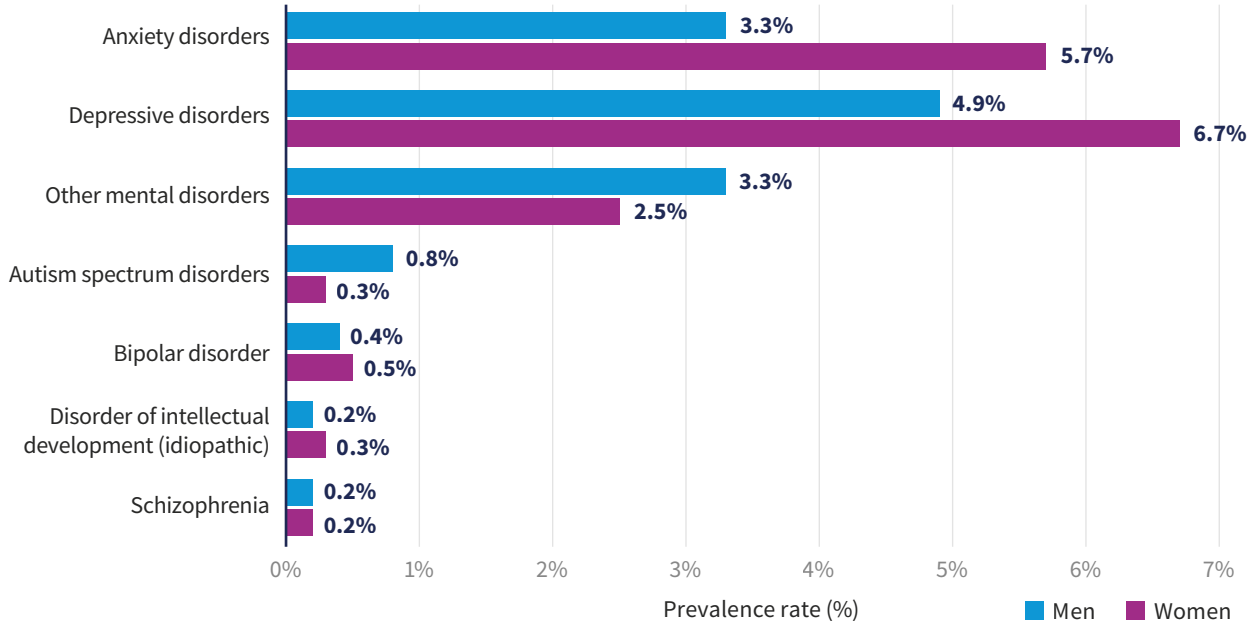
In 2021, around 14% of older adults, aged 70 years and over, were living with a mental disorder, mainly depressive and anxiety disorders (see Fig. 2.8).

Gender differences in rates of mental disorders increase in this age category, with 15.2% of females and 12.6% of males estimated to have a mental disorder *(3)*. Schizophrenia was less common in older adults, with a prevalence of 0.2% compared with 0.3% and 0.4% in younger adults aged 20–24 years and 24–29 years respectively. This difference may be partly explained by early death (see section 2.2.1 Premature mortality).

Notably, these figures exclude dementia, which is a major public health concern among older adults and is often addressed through mental health and aging policies and plans. In 2021, an estimated 8.8% of adults aged 70 years and over were living with dementia *(3)*. Dementia often cooccurs with depressive disorders. One 2019 study of older adults in the United Kingdom found that those with dementia were more than twice as likely to also have depressive disorders *(21)*.

FIG. 2.8

Global prevalence of mental disorders among older adults 70+ years of age (2021)



Source: IHME, 2024 *(3)*.

Notes: [a] A residual category within GBD 2021 which includes personality disorders without a comorbid mental or substance use disorder. While some older adults have ADHD, these are too few to be reflected here.

2.1.4 Geographical disparities

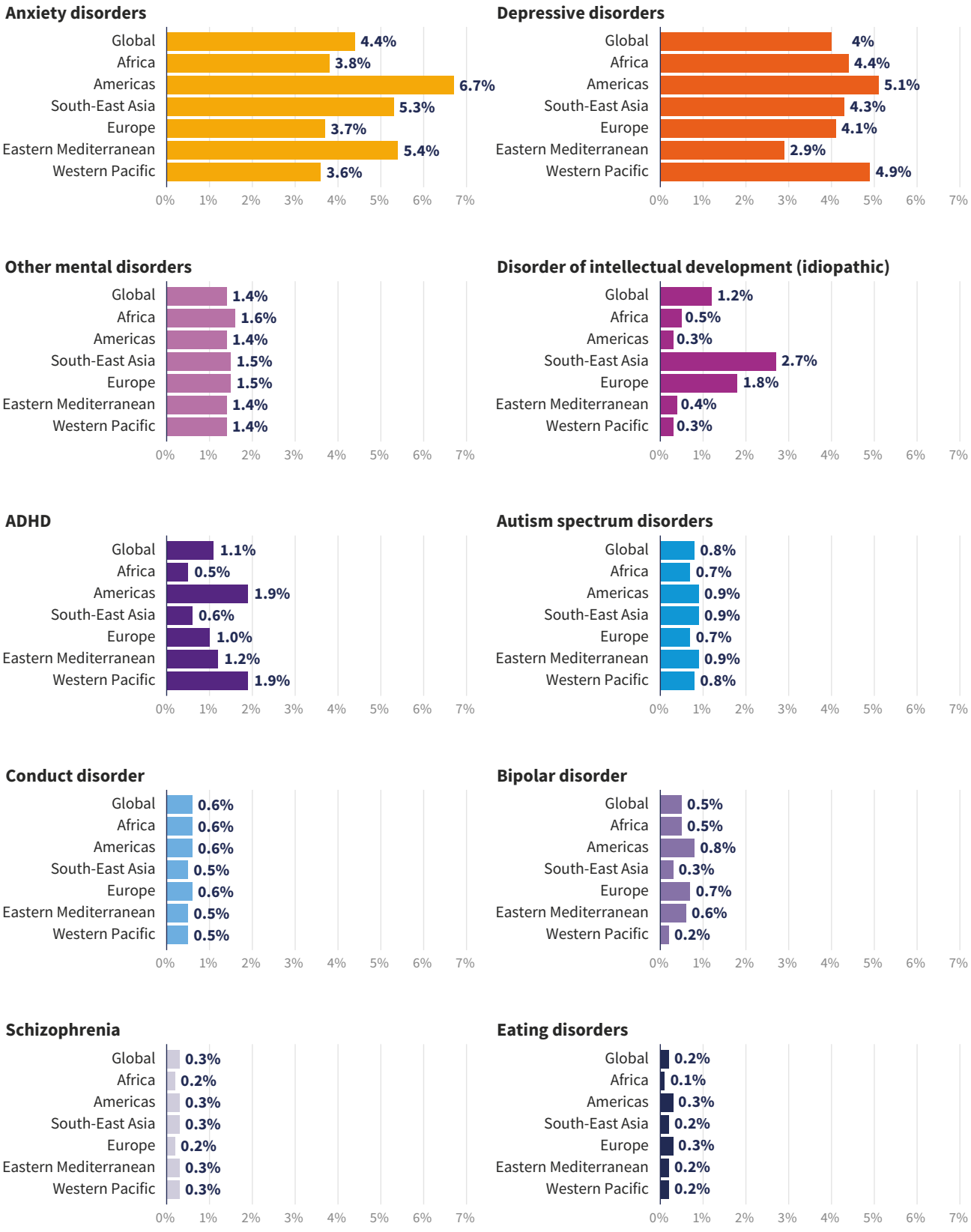
The prevalence of mental disorders varies by WHO region (see Fig. 2.9). Some mental disorders show greater regional variability than others.

Regional variations in prevalence estimates may be explained by various factors.

- Sociocultural factors affecting assessment: cultural differences in how mental health and mental health conditions are understood and conceptualized can influence people's readiness to report symptoms. Local concepts of distress – which can be associated with psychopathology – are typically not well-covered in epidemiological studies *(21)*. And while stigma and discrimination is high in all countries, it may even be higher in many LMICs, which could lead to underreporting. There may also be a relationship between mental health awareness and symptom reporting.
- Data availability: there are many parts of the world where GBD 2021 estimates are more uncertain due to lack of epidemiological data.
- Demographics: low-income countries tend to have a higher proportion of children under ten years of age, among whom mental disorders are much less common, which lowers overall prevalence rates.
- Risk and protective factors: for example, war and conflict contribute to the relatively higher rates of mental disorder. COVID-19 was a significant risk factor for mental disorders in 2021.
- Social connection, which likely differs by region, may be associated with lower rates of disorders. But there is no clear relationship between rates of mental disorders reported here and rates of loneliness, social isolation and social disconnection reported by the WHO Commission on Social Connection *(22)*.

FIG. 2.9

Age-standardized prevalence rates (%) of mental disorders across WHO regions (2021)



Source: IHME, 2024 *(3)*.

Combining factors such as age, sex and geographical location can reveal important differences in mental health needs. For example, in 2021, while an estimated 5% of the global population lived with anxiety disorders, the rate rose to around 12% among working age women in the Americas *(3)*. Similarly, while ADHD affected just 1 in 100 people across the life-course globally, prevalence reached 7% among boys aged 10–14 years in the Americas and Western Pacific *(3)*.

In all WHO regions, the estimated prevalence of mental disorders has increased since 2001, with the greatest increases taking place in WHO's Region of the Americas (rising from 15.3% to 17.1%) and WHO's European Region (from 14.0% to 15.4%) (see Fig. 2.10). WHO's Western Pacific and African Regions have consistently had the lowest prevalence reports since the turn of the century.

FIG. 2.10

Age-standardized prevalence of mental disorders across WHO regions (2001–2021)

Source: IHME, 2024 *(3)*.

2.2 Mortality

2.2.1 Premature mortality

Estimating mortality from mental health conditions is complex. Mental health conditions and suicide are rarely recorded as the cause of death on certificates, vital record databases or in national statistics. Yet poor mental health is often an important underlying or contributing factor. Across the world, people with mental health conditions are known to experience disproportionately higher mortality rates than the general population *(23)*.

Those with severe mental health conditions – including schizophrenia and bipolar disorder – have notably shorter life expectancies. People with bipolar disorder die on average 13 years earlier than the general population *(24)*. People with schizophrenia die nine years earlier *(25)*. Most of these deaths are due to preventable causes, especially cardiovascular disease, respiratory disease and infection, which are more common in people with mental health conditions *(26)*. In these cases, having a mental health condition may not be the cause of death, but it is likely to be a major contributing factor.

Side effects of medications prescribed for severe mental health conditions can have a role in premature mortality by contributing, for example, to obesity, glucose intolerance and dyslipidemia *(27, 28)*. Moreover, people with mental health conditions are more likely to experience well-known risk factors for noncommunicable diseases such as smoking, alcohol use, unhealthy diet and physical inactivity *(29)*.

This is compounded by fragmented health systems: once individuals enter mental health services, their physical health too often gets neglected. In both general and specialized mental health care settings, the signs and symptoms of physical illness are often misattributed to a concurrent mental health condition in what is known as diagnostic overshadowing *(30, 31)*. This has led to a systematic under-recognition and undertreatment of cardiovascular conditions among people living with schizophrenia and bipolar disorder *(32, 33, 34)*. WHO and its expert advisers have developed a multilevel intervention framework and guidelines to address these gaps *(35)*.

To better understand the true mortality burden of mental health conditions, researchers use natural history models that link prevalence to observed rates of excess deaths. While not part of official mortality estimates, which attribute deaths to the primary cause (such as cardiovascular disease), these models show that mortality from mental health conditions is grossly underestimated. A 2022 analysis showed that anyone with a severe mental disorder – but especially young people and women – have a higher risk of all-cause mortality than the general population *(24)*. The relative risk of all-cause mortality was three times higher for people with schizophrenia; and 2.5 times higher for people with bipolar disorder.

This large yet hidden mortality burden of mental health conditions has been referred to as a scandal that contravenes international conventions for the right to the highest attainable standard of health *(36)*.

> People with severe mental health conditions have shorter life expectancies than the general population.

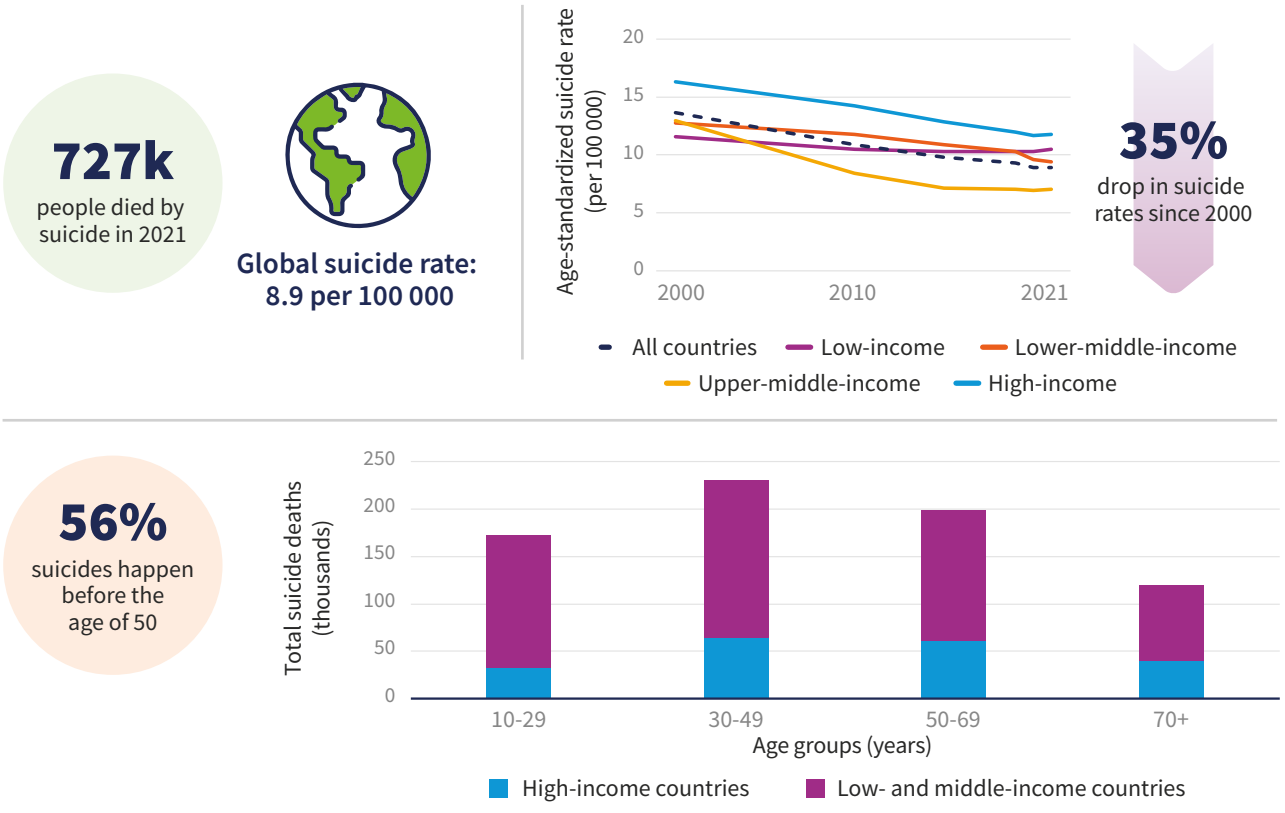
2.2.2 Suicide[5]

According to GHE 2021, suicide accounts for more than one in every 100 deaths (1.1%) globally *(37)*. For every death by suicide there are more than 20 suicide attempts *(38)*. Suicide affects people from all countries and contexts. And at all ages suicides and suicide attempts have a ripple effect on families, friends, colleagues, communities and societies.

In 2021, an estimated 727 000 people across all ages lost their lives to suicide (see Fig. 2.11). That equates to a global age-standardized suicide rate of 8.9 per 100 000. Estimates of suicide rates vary significantly across countries – from fewer than one death by suicide per 100 000 in some nations to more than 30 per 100 000 in others *(38)*. Nearly three-quarters (73%) of all suicides occur in LMICs, where most of the world's population live. High-income countries had the highest age-standardized suicide rate at 11.8 per 100 000, but low-income countries had an almost equally high rate of 10.5 per 100 000. High-income countries are more likely to have high-quality vital registration data, meaning that suicide mortality estimates from LMICs are less certain.

> Suicide accounts for **1 in 100** deaths globally.

FIG. 2.11
Suicides in 2021



Source: WHO, 2024 *(38)*.

5 Suicide data in this section comes from GHE 2021 (https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death).

Photo credit (next page): Women holding hands at a clinic in Afghanistan. © WHO

Globally, more than twice as many males die by suicide than women do.

In both males and females, suicide is a major cause of death among young people. In 2021, it was the second leading cause of death in 15–29-year-old females; and the third leading cause of death in males in this age group. Overall, it accounts for some 8% of all deaths among 15–29-year-olds. More than half (56%) of suicides happen before the age of 50 years. And suicide rates in people aged over 70 years are more than twice those aged 30–49 years *(38)*.

Globally, the age-standardized suicide rate dropped by 35% from 2000 to 2021, remaining stable through the COVID-19 pandemic despite an increase in suicide risk factors (see Box 2.2). Decreases since 2000 ranged from 3% in WHO's African Region and 26% in WHO's South East Asian Region to 30% in WHO's Eastern Mediterranean Region, 48% in WHO's European Region and 50% in WHO's Western Pacific Region *(38)*. By contrast, in WHO's Region of the Americas, the suicide rate increased by 17% in the same time period.

Progress in reducing suicide mortality must accelerate to meet the Sustainable Development Goal target of a one-third reduction by 2030. If the 2015–2019 trend continues, only a 12% reduction will be achieved by 2030. To reach the target, countries must triple their efforts and increase the annual average reduction from 1% to 3% *(39)*.

> Countries must triple their efforts in reducing suicide mortality to meet the UN SDG target of a one-third reduction by 2030.

For more information and insights to the latest GHE data on suicide, see WHO's *Suicide worldwide in 2021: global health estimates (40)*.

BOX 2.2

COVID-19 and suicide

During the COVID-19 pandemic, concerns emerged that suicide rates might rise due to increased risk factors such as social isolation, loneliness, domestic violence, alcohol misuse, job loss, financial stress, reduced access to mental health support, and worsening mental health problems.[a]

A 2021 international review of suicide data from 21 high- and upper-middle-income countries found no clear evidence of increased suicides during the early months of the pandemic.[b] This study was updated in 2022 with 33 countries, including three lower-middle-income countries, and found that suicide rates remained stable during the first 9–15 months of the pandemic. In some countries, suicide deaths were even lower than expected.[c]

There were, however, exceptions. In New Delhi, India, suicides rose, particularly among women, and in Japan, there was an increase among women and young people. These variations highlight how the pandemic's impacts on suicide differed across population groups.[c] Limited quality data from LMICs make it unclear how much the pandemic impacted societies with fewer financial safety nets, online health services, and other support systems.

The COVID-19 pandemic has been linked to an increase in mental health conditions, including depression and anxiety, particularly among women and young people.[d] The economic disruptions it caused fuelled a rise in living costs in many parts of the world.

In this evolving context, monitoring and preventing suicide remains critical. A whole-of-society, multisectoral approach is needed to address the social, cultural and psychological factors linked to suicide.

Sources:

[a] Gunnell et al, 2020 *(40)*.

[b] Pirkis et al, 2021 *(41)*.

[c] Pirkis et al, 2022 *(42)*.

[d] COVID-19 Mental Disorders Collaborators, 2021 *(16)*.

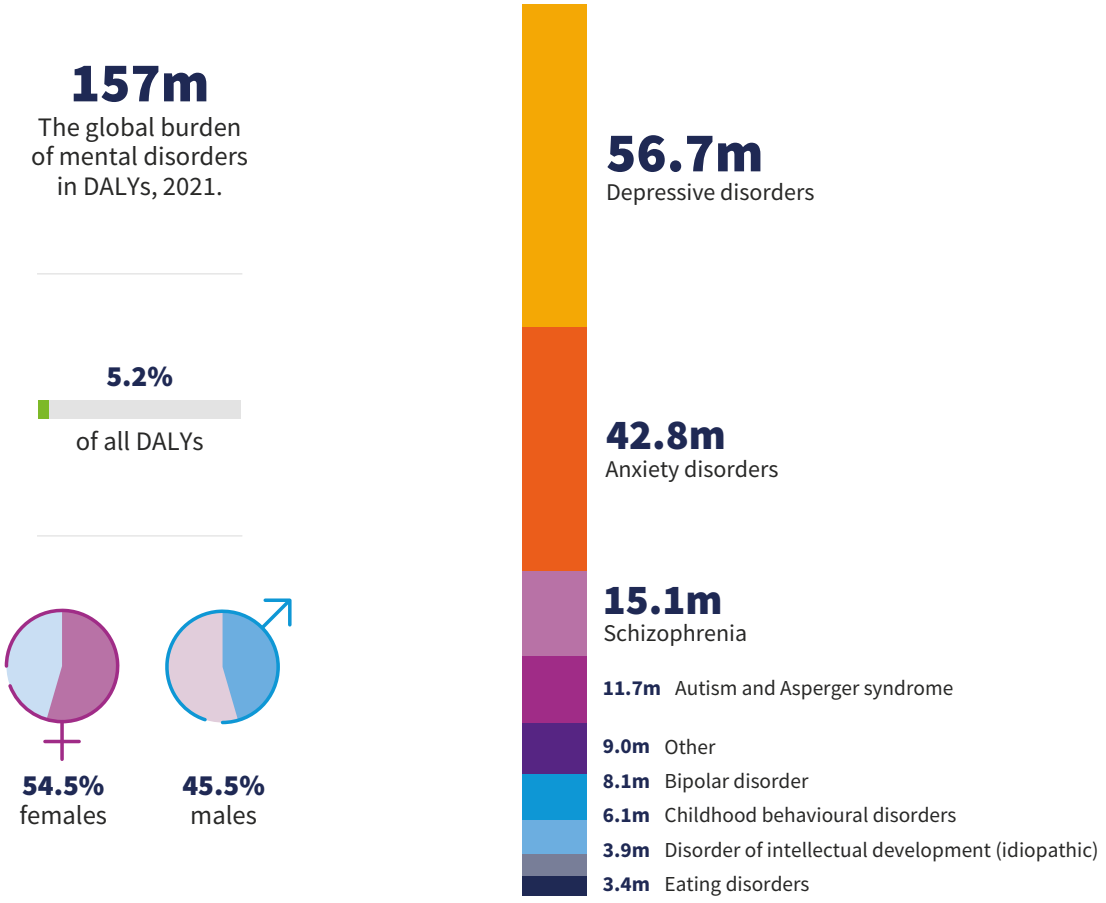
2.3 Burden[6]

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

In 2021, across all ages, mental, neurological and substance use disorders together accounted for one in ten DALYs (10.1%) worldwide *(43)*. Mental disorders accounted for 5.2% of the global burden (see Fig. 2.12). Neurological disorders accounted for another 3.7%; while substance use conditions accounted for 1.2%.

FIG. 2.12

Global burden of mental disorders in disability-adjusted life years (DALYs) (2021)



Source: WHO, 2024 *(44)*.

6 Burden estimates in this section come from GHE 2021, including DALY estimates (https://cdn.who.int/media/docs/default-source/gho-documents/global-health-estimates/ghe2021_daly_global_new.xlsx) and YLD estimates (https://cdn.who.int/media/docs/default-source/gho-documents/global-health-estimates/ghe2021_yld_whoregion_new.xlsx).

In all countries, the burden of mental disorders spans the entire life course: from early life, where conditions such as disorder of intellectual development (idiopathic) and childhood behavioural disorders are the biggest contributors to burden; through to adulthood and old age, where depressive and anxiety disorders dominate. Overall, the greatest burden is carried during early adulthood.

Across all mental disorders, most of the burden of mental health conditions manifests as YLDs, rather than YLLs. This is because of the way burden estimates are calculated, which does not attribute deaths to conditions such as depressive disorders or bipolar disorder. Also, in these calculations self-harm and suicide are covered under a separate category of intentional injuries *(44)*.

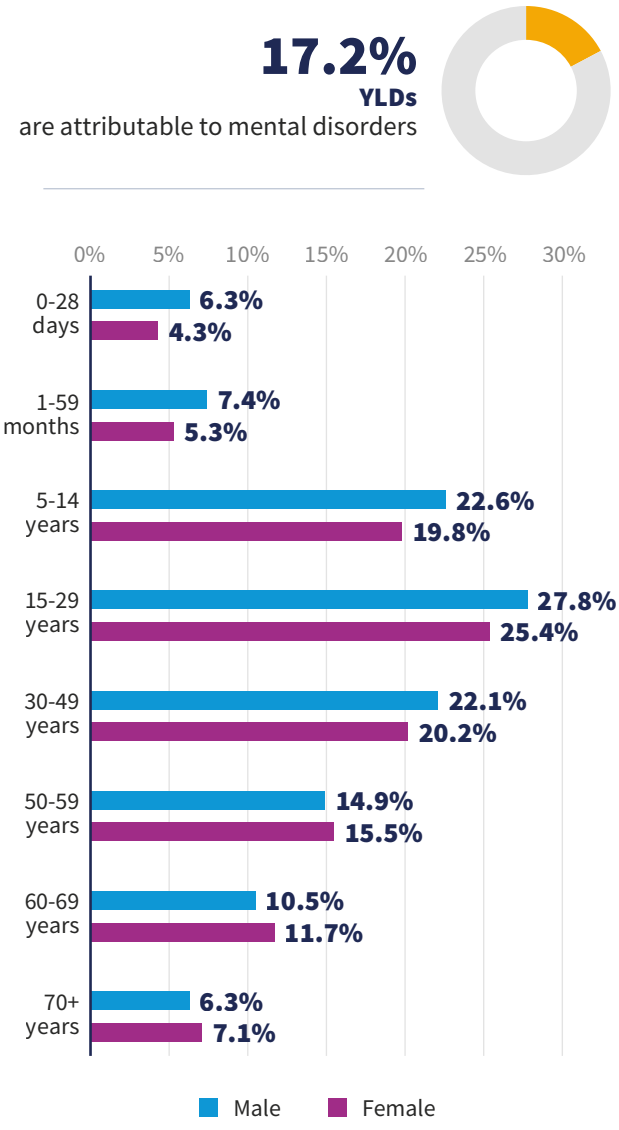
> Globally, mental disorders account for **more than 1 in 6** years lived with disability.

Mental disorders are the second leading cause of years lived with disability globally, accounting for more than one in every six (17.2%) YLDs (see Fig. 2.13). Substance use disorders account for a further 2.3% of YLDs; and neurological conditions account for 7.8%. Combined mental, neurological and substance use disorders account for more than one in every four YLDs globally.

The contribution of mental disorders to YLDs varies across the lifespan, from less than 10% for children under 5 and older adults over 70 to more than 26% for young people aged 15–29 years (see Fig. 2.13).

FIG. 2.13

Global proportion of all-cause years lived with disability (YLDs) attributable to mental disorders, across the life-course (2021)



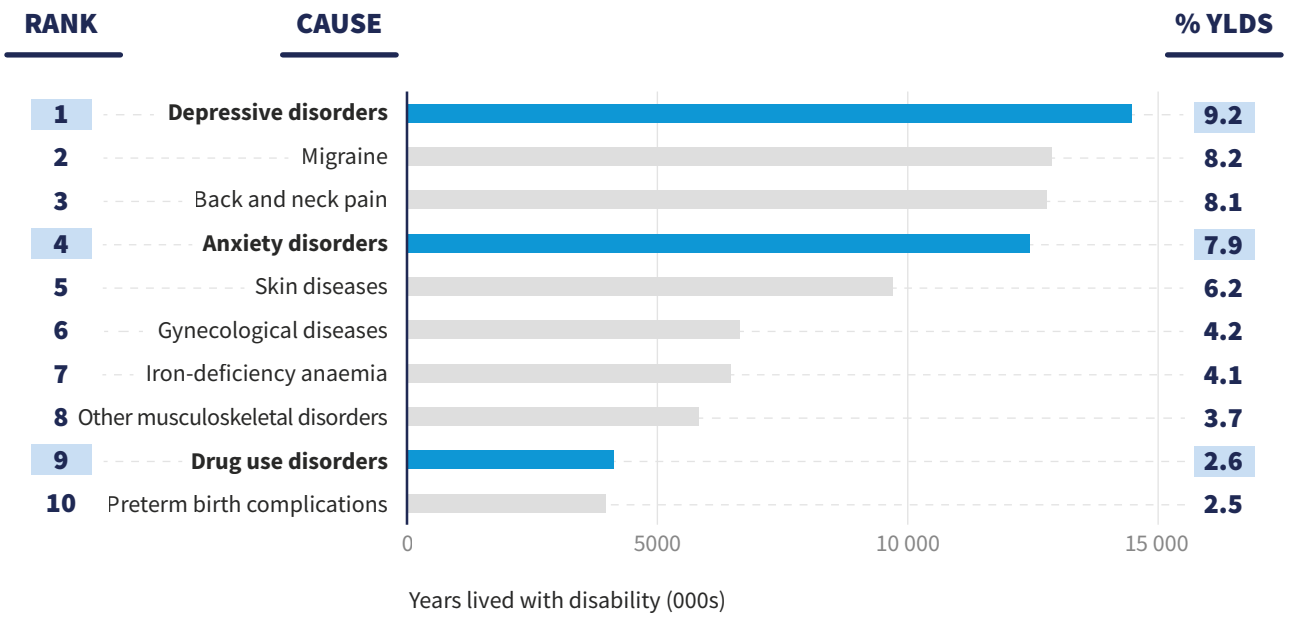
Source: WHO, 2024 *(45)*.

Depressive disorders are major contributors to YLDs in all age groups after 5 years, but especially for 15–29-year-olds, when they are the leading cause of YLDs worldwide (see Fig. 2.14). Anxiety disorders are also more burdensome from 15–29 years than during any other age, and at this age drug use disorders also feature among the top ten leading causes of YLDs, contributing 2.6% of all YLDs in this age group (see Fig. 2.14).

Both depressive and anxiety disorders remain significant contributors to YLDs throughout working ages, when individuals are expected to be the most productive within their communities. By the age of 60 years, anxiety disorders no longer rank among the top ten causes of YLDs. Depressive disorders remain in the top ten but drop to sixth place for 60–69-year-olds and ninth place for those aged 70 years or more, indicating a significantly lower relative burden in this age group compared with other health conditions, even though their prevalence remains high. In contrast, disorders such as Alzheimer's disease and other dementias become much more prominent contributors to disability in later life (see Fig. 2.14).

FIG. 2.14

Top ten leading causes of global years lived with disability (YLDs) for 15–29-year-olds (2021)

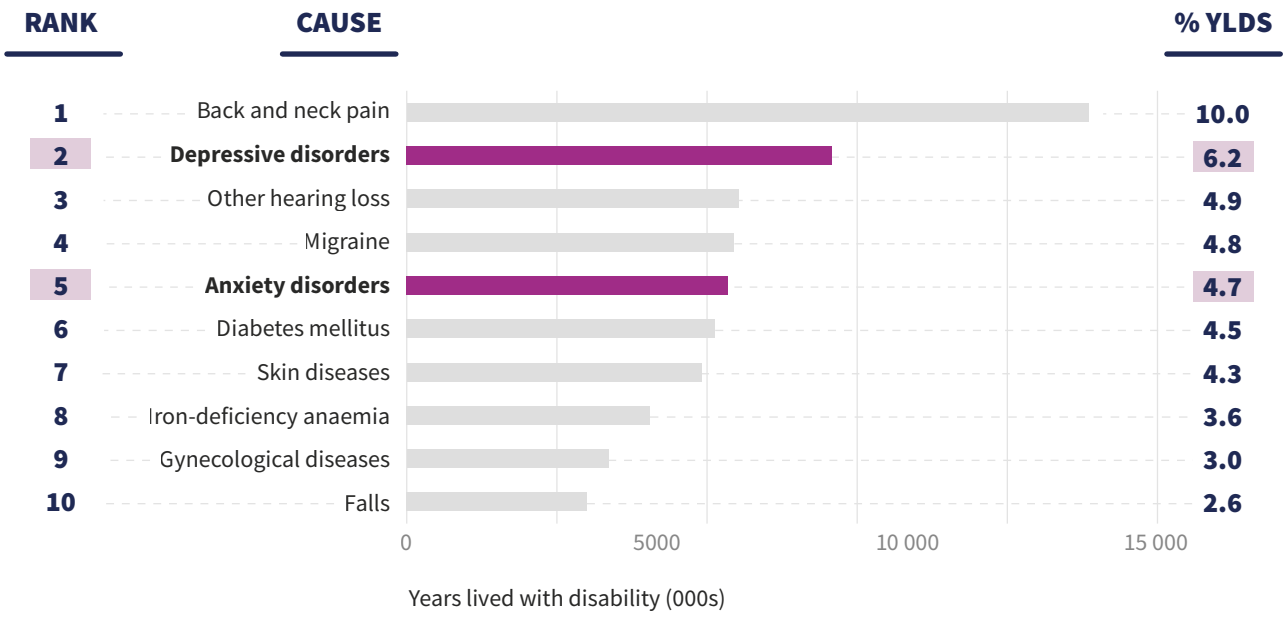


Source: WHO, 2024 *(46)*.

Since 2000, mental disorders have consistently been among the top ten causes of YLDs for all ages combined worldwide. In 2021, depressive disorders alone were the second leading cause of global YLDs, accounting for 6.2% of all YLDs (see Fig. 2.15). Anxiety disorders were the fifth leading cause of global YLDs, accounting for 4.7% of all YLDs. Schizophrenia was the 15th leading cause worldwide in 2021.

FIG. 2.15

Top ten leading causes of global years lived with disability (YLDs) (2021)



Source: WHO, 2024 *(46)*.

Three important modifiable risk factors for anxiety and major depressive disorder were quantified as part of GBD 2021: childhood sexual abuse (exposure before 15 years of age to any unwanted sexual contact); being a victim of bullying (intentional and repeated harm to children and adolescents attending school by peers) and intimate partner violence (any lifetime experience of physical or sexual violence perpetrated by a current or former intimate partner).

Being a victim of bullying and lifetime exposure to childhood sexual abuse accounted for 10.5% of all major depressive disorder YLDs globally *(46, 47)*. Being a victim of bullying alone accounted for 6.3% of YLDs for anxiety disorders globally. Intimate partner violence was responsible for 11% of DALYs for depressive disorders *(48)*.

3

Economic consequences

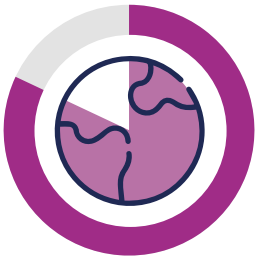
Mental health conditions impose significant economic costs on individuals, families and whole societies. These begin with the direct costs of care. In 2024, 42% of low-income countries and 72% of lower-middle-income countries responding to WHO's Mental Health Atlas 2024 survey reported including mental health care in publicly funded health or financial protection schemes (see Fig. 3.1) *(2)*. This means that many people who need mental health services must pay for their own care, often spending significant and potentially impoverishing sums out of pocket.

A survey on household costs associated with psychosis, depression, epilepsy and alcohol use disorder in six countries across sub-Saharan Africa and South Asia found that households where someone had such mental health conditions were economically worse off than control households. For example, they had lower housing standards, lower household income and fewer assets, as well as higher out-of-pocket and overall health care expenditures *(49)*. In high-income countries too, individuals with mental health conditions are more likely to live in lower-income households. For example, data from the Organization of Economic Development (OECD) show that people with severe mental health conditions are on average 83% more likely than expected to live in low-income households *(50)*.

These consequences significantly increase the likelihood of a household outspending its resources, which can lead to debt and poverty. A study in India showed that women with depression were three times more likely than other women to spend more than half their monthly household expenditure on out-of-pocket health care costs *(51)*.

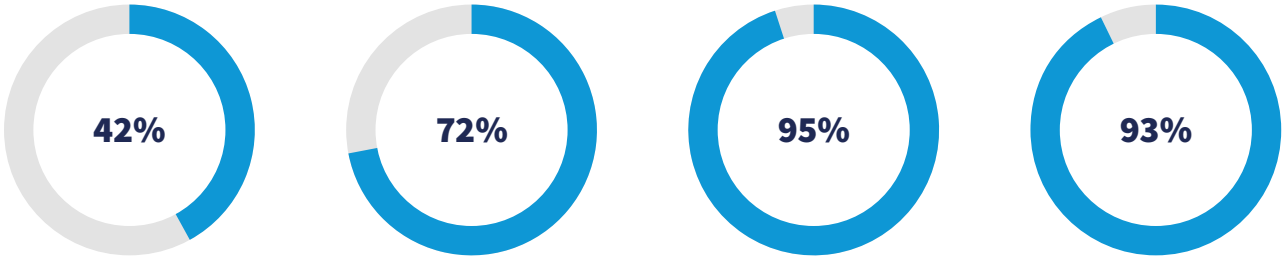
FIG. 3.1

Inclusion of mental health in publicly funded health or financial protection schemes



82%

of all responding countries include mental health in their publicly funded health or financial protection schemes



Low-income | Lower-middle | Upper-middle | High-income

Source: WHO, 2025 *(2)*.

Photo credit (previous page): Romaine Bebembassa, woman chief of command of the fire department in Bangui, Central African Republic. © MINUSCA / Hervé Cyriaque Serefio.

12 billion
productive work days are lost every year to depression and anxiety, at a cost of
US$ 1 trillion.

Beyond the direct costs of treatment, adults living with mental health conditions may not be able to work, or cannot work as well as usual, often for extended periods of time. Carers may be similarly affected. Young people with mental health conditions may struggle with school. Evidence from high-income countries shows that students with mental health problems are 35% more likely than their peers to repeat a grade *(51)*. They are less likely to reach a high level of education and can face substantial lifetime income losses. In OECD countries, workers with mental health conditions earn on average 17% less than workers without mental health conditions *(51)*.

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

These costs to society can be significant, often far outstripping direct health care costs. In 2016, researchers estimated that 12 billion productive work days were lost every year to depression and anxiety alone across 36 countries in the world (covering 80% of global population), at a cost of nearly US$ 1 trillion *(52)*. This includes days lost to absenteeism, presenteeism (when people go to work but underperform) and staff turnover.

The indirect costs related to mental health conditions can also be significant to countries. For example, analyses in seven countries (Bangladesh, Kenya, Nepal, Philippines, Uganda, Uzbekistan and Zimbabwe) estimated the economic burden of mental health conditions at between 0.5%–1.0% of gross domestic product. Productivity losses account for a large proportion of this economic burden *(53)*.

In 2020, a systematic review of cost-of-illness studies from around the world showed that the average annual societal cost of nine groups of mental health conditions – adjusted for purchasing power – ranges between US$ 1180 and US$ 18313 per treated person, depending on the condition *(54)*. This cost includes both direct costs of treatment and other services as well as other costs such as foregone production and income.

Financially, the most costly mental health condition per person globally was found to be schizophrenia, reflecting long hospital stays, functional impairments and social care. Depressive and anxiety disorders were much less costly per treated case; but they are much more prevalent, and so contribute substantially 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 *(53)*.

The economic burden of mental health conditions is estimated at between
0.5%–1.0%
of gross domestic product.

But cost-of-illness studies do not provide a complete picture of the societal costs of mental health conditions. Typically, they do not consider the negative economic impacts of mental health conditions, such as reduced economic consumption. And many people with mental health conditions are more likely to seek less demanding employment. Including these factors

into one modelling study led researchers to estimate the cost of mental health conditions in the United States at US$ 282 billion annually, which is 30% higher than previous estimates *(55)*.

Standard cost-of-illness studies also fail to attach monetized value to people outside the paid workforce, including carers and home-makers. Yet family members and other informal carers often provide a large proportion of mental health care, especially in low-resource settings, with significant social, economic and emotional cost to themselves and others *(56, 57)*. Among all health conditions, mental health conditions account for one of the highest annual costs of informal care *(58)*.

Cost-of-illness studies also tend to only focus on productivity losses, rather than on other social factors that individuals may value more, such as interpersonal relationships, or learning opportunities for adolescents and young adults. And, importantly, they do not include intangible costs such as the level of psychological suffering that may be experienced.

4

Gaps in mental health systems

People with mental health conditions are severely underserved. Results from the latest assessment in WHO Member States – the Mental Health Atlas 2024 – show that mental health systems all over the world continue to be marked by major gaps in information, governance, resources, and services for mental health (see Fig. 4.1). These gaps are important because they hamper a country's mental health response. The sections that follow highlight the defining features of key gaps.

FIG. 4.1

A snapshot of key gaps in mental health transformation

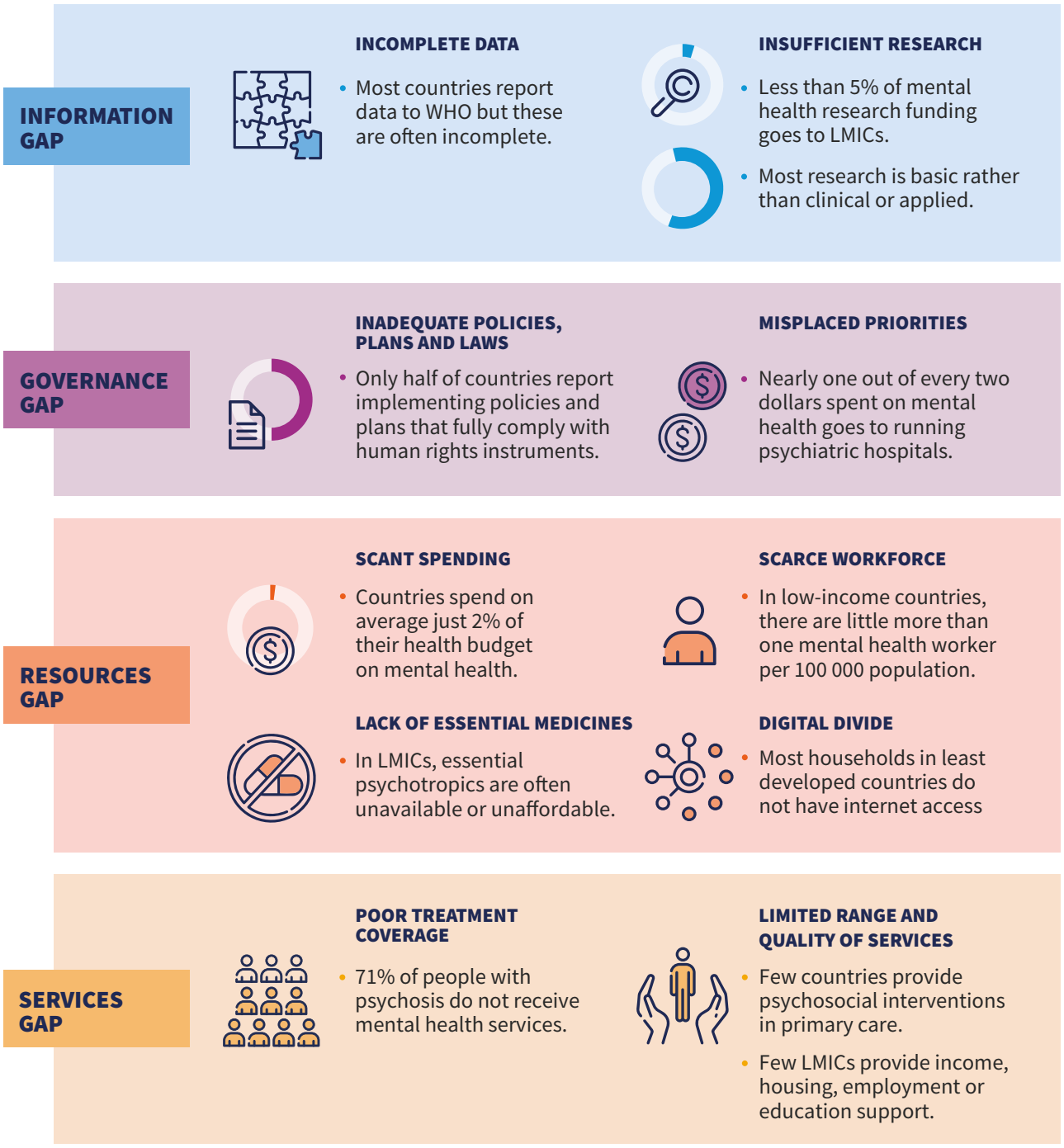


Photo credit (previous page): Woman sitting in a café in Amman, Jordan. © Getty Images / Yulia Denisyuk / Bell Collective

4.1 The information gap

4.1.1 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, as well as epidemiology.

There has been much progress in the past decade. Since 2014, at least three-quarters of WHO Member States consistently report data on mental health to WHO *(2)*.

Yet often the data that are reported are incomplete, particularly on service availability and use, which can be difficult to track. Although most countries (85% of 144 responding Member States) do regularly compile data on mental health service activity, in nearly half (42%) of them these data are only compiled as part of general health statistics and are not specific to mental health. A third of low-income countries and more than one in five lower-middle-income countries had not compiled any mental health data in the past two years.

In many cases, data reported from LMICs predominantly come 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 *(59)*. This is a major limitation, given the importance of moving mental health care away from psychiatric hospitals to general hospitals and other community-based settings and the need to keep watch over these changes (see also section 4.4.2 Variable quality and range of services available).

The lack of comprehensive, independent and comparable data poses a major barrier to monitoring and accountability in mental health.

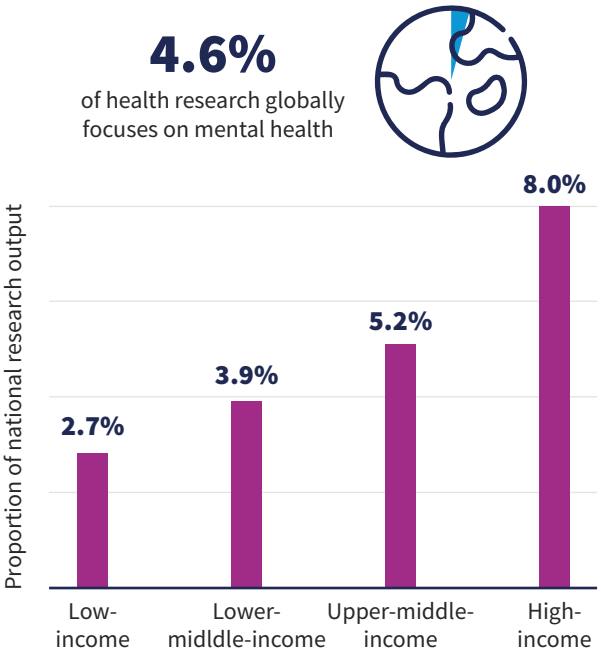
4.1.2 Insufficient and imbalanced research

The second part of the information gap relates to insufficient research that could help countries develop and implement relevant and tailored intervention strategies. The absolute level of mental health research output (as measured by published studies reflected in research databases) rose by 12% between 2013 and 2019 *(60)*. But other health research output rose even faster, so the proportion of health research focused on mental health actually fell slightly during that period (from 5.0% in 2013 to 4.6% in 2019).

There were also major differences in mental health research across regions and income groups. In 2019, the proportion of a country's health research output that was focused on mental health was nearly three times greater in high-income countries compared with low-income countries (see Fig. 4.2).

FIG. 4.2

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



Source: WHO, 2021 *(61)*.

The imbalance in mental health research output is mirrored by inequities in mental health research investment. From 2015–2019, an annual US$ 3.7 billion was spent globally on mental health research, equivalent to 4% of all research funding and 7% of health research funding *(61, 62)*. The vast majority (89%) of mental health research grants were funded by high-income countries, with little funding for mental health research in most of Africa, the Middle East and central Asia *(63)*.

Most mental health research is also done in high-income countries *(63)*. 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 *(64)*.

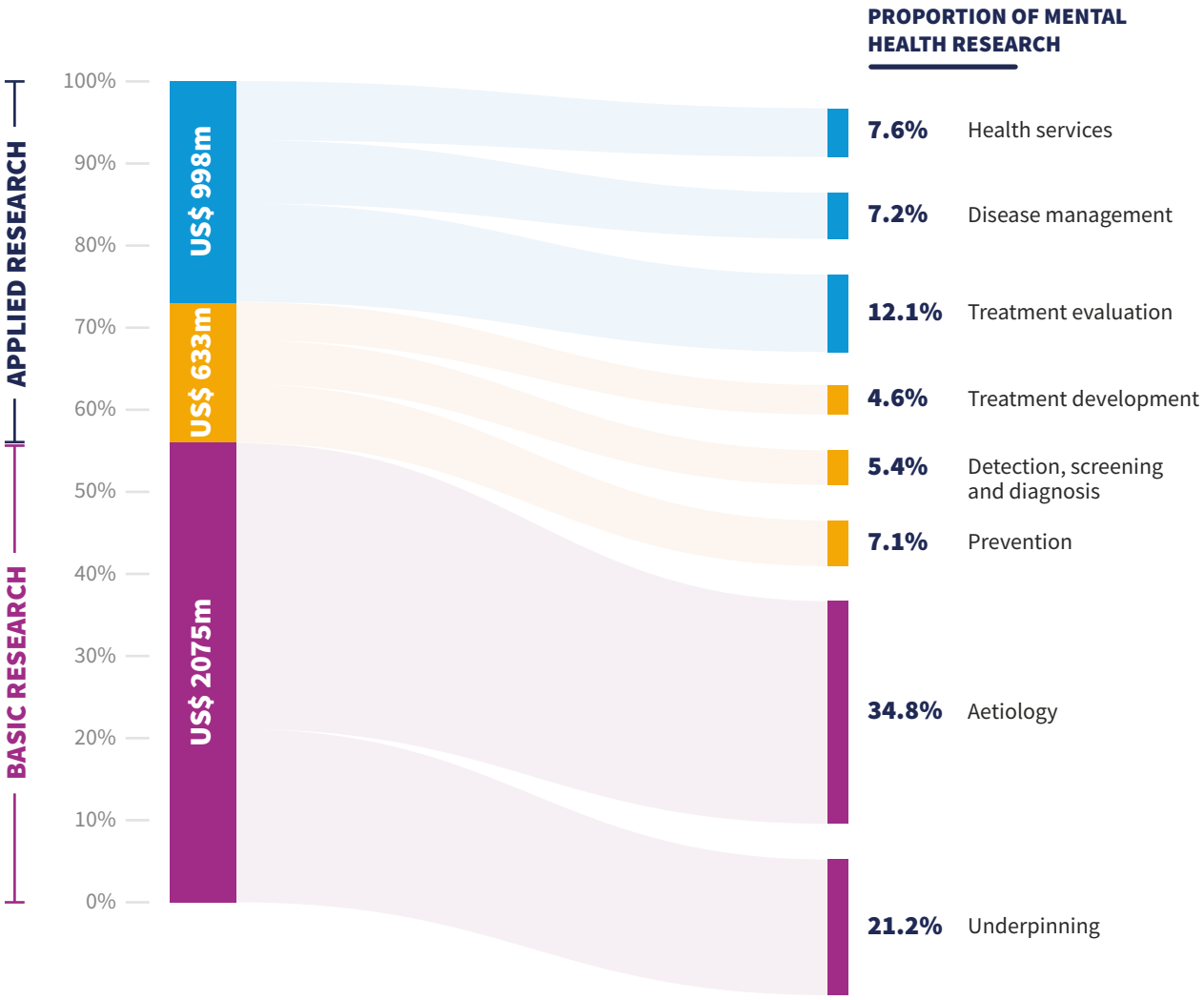
Historically, the intended beneficiaries of mental health research – people with lived experience of mental health conditions – have not been involved in decision-making about how research funds are spent, although this has begun to change. A 2023 global survey of government and private funders found that the number of organizations collaborating with people with lived experience had doubled in the previous five years *(65)*. Such collaboration may take different forms, from setting priorities and reviewing funding applications to designing programmes and supporting funded projects. Yet in most cases, people with lived experience are not represented in actual funding decisions.

From 2015–2019, more than half (56%) of all global funding for mental health research was spent on basic research compared with clinical or applied research (see Fig. 4.3). Moreover, some fields of mental health were underfunded compared with others.

Suicide and self-harm, which is the subject of the only explicit Sustainable Development Goal indicator on mental health, received less than 0.7% of the overall mental health research funding. While other research on mental health may indirectly impact suicide, national suicide rates are much more likely to change through specific suicide prevention interventions *(66)*.

FIG. 4.3

More than half of mental health research is focused on the basic end of the spectrum



Source: Woelbert et al, 2020 *(63)*.

4.2 The governance gap

4.2.1 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, 89% of WHO Member States responding to the Mental Health Atlas 2024 survey reported having a mental health policy or plan in place – either standalone or integrated into general health policies or plans. More than half (61%) of responding countries reported updating their mental health plans within the previous four years. More than half (56%) reported having a

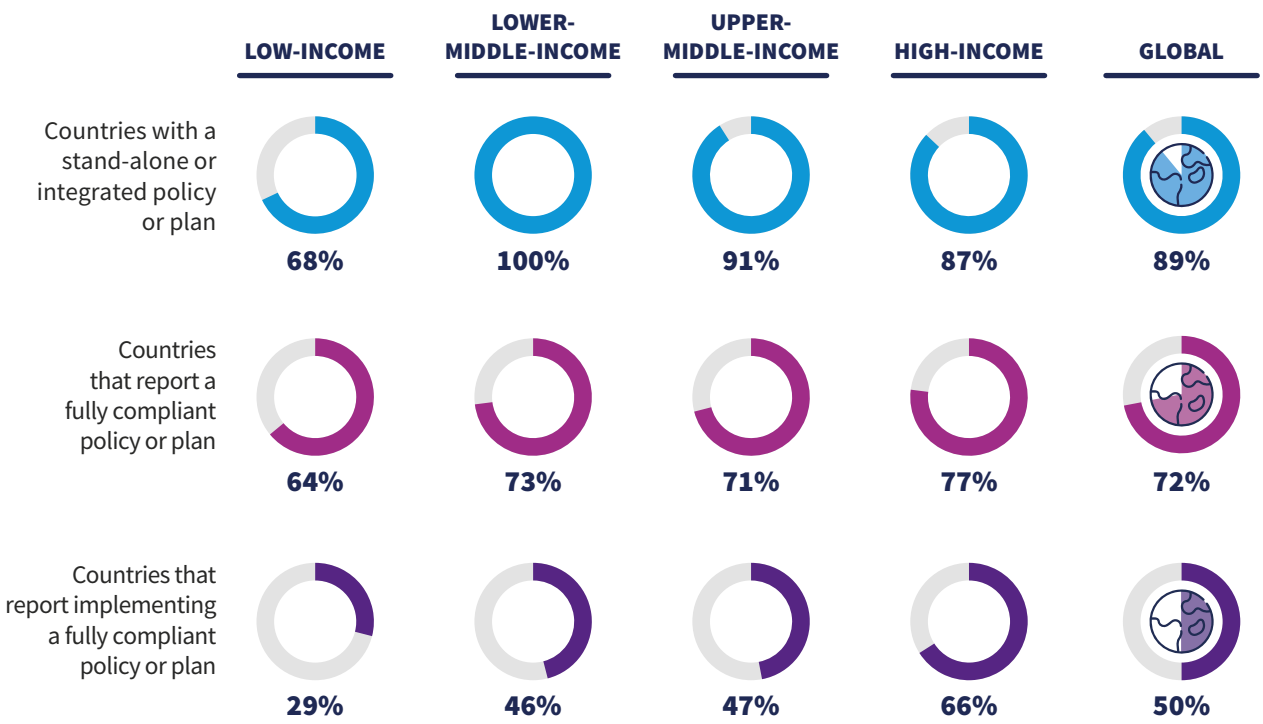
mental health plan specifically for children and adolescents, 77% of which had been updated in the previous four years. Nearly half (42%) also reported having a mental health plan specifically for older adults, 58% of which had been updated in the previous four years.

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 *(67)*.

Nearly three-quarters (72%) of responding WHO Member States self-reported that their mental health policies or plans fully complied with human rights instruments. More responding countries (84%) reported having specific indicators or targets to monitor implementation. Yet fewer than one fifth reported full allocation of financial resources for these plans. As a result, just half of the responding countries reported full implementation of policies or plans that also met human rights standards. This figure varied widely by income level, from 66% in high-income countries to 29% in low-income countries (see Fig. 4.4).

FIG. 4.4

The state of national mental health policies and plans grouped by country income group (2024)



Source: WHO, 2025 *(2)*.

A similar pattern is seen in mental health legislation: 72% of responding WHO Member States reported having a standalone law for mental health; 33% of these laws had been revised in the previous four years. Most (69%) responding countries reported that their laws partially complied with human rights instruments; only 43% reported full compliance.

People with lived experience of mental health conditions are much more involved in shaping policies than making laws: 80% of responding countries said they consulted people with mental health conditions when creating standalone mental health policies, but only 59% did so for legislation *(2)*.

4.2.2 Disparities and misplaced priorities

Within broader health policies and plans, most LMICs give little attention to mental health.

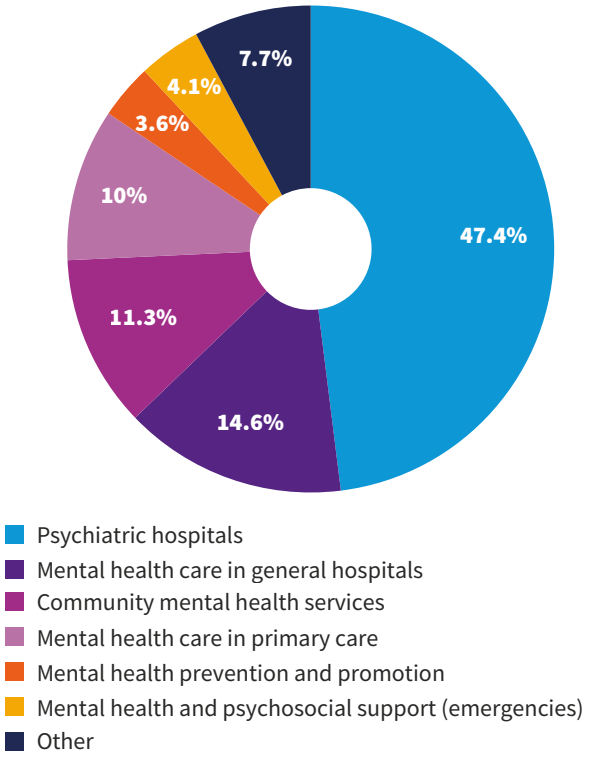
Adult mental health services are typically prioritized over services for children or older adults, leading to less available or appropriate care for these groups. Targeted services are also deficient for many marginalized groups such as ethnic, sexual and gender minorities, homeless people, refugees, and migrants. Importantly, it is not only people in low-income countries that receive less accessible and poorer quality care, but marginalized groups across countries *(68, 69)*.

Resource allocation to psychiatric hospitals (staff, budgets, and beds) continues to dominate mental health care in many countries, especially LMICs. More than half of mental health expenditure in LMICs goes towards psychiatric hospitals (compared with 25% in high-income countries) *(2)*. Based on data from 49 WHO Member States, stand-alone inpatient psychiatric hospitals accounted for close to half (47%) of government spending on mental health in 2024 *(2)*.

Only 11%
of global government funding was allocated to community mental health services.

By contrast, only 11% and 10% were allocated to community mental health services and mental health in primary care, respectively (see Fig. 4.5). This inefficient way of using resources is inconsistent with WHO Member States' commitment to decentralize mental health care *(70)*. Indeed, only 8.7% of countries responding to the Mental Health Atlas 2024 survey reported having fully completed the transition away from psychiatric hospitals to community-based care. More than a third of LMICs had yet to start reform.

FIG. 4.5
Average government spending on mental health (2024)



Source: WHO, 2025 *(2)*.

Notes: These figures represent the average government spending on mental health across 49 responding countries to the 2024 Mental Health Atlas survey.

International donors similarly sideline 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.

Only a few donor countries have mental health strategies included in their foreign aid policy *(71)*.

While health budget allocation should not be based on disease burden alone, burden is a factor to be considered when setting priorities for health interventions. In 2021, just 0.2% of global development assistance for health went to mental health *(72)*, even though mental disorders accounted for 5.2% of DALYs that same year *(44)*.

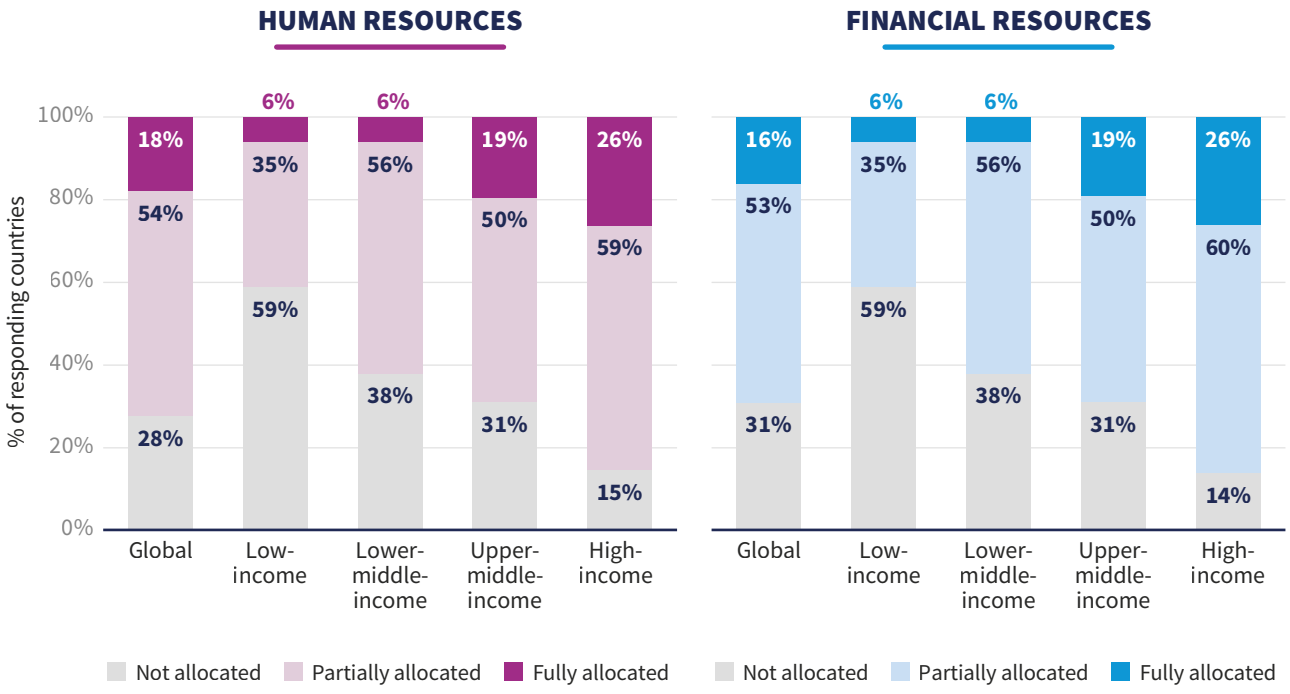
4.3 The resources gap

The limited implementation of mental health plans, policies and legislation is largely due to a lack of both human and financial resources. These resources are also unfairly distributed across countries, regions and communities, leaving those in socioeconomically deprived areas with the least access to care *(2)*.

The Mental Health Atlas 2024 survey shows that only 18% of responding countries had fully allocated human resources to implement their mental health policy or plan *(2)*. Even fewer (16%) had fully allocated financial resources. This resource gap is particularly stark among low- and lower-middle income countries, where just 6% report having been fully allocated the resources they need to implement their policy or plan (see Fig. 4.6).

FIG. 4.6

Allocation of resources for implementing countries' mental health policies or plans (2024)



Source: WHO, 2025 *(2)*.

Notes: Values represent proportion of responding countries (133 out of 194 Member States in 2024).

Photo credit (previous page): Juan Alberto nurse's aid in the indigenous community of Concordi, Colombia.

4.3.1 Scant spending

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

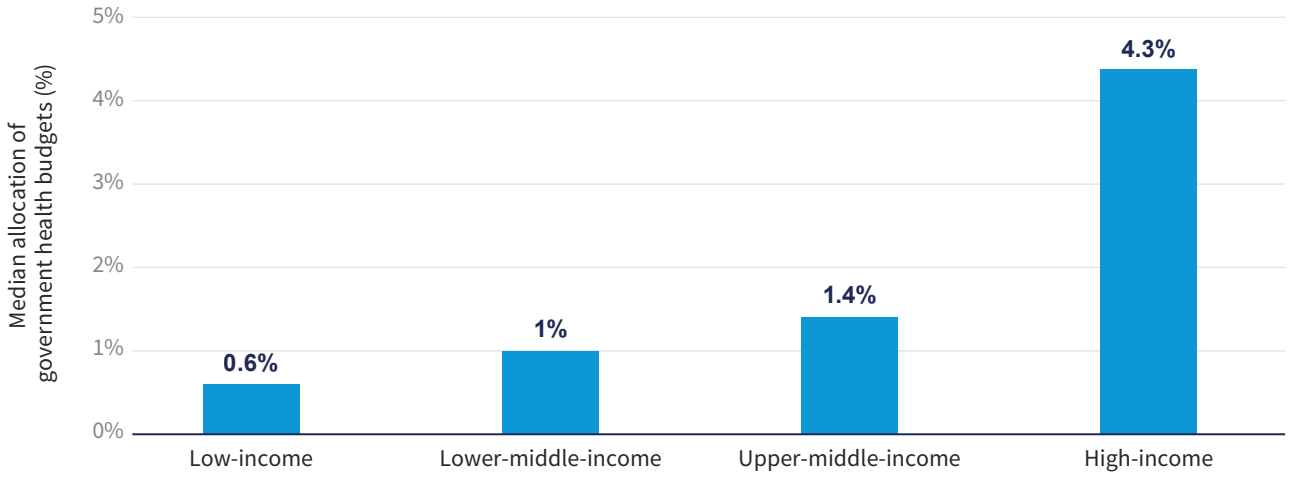
Governments typically provide most of the financing for mental health but in many cases, calculating their spending can be difficult. Budgets for general health care tend to allocate funds to generic categories such as hospitals or primary health care, rather than targeting services for specific conditions (such as depression). All health conditions treated at a particular level of care or facility are then funded from the generic allocation. The budget may further be broken down into allocations for medicines, personnel and equipment for instance; but it will rarely describe funds specifically for mental health care.

Even so, most countries dedicate only a small fraction of their health care budgets to mental health; and their spending is disproportionately low to mental health needs within their population. Although a few high-income countries spend up to or more than 10% of their respective health budgets on mental health, data submitted by 75 countries to the Mental Health Atlas 2024 survey show that the median for public spending on mental health ranges from 0.6% to 4.3% of government health budgets, and is even lower in LMICs (see Fig. 4.7).

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

FIG. 4.7

Public spending on mental health, as a proportion of government health budgets (2024)



Source: WHO, 2025 *(2)*.

External organizations, including donor agencies and philanthropic bodies, also contribute to mental health financing through development assistance. In 2023, development assistance for mental health was 7% lower than in 2018, before the pandemic *(73)*. And by 2025, major cuts to international aid had substantially reduced the availability of such assistance *(73)*.

The annual gap in mental health financing remains huge. A 2023 analysis estimates the gap in domestic expenditure on any kind of mental health care to be US$ 3.1 billion across LMICs *(72)*. Across high-income countries, where health budgets are sizeable, the estimated gap rises to US$ 196 billion *(72)*.

Supporting social integration for people living with mental health conditions requires action across social services, education, labour and justice. Investments by these sectors in mental health tends to be even less than those made by the health sector. Such investments should be captured and tracked in future summary statistics.

4.3.2 Scarce workforce for mental health

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

Two-thirds of WHO Member States responding to the Mental Health Atlas 2024 survey reported just one psychiatrist to serve 200 000 or more people. Other mental health care providers who are trained to use psychosocial interventions are even scarcer *(2)*. In low-income countries there are little more than one mental health worker of any kind per 100 000 population, compared with more than 60 in high-income countries; the median across all countries is 13.5 mental health workers per 100 000 population (see Fig. 4.8). Across all income groups, nurses make up 43% of the global workforce for mental health.

Globally, there is a great shortage of specialized mental health workers for children and adolescents, with a median of 1.5 mental health workers of any kind per 100 000 population. In low-income countries, the mental health workforce for children and adolescents is almost non-existent, with a median number of mental health workers as low as 0.05 per 100 000 population.

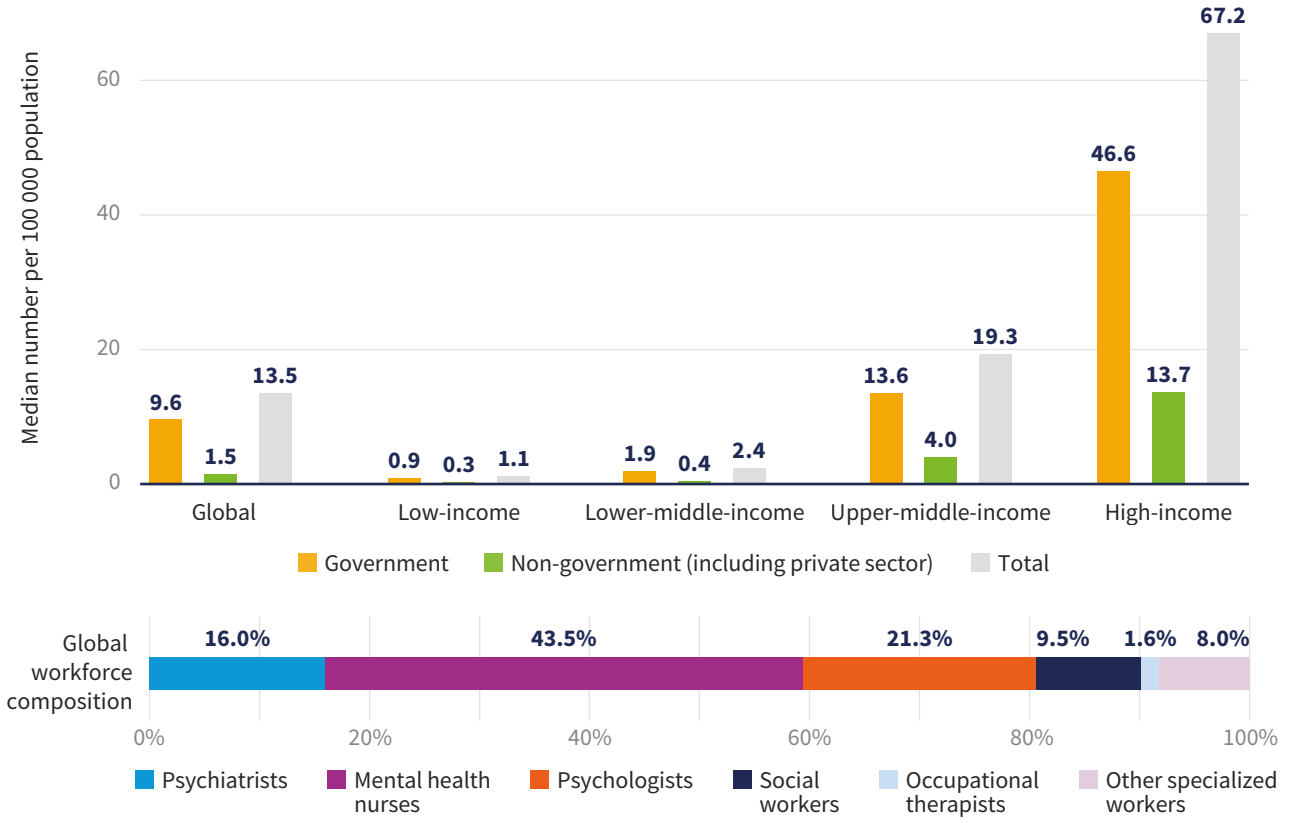
> In low-income coutries, the mental health workforce for children and adolescents is almost non-existent.

The scarcities in skills are compounded because few non-specialist doctors, nurses, and clinical officers have been trained to recognize and treat people with mental health conditions in primary health care. In 2024, 90% of WHO Member States reported providing such training *(2)*. This indicates an appetite for task-sharing. Yet most countries still have nowhere near the level of trained and skilled personnel required to provide for everyone in need, with only 12% of WHO Member States meeting all criteria for integrating mental health into primary care (see section 4.4 The services gap). To move towards universal health coverage, countries must go beyond training specialists and task-sharing with primary care, to rapidly scale up other solutions, including training and supervising community providers to provide psychological counselling, enabling self-help and making better use of digital technologies *(1)*.[7]

7 For more information on strategies for scaling up mental health care, see Chapter 7 of WHO's *World mental health report: transforming mental health for all* (https://iris.who.int/handle/10665/356119).

FIG. 4.8

The specialized mental health workforce



Source: WHO, 2025 *(2)*.

4.3.3 Lack of essential medicines

Evidence-based mental health care includes medicines and psychosocial interventions. Accordingly, another aspect of the resources gap is limited availability of essential psychotropic medicines, especially in LMICs. Even when they are available, their cost can prove a major barrier to access.

A 2022 review of 112 national essential medicines lists found inequities in the listing, availability, pricing and affordability of essential psychotropic medicines (*74*).

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

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

The actual availability of different essential psychotropic medicines was lower in the public sector compared with the private sector, and well below 50% worldwide, often much lower in low-income countries where there is a high incidence of stock-outs. Medicines in the private sector were associated with the highest prices, but even in the public sector medicines were more expensive than procurement prices. In the public sector of low-income countries, the antidepressant medicines amitriptyline and fluoxetine were three times more expensive than the international unit reference price. The anti-anxiety medicine diazepam was 10 times more expensive.

Overall, the review found that essential psychotropic medicines were less affordable to people in low-income countries compared with people in other countries *(75)*.

4.3.4 A digital divide

Whether through electronic systems or mobile applications, digital technologies are becoming a standard part of mental health care around the world. They can be key to scaling up access to care for common mental health conditions such as depression or anxiety and can also provide a platform for providing remote care where access to in-person services is limited or disrupted, for example in rural or underserved areas, or during health emergencies.

But relying too heavily on digital technologies to deliver mental health services risks excluding some of the world's most vulnerable people from accessing the care they need. Access to mobile phones has grown exponentially in recent years, with four out of five people globally owning a mobile phone in 2024, and mobile networks covering 96% of the world population *(75)*. Yet around one third of the world's population – 2.6 billion people – are still offline. Just 27% of people in low-income countries were connected to the internet in 2024, compared with 93% of people in high-income ones.

Across all regions, people living in rural areas were almost half as likely to be connected to the internet than those living in urban areas. Women and older adults are less likely to use the internet than men or young people. The gap in internet use between youth and adults had shrunk since 2021 but in low-income countries, 15–24-year-olds are still twice as likely to use the internet than other individuals. And even though adolescents are high adopters of mobile technologies, parental consent laws, privacy concerns and content governance remain barriers to scalable digital mental health interventions for minors.

Surveys in high-income countries further suggest that people living with mental health conditions face a heightened risk of digital exclusion, because of material deprivation and diminished opportunities to use or be trained in information technology or the internet, including people residing in long-term care facilities *(76)*.

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

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

4.4 The services gap

4.4.1 Poor treatment coverage

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

While not everybody with a mental health condition requires treatment, the gap between needs and services remains unacceptably large. A large proportion of people with mental health conditions receive no formal care at all. In 2021, WHO estimated that only 29% of people with psychosis receive mental health services *(61)*.

Treatment coverage varies across countries and from one mental disorder to another. For example, while high-income countries report treating 71% of people with psychotic disorders, only 12% of people with these disorders receive mental health care in low-income countries *(61)*. For depression, service coverage is consistently low across countries: even in high-income countries, only one third of people with major depressive disorder receive mental health treatment *(77)*.

Even fewer receive care that meets minimum standards for adequacy. A 2024 study estimated that in 2021, fewer than one in ten (9%) people with depression received minimally adequate treatment, defined in the study as pharmacotherapy (one month of medication, plus four visits to a medical doctor) or psychotherapy (eight visits) *(78)*. Globally, women were more likely than men to receive minimally adequate treatment. Adults over 40 years were also more likely to receive services, leading to bigger treatment gaps for younger people, with less than 5% of 15–19-year-olds with depression globally receiving minimally adequate treatment.

Minimally adequate treatment coverage was highest in high-income countries (27%) and lowest in LMICs, often falling below 3% in parts of sub-Saharan Africa and Asia *(79)*. In total, 90 countries were estimated to have less than 5% of people with depression receiving minimally adequate treatment. While there have been improvements since 2000, the treatment gap for depression remains very large.

4.4.2 Variable quality and range of services available

In all countries, gaps in service coverage are compounded by variability in quality of care. Quality includes how well mental health care aligns with human rights principles and supports social inclusion *(79)*.

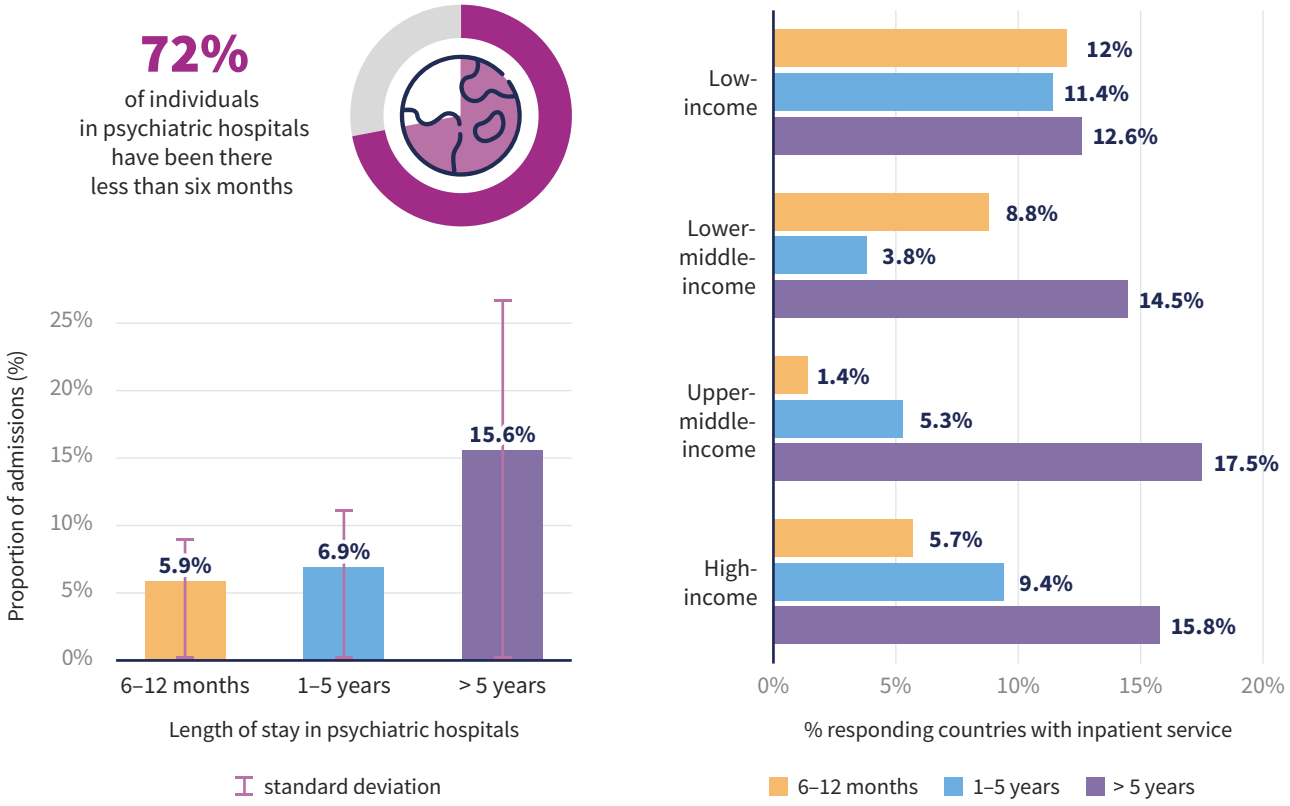
Though difficult to quantify, mental health care does not align with human rights principles throughout the world *(80)*. Psychiatric hospitals in particular are too often associated with poor living conditions and ill-treatment, including cruelty, abuse and neglect *(81, 82)*. Responses from 45 countries to the Mental Health Atlas 2024 survey suggest that around half (49%) of psychiatric hospital admissions are involuntary. Responses from 63 countries indicate that while most (72%) of individuals in these facilities have been there less than six months, a significant number remain hospitalized for longer (see Fig. 4.9).

Across responding countries, 6% of all people in psychiatric hospitals are reported to have stayed

between six months and a year; 7% have stayed between one and five years; and 16% are reported to have stayed for more than five years. These estimates vary across income groups. For example, in low-income countries, an average of 13% of individuals in a psychiatric hospital was estimated to have been there for more than five years, compared with 18% and 16% in upper-middle- and high-income countries respectively.

FIG. 4.9

Long stays in psychiatric hospitals (2024)



Notes. Values represent mean value of responding countries (63 out of 194 Member States in 2024).

Notes. Values represent mean value of responding countries (low-income n=8; lower-middle-income n=16; upper-middle-income n=20; high-income n=19.

Source: WHO, 2025 (2).

In and out of psychiatric hospitals, the range of interventions available for mental health care is often severely limited, with few additions or alternatives to biomedical-based care available. In 2024, WHO Member States responding to the Mental Health Atlas 2024 survey reported that pharmacological interventions were much more widely available than psychosocial interventions *(2)*. The largest gaps were found in high-income countries: 80% of high-income countries responding to the 2024 Mental Health Atlas survey reported providing pharmacological interventions at primary care facilities; but only 30% provided psychosocial interventions there. In LMICs, the gap in availability between different types of interventions was much smaller, but that is because neither type is widely provided in primary health care.

In many countries mental health care systems also fail to provide the full range of social support that people living with mental health

conditions can require. In 2024, a large majority (87%) of responding high-income countries reported organizing income support to people with mental health conditions, compared with 11% of low-income countries and 19% of lower-middle-income countries *(2)*.

Other types of critical social support – including housing, employment, education and legal support – are scarce almost everywhere. Fewer than half of all responding countries reported providing any of these types of support; and only 18% reported providing all of them *(2)*. Social care support was the most frequently reported type of support, available in 72% of 144 responding Member States. Housing was the least reported available form of support globally (39%), but especially so in lower-middle and low-income countries (6% and 11% respectively).

5 Conclusion

This report draws on the latest epidemiological and system-level data to outline the state of mental health and mental health systems in the world. It confirms that mental health needs remain vast and ubiquitous; and it shows that responses remain grossly insufficient and inadequate.

Mental disorders affect more than a billion people across all regions and demographics and cause immense human suffering. They are the leading cause of disability while suicide remains a major cause of death. The economic consequences are enormous, with productivity losses significantly outstripping costs of care. Yet all over the world – but especially in LMICs – mental health systems remain under-resourced, fragmented, inequitable and often inaccessible.

These data are more than numbers. They are a wake-up call. In 2025, more than halfway to the Sustainable Development Goals deadline of 2030, the world remains off track to meet target 3.4, which includes promoting mental health and well-being as a core component alongside reducing by one third premature mortality from noncommunicable diseases and suicide.

Without smart, accelerated and coordinated action, hundreds of millions will continue to suffer unnecessarily, and the broader goals of sustainable development will remain out of reach.

This update provides essential data to guide national and global dialogue. It highlights where progress is being made and where critical gaps persist. It is a useful and important tool for policy-makers, implementers and advocates alike.

Photo credit (previous page): Schoolboy standing in doorway in village near Tonle Sap, Cambodia. © Getty Images / Hadynyah

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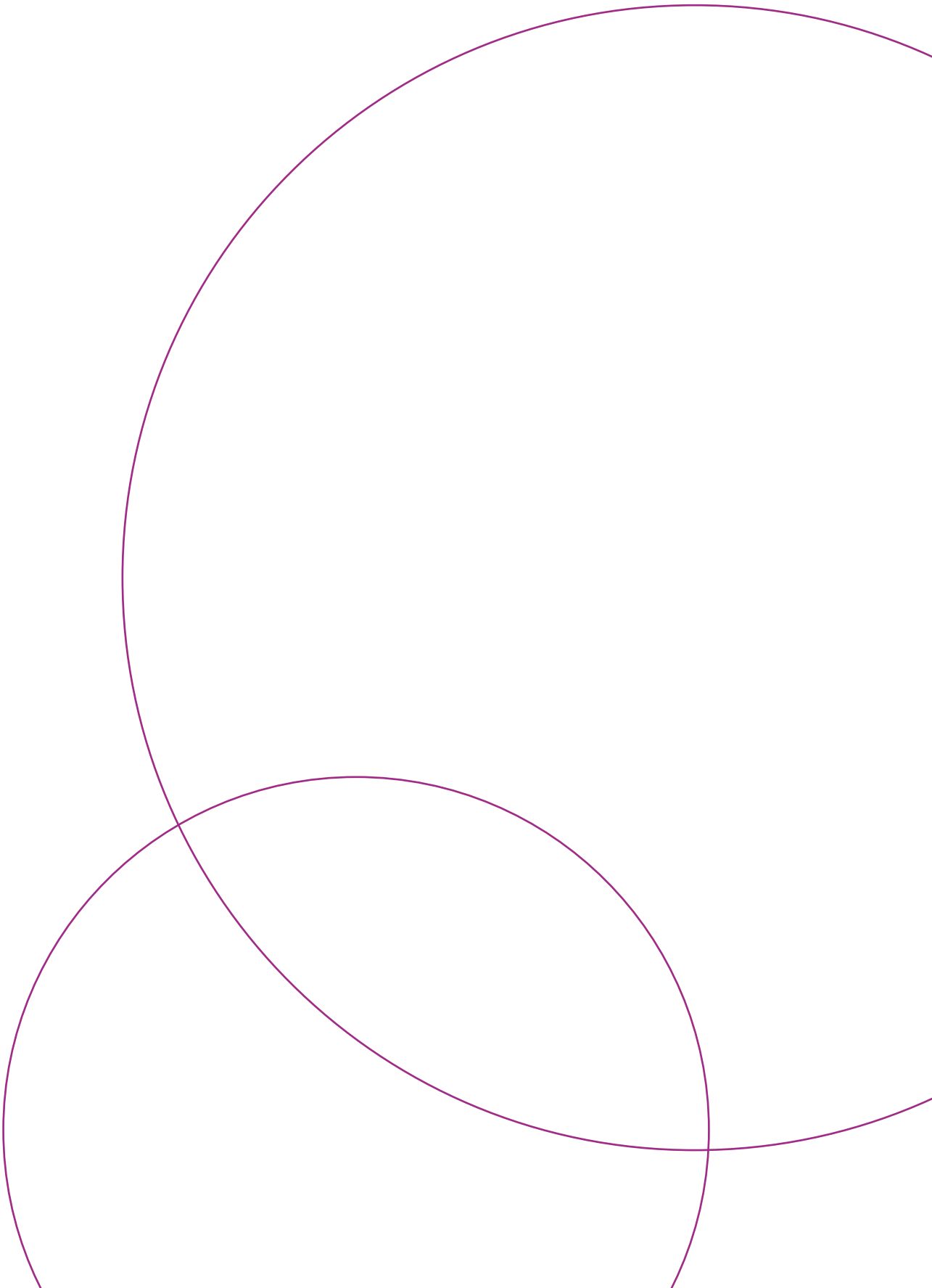

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